

MEDICAID EXPANSION & FEDERAL WAIVERS

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House Bill 4714 (Substitute S-9, as amended)

Sponsor: Rep. Matt Lori

House Committee: Michigan Competitiveness

(Enacted as PA 107 of 2013)

Senate Committee: Government Operations

Complete to 8-29-13

A SUMMARY OF HOUSE BILL 4714 AS PASSED BY THE SENATE

The bill would provide for the expansion of the state Medicaid program as permitted under the federal Affordable Care Act, effective on January 1, 2014, and would require the state to seek waivers from the federal government to allow modifications to the Medicaid program that would accompany the expansion (i.e., the increased number of eligible individuals). The bill also contains numerous amendments to the program that would apply whether or not the waivers were obtained and whether or not Medicaid eligibility was expanded.

Medicaid Expansion (Sec. 105D and Sec. 106)

The bill would amend the Social Welfare Act to allow adults less than 65 years of age with an annual income level up to 133% of federal poverty guidelines¹ to enroll in the medical assistance program (Medicaid) unless:

(1) The state Department of Community Health (DCH) is unable to obtain a federal waiver from the US Department of Health and Human Services meeting certain criteria established in the bill; or

(2) Federal government matching funds for the program were reduced below 100% and annual state and other nonfederal savings associated with the implementation of the program were not sufficient to cover the reduced federal match. The DCH would have to determine (and the State Budget Office approve) how state and other savings are to be calculated, by June 1, 2014.

State Savings

The term "state savings" used above means any state fund net savings, (calculated as of the closing of the financial books of DCH at the end of each fiscal year) that result from the Medicaid expansion program. The savings are to result from a reduction in spending from the following state fund accounts: adult benefit waiver, non-Medicaid community mental health, and prisoner health care. Any identified savings from other state fund

¹ For an individual, the federal poverty threshold for 2013 is \$11,490, so 133% would be about \$15,280; for a family of four the threshold is \$23,550, so 133% would be about \$31,320. The expansion could result in an additional 400,000 enrollees initially. For additional information, see the background information in the **Fiscal Impact** section.

accounts would have to be proposed to the Appropriation Committees of the House and Senate.

Savings Directed to Roads and Risk Reserve Fund

The bill stipulates that it is the intent of the Legislature that for the fiscal year ending September 30, 2014 only, \$193 million of the state savings (the current estimate for total net savings) be deposited in the Roads and Risks Reserve Fund. That fund was created by Public Act 59 of 2013, the FY 2013-24 general omnibus appropriation bill with an initial balance of \$230 million. Under that bill, funds may only be spent from the Roads and Risks Reserve Fund upon appropriation. One-half of the reserve funds are available for appropriation for roads effective October 1, 2013. It is the stated intent of the Legislature that the balance of the reserve funds will be appropriated for roads effective February 1, 2014, if those funds have not been appropriated for other purposes prior to that date.)

Two Waivers

The bill is understood to require two waivers to be sought. The first waiver would be the Medicaid expansion request described in more detail beginning on Page 4 of this summary, under which the expanded program could begin as early as January 1, 2014, and would feature cost-sharing requirements (including copays) and special cost-sharing accounts into which the newly eligible enrollees would contribute, as well as other criteria. The newly eligible would have to contribute up to 5% of income for cost-sharing requirements; however, contributions could be reduced if certain healthy behaviors were being addressed.

A second waiver, for which approval would have to be received from the federal government by December 31, 2015, would allow the state to require individuals who had received medical assistance coverage for 48 months under the expanded program and who were between 100% and 133% of the federal poverty guidelines to choose one of the following options:

- (1) Purchase private insurance coverage through an American health benefit exchange operated in the state by changing their Medicaid eligibility status so as to be considered eligible for federal advance premium tax credit and cost-sharing subsidies from the federal government; or
- (2) Remain in the Medicaid program but increase cost-sharing requirements up to 7% of income (from the maximum of 5% cited earlier), and require minimum contributions of 3.5% (instead of 2%), with reductions again possible for certain healthy behaviors. This would be the default option if an enrollee failed to choose one of the two options by the deadline, as determined by the DCH.

The DCH would have to notify enrollees 60 days before the end of the enrollees' 48th month that coverage under the current program was no longer available to them and that they must choose one of the two items cited above.

If Second Waiver not Approved, not Renewed, or Canceled

If this second waiver were not approved by December 31, 2015, medical coverage would no longer be provided to the expanded population. The DCH would have to notify enrollees by January 31, 2016, that coverage would terminate on April 30. If a waiver were approved but required subsequent renewal and the renewal request were not approved, or if a waiver request were canceled, the department would have to provide four months' advance notice of the termination of coverage.

The bill specifies that the provisions of the waivers, and the choices above, would not apply to individuals cited under 42CFR 440.315 of federal law. That section describes certain exempt individuals, e.g., pregnant women, the blind or disabled, individuals entitled to benefits under Medicare, the terminally ill in hospice care, parent or caretaker relatives, and the medically frail, among others. See: <http://www.law.cornell.edu/cfr/text/42/440.315>

Individuals Eligible for both Medicaid and Medicare

The bill also requires the DCH to pursue any and all necessary waivers to enroll individuals eligible for both Medicaid and Medicare into the four integrated care demonstration regions² beginning July 1, 2014.

Termination of Expansion If Waiver Approval Not Received

If the DCH did not receive approval for both of the waivers before December 31, 2015, the Medicaid expansion program would be terminated.

No Penalty if Waivers Rejected

The DCH must request written documentation from the federal government that if the waivers are rejected causing the Medicaid program to revert to the previous eligibility requirements (excluding any waivers that have not been renewed), there would be no financial federal funding penalty to the state associated with the implementation and subsequent cancellation of the expansion program. If the DCH does not receive this documentation by December 31, 2013, it could not implement the program. Also, if the second waiver were not approved, then by January 31, 2016, the DCH would have to notify enrollees that the program was to be terminated on April 30, 2016. The notification must state that the failure of the federal government to approve the waiver is the reason for the termination of enrollment.

² "The Michigan Department of Community Health (MDCH) is developing a demonstration program to strengthen services and supports for individuals who are dually eligible for Medicare and Medicaid. In the demonstration, services and supports for persons who are dually eligible will be delivered by newly created Integrated Care Organizations (ICOs) and currently existing Prepaid Inpatient Health Plans (PIHPs). ICOs will be responsible for the provision of all physical health, long term care, and pharmacy services, while PIHPs will be expected to cover behavioral health and rehabilitative services for people with developmental disabilities, mental illness, or substance use issues. The ICOs and PIHPs will be connected through the Care Bridge, a care model that requires the coordination of services and supports between the two entities and involved providers." (From DCH website)

Copy of Approved Waiver to Legislature

The DCH would have to submit a written copy of approved waiver provisions to the Legislature for review not more than seven calendar days after receiving each of the official waiver-related written correspondence from the US Department of Health and Human Services.

Waiver One: the Expansion Waiver

Under the bill, the DCH is required to seek a waiver from the US Department of Health and Human Services to do all of the following (without jeopardizing federal match dollars or otherwise incurring federal financial penalties and upon approval of the waiver):

- Enroll individuals eligible under the federal Affordable Care Act, who met citizenship requirements, and who are otherwise eligible for the Medicaid program into a contracted health plan (i.e., managed care organization) that provides for an account into which money from any source can be deposited to pay for incurred health expenses, including but not limited to copays. (The bill cites as possible sources: the enrollee, the enrollee's employer, and private or public entities.) The account would be administered by DCH and could be delegated to a contracted health plan or a third party administrator, as considered necessary. The DCH could not begin enrollment until January 1, 2014, or until the waiver was approved by the US Department of Health and Human Services, whichever was later. (A "contracted health plan" is defined to mean a managed care organization with whom the state has contracts to provide or arrange for comprehensive health care services authorized under the act.)
- Ensure that contracted health plans track all enrollee copays incurred for the first six months that an individual is enrolled in the program and calculate the average monthly copay experience for the enrollee. The enrollee would be required to remit each month the average copay amount calculated by the health plan into the enrollee's account. The average copay amount would be adjusted at least annually to reflect changes in the enrollee's copay experience.

The DCH would have to ensure that each enrollee received quarterly statements that included expenditures from the account, account balance, and the cost-sharing amount due for the following three months. DCH must pursue a range of consequences for enrollees who consistently failed to meet their cost-sharing requirements. The department must report its plan of action for such enrollees to the Legislature by June 1, 2014.

- Give the newly eligible enrollees a choice in choosing among contracted health plans.
- Ensure that all newly eligible enrollees have access to a primary health care practitioner licensed, registered, or otherwise authorized to engage in a health care profession in the state and to preventive services. The DCH must ensure that the contracted health plans have procedures to ensure that the privacy of enrollees is protected in accordance with federal law. The department would have to require that

all new enrollees be assigned and have the initial appointment scheduled with their primary care practitioner within 60 days of initial enrollment. The department would have to monitor and track contracted health plans for compliance and take such compliance into account in any incentive programs.

- Require enrollees with annual incomes between 100% and 133% of federal poverty guidelines to contribute not more than 5% of income for cost-sharing requirements. Cost-sharing includes copays and contributions made into the enrollee accounts. Such contributions would not apply for the first six months of enrollment. Required contributions to an account to pay for incurred health expenses would be 2% of income. Notwithstanding this minimum, required contributions could be reduced by the contracting health plan. However, reductions could only occur if healthy behaviors were being addressed, as attested to by the contracted health plan based on uniform standards developed by DCH in consultation with the health plan.

The healthy behavior standards must include (although they are not limited to) completing a DCH-approved annual health risk assessment to identify unhealthy characteristics. The bill lists such characteristics as alcohol use, substance abuse disorders, tobacco use, obesity, and immunization status. Copays could be reduced if healthy behaviors are met but not until annual accumulated copays reach 2% of income. However, copays for specific services could be waived by the health plan if the desired outcome is to promote greater access to services that prevent the progression of, and complications related to, chronic diseases.

If an enrollee becomes ineligible for medical assistance, the remaining balance in the account would be returned in the form of a voucher for the sole purpose of purchasing private insurance.

- Design and implement, by July 1, 2014, a copay structure that encourages use of high-value services while discouraging low-value services, such as non-urgent use of emergency rooms.
- Inform enrollees during the enrollment process about advance directives and require them to complete a DCH-approved advance directive on a form that includes an option to decline. The advance directives would be transmitted to the Peace of Mind Registry Organization for inclusion in the registry.
- Develop incentives, by April 1, 2015, for enrollees and providers who assist the DCH in detecting fraud and abuse in Medicaid. The DCH must provide a report that includes the type of fraud detected, the amount saved, and the outcome of the investigation to the Legislature.
- Allow for services provided by telemedicine from a practitioner authorized under the Public Health Code to engage in a health profession where the patient is located.

Treasury and Lottery Intercepts

DCH would have to coordinate with the Department of Treasury to create a procedure for offsetting the state tax refunds of an enrollee who owed a liability to the state of past due uncollected cost-sharing, as allowable by the federal government. The procedure would have to include a guideline that DCH submit to the Department of Treasury, not later than November 1 each year, all requests for the offset of state tax refunds claimed on returns filed or to be filed for that tax year. (Any nonpayment of required cost-sharing would be considered a liability to the state under the Revenue Act.)

Also, any nonpayment of required cost sharing would be considered a current liability to the state under the Lottery Act and would be subject to the usual procedures for such liabilities.

Recommendations on How to Determine Income Levels and Enrollment

The director of the DCH would have to submit a recommendation to the Senate Majority Leader, the Speaker of the House, and the State Budget Office on how to most effectively determine Medicaid eligibility and enrollment for all applicants by January 1, 2015. DCH could delegate the function to another state agency, perform the function directly, or contract with a private or nonprofit entity, consistent with state law.

Vendors: Cost Saving & Health Improvement

DCH must make available at least three years of state Medicaid program data, without charge, to any vendor considered qualified by the department who indicated interest in submitting proposals to contracted health plans in order to implement costs savings and population health improvement opportunities through the use of innovative information and data management technologies.

Any program or proposal to health plans would have to be consistent with the state's goals of improving health; increasing the quality, reliability, availability, and continuity of care; and reducing the cost of care of the newly eligible enrollees. The use of data for the purpose of assessing the potential opportunity and subsequent development and submission of formal proposals to contracted health plans would not be considered a cost or contractual obligation to the DCH or the state.

The following provisions would apply whether or not either or both of the waivers requested were approved, the Patient Protection and Affordable Care Act was repealed, or the state terminated or opted out of the program being established in the bill.

Enrollment in Contracted Health Plans

By September 30, 2015, the DCH would have to develop and implement a plan to enroll all existing fee-for-service enrollees into contracted health plans if allowable by law, if Medicaid is the primary payer and if that enrollment is cost effective. This would include all newly eligible enrollees. The DCH must include contracted health plans as the mandatory delivery system in its waiver request.

Additional Integration into Managed Care

By September 30, 2015, the DCH would have to identify all remaining populations eligible for managed care, develop plans for their integration into managed care, and provide recommendations for a performance bonus incentive plan mechanism for long-term care managed care providers consistent with other managed care performance incentive plans.

By that same date, the DCH would have to make recommendations for a performance bonus incentive plans for long-term care managed care providers of up to 3% of their Medicaid capitation payments, consistent with other managed care performance bonus incentive plans. These payments would have to comply with federal requirements and be based on measures that identify the appropriate use of long-term care services and that focus on consumer satisfaction, consumer choice, and other appropriate quality measures applicable to community-based and nursing home services. Where appropriate, these quality measures must be consistent with quality measures used for similar services implemented by the integrated care for duals demonstration project.

Performance Bonus Incentive Pool

Beginning October 1, 2015, the DCH must withhold, at a minimum, 0.75% of payments to health plans, except specialty prepaid plans, for the purpose of expanding the existing performance bonus incentive pool. [Under current DCH policy a portion of capitated payments (.19%) made to Medicaid HMOs is withheld for deposit in this pool; the money in the pool is used to create incentives for providers to engage in certain behaviors.] Distribution of funds from the pool would be contingent on the health plan's completion of the required performance or compliance metrics.

By October 1, 2015, the performance bonus incentive pool for contracted health plans that are not specialty prepaid health plans must include inappropriate utilization of emergency departments, ambulatory care, contracted health plan all-cause acute 30-day readmission rates, and generic drug utilization (when such an alternative exists for a branded product and consistent with the Public Health Code), as a percentage of the total.

These measurement tools must be considered and weighed within the six highest factors used in the formula.

Performance Bonus Incentive Pool (Specialty Prepaid Health Plans)

Beginning October 1, 2015, the DCH must withhold, at a minimum, 0.75% of payments to specialty prepaid health plans for the purpose of establishing a performance bonus incentive pool. Distribution of funds would be contingent on a plan's completion of required performance or compliance metrics, including at a minimum: partnering with other plans to reduce nonemergent emergency department utilization, increased participation in patient-centered medical homes, increased use of electronic health records and data sharing with other providers, and identification of enrollees who may be eligible for services through the Veterans Administration.

Actuarial Soundness of Capitated Payments

The bill requires the DCH to ensure that all capitated payments made to contracted health plans are actuarially sound.

Pharmaceutical Benefit

By September 30, 2016, the DCH would have to implement a pharmaceutical benefit that utilized copays at appropriate levels allowable by the Centers for Medicare and Medicaid Services to encourage the use of high-value, low cost prescriptions, such as generic prescriptions when such an alternative existed for a branded product and 90-day prescription supplies, as recommended by the enrollee's prescribing provider and as is consistent with the state's Public Health Code.

Uncollected CoPays

The DCH must work with providers, contracted health plans, and other departments as needed to create processes that reduce the amount of uncollected copays and reduce the administrative cost of collecting cost-sharing. To this end, a minimum of 0.25% of payments to contracted health plans would be withheld for the purpose of establishing a cost-sharing compliance bonus pool beginning October 1, 2015. The distribution of funds from the cost-sharing compliance pool would be based on the contracted health plans' success in collecting cost-sharing payments. The DCH would be required to develop the methodology for distribution of these funds.

Financial Incentives

By January 1, 2014, the DCH in collaboration with the contracted health plans and providers would have to create financial incentives for all of the following: (1) contracted health plans that meet specified population improvement goals; (2) providers who meet specified quality, cost, and utilization targets; and (3) enrollees who demonstrate improved health outcomes or maintain healthy behaviors as identified in a risk assessment by their primary health care practitioner.

Administrative Costs

The DCH would have to maintain administrative costs at a level of not more than 1% of DCH's appropriation for the state Medicaid program. These costs would be capped at the total administrative costs for the fiscal year ending September 30, 2016, except for inflation and project-related costs required to achieve medical assistance net General Fund savings.

Cost-Sharing Procedures and Compliance Metrics

By October 1, 2015, the DCH would have to establish uniform procedures and compliance metrics for utilization by the health plans to ensure that cost-sharing requirements were being met. This would include ramifications for the plans' failure to comply with performance or compliance metrics.

Substance Abuse

The DCH would have to measure contracted health plan or specialty prepaid health plan performance metrics on application of standards of care as they relate to appropriate treatment of substance abuse disorders and efforts to reduce such disorders.

Hospital Charges

A hospital participating in Medicaid must accept 115% of Medicare rates as payments in full from an uninsured individual with an annual income level up to 250% of the federal poverty guidelines.

Michigan Health Care Cost and Quality Advisory Committee

The directors of the Departments of Community Health and of Insurance and Financial Services (DIFS) must establish a Michigan Health Care Cost and Quality Advisory Committee consisting of eight or more members. Members would include the two directors (or their designees), one staff member from each department, and the chairs and minority vice chairs of the House and Senate Health Policy Committees (or their designees). Those committee members would elect a chairperson and appoint additional members need to perform committee duties.

The advisory committee would have to issue a report by December 31, 2014, with recommendations on the creation of a database on health care costs and health care quality in the state. The report would be transmitted to the Legislature and made available on the DCH and DIFS websites.

The report would have to include at least: a review of existing efforts across the US to make health care cost and quality more transparent; a review of proposed legislation in Michigan to make health care costs and quality more transparent; a review of any existing standards governing the operation of similar databases; a consideration of both price and quality of health care services rendered in the state; transparency and privacy issues; the possible impact of uncompensated care on commercial insurance rates; and other methods to accurately estimate the uncompensated care impact on commercial insurance rates.

Studies and Reports

Uncompensated Care

The bill specifies that the Medicaid expansion program is being created in part to extend health coverage to the state's low-income citizens and to provide health insurance cost relief to individuals and to the business community by reducing the cost shift related to uncompensated care. (Uncompensated care does not include courtesy allowances or discounts given to patients.) The Medicaid hospital cost report would be part of the uncompensated care definition and calculation. In addition to that report, the DCH would have to collect and examine other relevant financial data for all hospitals and evaluate the impact that providing medical coverage to the expanded population of enrollees has had on the actual cost of uncompensated care. This would be reported for all hospitals in the state.

By December 31, 2014, the DCH would have to make an initial baseline uncompensated care report containing at least the data described above to the Legislature, and each December 31 after that would have to make a report regarding the preceding fiscal year's evidence of the reduction in the amount of the actual cost of uncompensated care compared to the initial baseline report. The baseline report would use fiscal year 2012-13 data.

Adjustments to Disproportionate Share Payments

Based on the evidence of the reduction in the amount of the actual cost of uncompensated care borne by the hospitals in Michigan, beginning April 1, 2015, the DCH must proportionately reduce the disproportionate share payments to all hospitals and hospital systems for the purpose of producing General Fund savings. The DCH would have to recognize any savings from this reduction by September 30, 2016. All required reports would have to be made available to the Legislature and be easily accessible on the DCH website.

Impact on Insurance Rates

The Department of Insurance and Financial Services would be required to examine the financial reports of health insurance companies and evaluate the impact that providing coverage to the expanded population has had on uncompensated care as it relates to insurance rates and rate filings, as well as its net effect on rates overall. DIFS must consider the evaluation in the annual approval of rates. By December 31, 2014, DIFS must make an initial baseline report to the Legislature regarding rates, and each December 31 after that must make a report regarding the evidence of the change in rates compared to the initial baseline report. All the reports must be made available to the Legislature and be made available and easily accessible on the department's website.

Improving Medicaid's Effectiveness and Performance

DCH would have to explore and develop a range of innovations and initiatives to improve the effectiveness and performance of the Medicaid program and to lower overall health care costs in the state. The department would have to report the results of these efforts to the Legislature and to the House and Senate Fiscal Agencies by September 30, 2015. The report would have to be available on the departmental website. The DCH would have to pursue a broad range of innovations and initiatives, to include at a minimum the following:

- The value and cost effectiveness of optional Medicaid benefits as described in federal statute.
- The identification of private sector (primarily small business) health coverage benefit differences compared to the Medicaid program services, and justification for the differences.
- The minimum measures and data sets required to effectively measure the Medicaid program's return on investment for taxpayers.
- Review and evaluation of the effectiveness of current incentives for contracted health plans, providers, and beneficiaries, with recommendations for expanding and refining

- incentives to accelerate improvement in health outcomes, healthy behaviors, and cost effectiveness, and review of the compliance with required contributions and copays.
- Review and evaluation of the current design principles that serve as the foundation for the state's Medicaid program to ensure the program is cost effective and that appropriate incentive measures are used. The review must include, at a minimum, the auto-assignment algorithm and performance bonus incentive pool.
 - The identification of private sector initiatives used to incent individuals to comply with medical advice.

Symposium on Emergency Department Utilization

By November 30, 2013, the DCH must convene a symposium to examine the issues of emergency department overutilization and improper use. By December 31, 2014, the DCH would have to submit a report to the Legislature identifying the causes of overutilization and improper use and specific best practice recommendations for decreasing overutilization and improper use of emergency departments and how those best practices were being implemented. The department would have to contract with an independent third party vendor to review the various required reports on uncompensated care (and other data as needed) and develop a methodology for measuring, tracking, and reporting medical cost and uncompensated care cost reduction or rate of increase reduction and their effect on health insurance rates, along with recommendations for ongoing annual review. The final report and recommendations are to be submitted to the Legislature by September 30, 2015.

Definition of "Legislature"

For the purpose of submitting reports and other information and data only, the term "Legislature" refers to the Senate Majority Leader, Speaker of the House, the chairs of the Senate and House Appropriations Committees, the chairs of the Senate and House Appropriation Subcommittees on the Department of Community Health Budget, and the chairs of the Senate and House Standing Committees on Health Policy.

Appropriations

The bill would make appropriations to the Departments of Community Health and Corrections for FY 2013-2014. They are detailed on a chart attached to the summary.

FISCAL IMPACT:

Background Information

The FY 2013-14 Executive Budget proposed to incorporate the Medicaid expansion included under the federal Affordable Care Act into Michigan's Medicaid Program and state budget, thereby expanding program eligibility to 133% of the federal poverty level, which could be as many as 400,000 enrollees initially. Concurring with the proposed budget action would result in an estimated \$1.7 billion in federal funds being received by the state in FY 2013-14 and an estimated \$193.0 million in GF/GP savings due to 100% federal payment of certain costs currently being financed with state funds. Those amounts are 3/4-year amounts and would increase in FY 2014-15.

The initial state budget approved by the Legislature for FY 2013-14 does not incorporate the proposed expansion. Funding adjustments would, however, be enacted through this bill.

Additional information on the projected fiscal impact of the Executive's proposed Medicaid expansion is available in this HFA memorandum, although estimates have been slightly revised since that time:

<http://www.house.mi.gov/hfa/PDFs/Medicaid%20Expansion%20Memo%20Mar4.pdf>

Summary

HB 4714 would apply certain conditions to the Medicaid expansion proposed under the Executive Budget and includes other Medicaid program modifications. Several changes to the Medicaid program delineated in the bill are premised on the approval of two federal waivers, which contain several requirements that may or may not be agreed to by the federal Centers for Medicaid and Medicare.

The bill requires that the waiver conditions be that if federal financing falls below 100%, annual state savings and other nonfederal net savings associated with the expansion must completely provide for the State match. The Affordable Care Act stipulates that 100% federal funding will no longer be available beginning January 1, 2017. (Beginning in 2017, federal financing would drop to 95% and then drop to 90% beginning in 2021.) State savings will continue, however, due to federal match being applied toward certain mental health-related and other costs currently funded solely by the state. Current projects indicate the savings will exceed the match costs through FY 2019-20. However, the precise year in which the match costs will begin to exceed the state savings is subject to a number of uncertainties.

The bill would make appropriations to the Departments of Community Health for medical services reform, mental health reform, and administration, and would make negative appropriations to reflect savings—for Plan First Family Planning, Medicaid adult benefits (physical and mental health), and community mental health non-Medicaid services. The appropriations would be derived from federal revenues and state-restricted revenues and would reflect a reduction in appropriations from state GF/GP revenue. The bill would also make a negative appropriation to the Department of Corrections. Overall, the reduction in revenue from GF/GP revenue would total just under \$193.0 million. (See the accompanying chart on page 17 for details.)

The proposed Medicaid expansion and conditions proposed under this bill are generally expected to have a positive fiscal impact on state-level health care costs, subject to a number of uncertainties and complexities described below.

The 1st Waiver

The first waiver indicated in HB 4714 requires the DCH to submit to the federal government a Medicaid expansion request which would cover the same population as

outlined in the Governor's plan which could begin as soon as January 1, 2014. The bill requires that the following conditions be included in the waiver request.

- Enroll this population into contracted health plans, of their choice, which provide for health savings account (HSA)-like accounts
- Ensure that enrollees have access to a primary care practitioner and to preventive services
- Require enrollees with annual incomes between 100-133% of the FPL to contribute not more than 5% of their income for medical care expenses (does not apply to the first 6 months of enrollment). Contributions may be reduced if enrollees meet certain health goals.
- Enrollees must be given the opportunity to complete an advanced directive
- Incentivize enrollees to assist the DCH in detecting Medicaid fraud and abuse
- Allow for services provided through telemedicine.

One of the largest impacts of this initial waiver would be the 100% federal funding for health care services of an additional 400,000 Medicaid enrollees. Assuming that the Medicaid qualifying FPL is increased to 133% on January 1, 2014, the State is estimated to receive \$1.7 billion of federal dollars in FY 2013-14 and \$2.2 billion in FY 2014-15, assuming 100% funding by the federal government. These additional revenues in the health care economy will likely spill over into Michigan's other economic sectors, but the overall economic impact cannot be quantified.

Related to the potential influx of \$1.7 to \$2.2 billion is the effect on the amount collected by the Department of Treasury of Health Insurance Claims Assessment revenue. The bill includes an estimated increase of \$13.1 million in FY 2013-14 resulting from additional taxable claims which are expansion based.

Existing state GF/GP support for physical and mental health programs have been identified that would be reduced due to the Medicaid expansion:

- Non-Medicaid Mental Health
- Out-prison healthcare for incarcerated individuals (Corrections budget)
- The Adult Benefits Waiver
- PlanFirst! Family Planning Waiver

The non-Medicaid Mental Health program would experience the largest amount of savings. Approximately \$153.0 million GF/GP would no longer be necessary to support the program as more individuals would qualify for Medicaid under the expanded FPL and would be 100% federally covered beginning in 2014. Including savings from the other programs listed, total estimated indirect GF/GP savings would be \$192.8 million GF/GP in FY 2013-14.

An additional impact of the expanded Medicaid population would be the amount of uncompensated health care borne by providers. It is assumed that the additional federal health care funding will lower provider's uncompensated care; some portion of those costs/losses are typically being shifted to private health insurance purchasers. The

Department of Community Health has indicated that an insured family, or employer, could realize a \$400 reduction in annual health care insurance cost through the reduction of uncompensated care costs brought about by extending insurance coverage to this new population.

The State of Michigan provides health insurance coverage to approximately 47,500 active state employees through state-sponsored health insurance. If the State could save \$400 in annual health insurance costs per employee, then the amount would be approximately \$19.0 million annually. No estimate is provided on savings to local units of government.

Related to potential uncompensated care savings is a possible reduction in the State's support of the disproportionate share hospital (DSH) pool. Of the \$428.0 million FY 2012-13 DSH pool, \$9.0 million GF/GP is used as partial match for \$45.0 million sub-pool. These payments are made to hospitals that serve a high percentage of low-income patients that are either uninsured or are covered by Medicaid, State Medical Programs or Children's Special Health Care Services.

It may be decided at some point that the \$45.0 million DSH pool be reduced given lower uncompensated care costs resulting from the expansion. The ACA includes a planned reduction in the gross pool size and anticipated the federal savings to help fund the ACA. Language in the bill requires the DCH to make proportionate reductions in DSH payments to hospitals based on the reported reductions in uncompensated care. When and how much the State changes the level of the \$45.0 million pool is indeterminate.

The proposed bill also requires that enrollees with annual incomes between 100% and 133% of the FPL make contributions of up to 5% for their cost sharing requirements. Assuming that the average annual income is \$13,000, a 5% contribution is \$650. Multiplied by 150,000, the estimated number of affected individuals, the amount is \$97.5 million annually. As long as the federal government is financing the program entirely, savings would not accrue to the State. The 5% may be a combination of copays and premiums or other cost sharing concepts. It is generally understood that copays may be cost savings to the State or federal government by lowering provider rates, but that a large share of those savings end up being a cost shift to providers that cannot collect all of the copay amounts. Required contributions to an account used to pay for health expenses can be reduced to if healthy behaviors are met. Required contributions can be no less than 2% of income.

Improving the health of an additional 400,000 Michigan residents would be expected to result in short and long-term savings in health care costs by investing in preventive care and minimizing expensive emergency room care. A healthier working population has positive business economic impacts such as greater worker productivity and lower absenteeism both resulting in a better business climate. The magnitude of those impacts, however, cannot be quantified.

The 2nd Waiver

A second waiver, to be approved by December 31, 2015, would require that after 48 months of cumulative Medicaid eligibility the expansion population with annual incomes between 100% to 133% of the FPL would have to make the choice either to change their Medicaid program eligibility status, in accordance with federal law, to purchase private insurance coverage through the exchange and be eligible for federal subsidies, or, remain in the Medicaid program but pay up to 7% of their annual income in cost sharing. The contributions to an account used to pay for incurred health expenses can be reduced if healthy behaviors are addressed.

The population expected to be within the 100% to 133% FPL threshold is estimated to be 150,000. It is difficult to anticipate the federal subsidies available and the cost of insurance of the yet-to-be-developed exchange. Assuming that the average annual income is \$13,000 for this population, a 7% contribution is \$910. Multiplied by 150,000, the estimated number of affected individuals, the amount is \$136.5 million annually, assuming all affected individuals are able to and choose to pay the contribution in order to have health insurance coverage. If this waiver is not approved by December 15, 2015, then the expansion population is no longer covered and the DCH shall notify enrollees by January 1, 2016, that the program shall be terminated on April 30, 2016.

Other Program Modifications

The bill requires any hospital participating in Medicaid to accept 115% of Medicare rates as payments in full from an uninsured individual with an annual income level up to 250% of the federal poverty guidelines. This action may give financial relief to poor individuals but may be a disincentive for some hospitals to participate in the Medicaid program.

By September 30, 2016, the DCH is required to have developed and implemented a plan to enroll all fee-for-service enrollees into contracted health plans if allowable by law, if the medical assistance program is the primary payer and enrollment is cost effective. Currently, the majority of Medicaid enrollees not included in a managed care plan are those receiving long-term care services and the "spend-down" population. The DCH is currently working with the federal government to manage the care of the dual eligible population, those individuals who have health care coverage under both Medicaid and Medicare. It is generally assumed that savings would be derived by enrolling more Medicaid eligibles into a managed care system.

The bill requires the DCH to work with providers, contracted health plans, and other departments to create a process to reduce the amount of uncollected copays and deductibles. There will be a financial cost to the State or subcontractor for copay and premium collections that probably would be covered by the collected amounts.

The DCH and the Department of Insurance and Financial Services (DIFS) are to prepare reports related to the effects of the Medicaid expansion on uncompensated care costs and

health insurance rates, respectively. There will be indeterminate administrative expenses related to the preparation of these reports.

The bill also requires the DCH to provide a report that will assess the value and cost effectiveness of the current Medicaid program, incentives for Medicaid HMOs and beneficiaries, measures used to calculate return on investment and a comparison of the differences between primarily small business and Medicaid health care benefits. There will be some cost to the Department to construct this report, but may result in savings depending on the outcome of the analysis.

By January 1, 2014, the DCH, contracted health plans, and providers are required to create financial incentives for contracted health plans that meet specified population improvement goals, for providers who meet specified quality and cost targets, and for enrollees who demonstrate improved health outcomes and maintain healthy behaviors. Although there would be costs to the State for these incentives, the aforementioned improvements should come with health care expenditure savings to the State.

The bill requires the DCH to ensure that all capitated payments made to contracted health plans are actuarially sound. The federal government requires actuarial soundness of Medicaid contracted health plans and there is a cost to the State for this assurance.

The DCH is required to maintain administrative costs at a level of not more than 1% of the DCH's state medical assistance program. The total administrative costs are capped at the level of year-end FY 2015-2016 expenditures. Exceptions are made for increases that generate Medicaid savings or for inflation. This cap on administrative expenses may hold down State costs, depending on implementation and the interpretation of the definition of administrative costs.

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■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.



HB 4714 (S-9) Appropriation Detail - Section 105E

The bill would make appropriations to the Departments of Community Health for Medicaid expansion increasing federal revenues by \$1.7 million and negative appropriations to generate GF/GP savings of \$192.7 million including both the Departments of Community Health and Corrections. (See the chart below for details.)

	FY 2013-14 Amounts			
	<u>Federal</u>	<u>Restricted</u>	<u>GF/GP</u>	<u>Total</u>
Department of Community Health (DCH)				
Medical Services Reform	\$1,395,876,600	\$0	\$0	\$1,395,876,600
Mental Health Reform	288,646,900	0	0	288,646,900
Plan First! Family Planning Waiver	0	0	(1,072,200)	(1,072,200)
Medicaid Adult Benefits Waiver (<i>Physical Health</i>)	0	0	(14,723,900)	(14,723,900)
Medicaid Adult Benefits Waiver (Mental Health)	0	0	(6,680,600)	(6,680,600)
Community Mental Health Non-Medicaid Services	0	0	(152,931,100)	(152,931,100)
<i>Health Insurance Claims Assessment (HICA) offset</i> Administration	0 20,000,000	13,145,000 0	(13,145,000) 20,000,000	0 40,000,000
DCH Subtotal:	\$1,704,523,500	\$13,145,000	(\$168,552,800)	\$1,549,115,700
Department of Corrections				
Prisoner Re-Entry Local Service Providers	\$0	\$0	(\$377,200)	(\$377,200)
Prisoner Re-Entry Department of Corrections Programs	0	0	(3,189,400)	(3,189,400)
Subtotal - Prison Re-Entry and Community Support:	0	0	(3,566,600)	(3,566,600)
Substance Abuse Testing and Treatment Services In Field Operations Administration	0	0	(8,066,100)	(8,066,100)
Prisoner Health Care Services In Health Care	0	0	(12,579,500)	(12,579,500)
DOC Subtotal:	\$0	\$0	(\$24,212,200)	(\$24,212,200)
Total Both Departments:	\$1,704,523,500	\$13,145,000	(\$192,765,000)	\$1,524,903,500