Colorado Medical Society

Position Paper

Medicaid

The Colorado Medical Society (CMS) supports efforts to create a streamlined Medicaid program that will promote state innovation and efficient use of funds, while maintaining the program's role as a safety net for the state's poorest and most vulnerable populations. A major challenge in restructuring the Medicaid program is to appropriately balance Colorado's interests in securing increased flexibility in light of fewer federal funds for Medicaid against the very real needs of the people that the Medicaid program is intended to serve, most of whom have no other means of access to health care coverage.

As compared to some state programs for which broad waivers have been granted, the State of Colorado has historically placed budgetary concerns over those of patient access and choice, reasonable provider reimbursement, and solvency of participating managed care entities. The result has been that recipients' access to quality medical care has been inadequate. The CMS believes that flexibility of the state government must be tempered by the need for accountability standards designed to ensure that Colorado programs fulfill Medicaid's objective of improving access to quality medical care and comply with fundamental protections embodied in the federal Medicaid Act. Such standards are also critical to assuring that the Colorado Medicaid program will have sufficient provider participation to meet the recipients' needs, without resorting to coercive approaches to securing that participation. Moreover, with Colorado's interest in moving the Medicaid population into managed care systems in hopes of achieving savings, safeguards are necessary to ensure that Medicaid recipients receive high quality, cost effective care and are treated fairly. CMS opposes the transfer of all Medicaid eligibles into capitated Health Maintenance Organization (HMO) managed care at this time. Independent studies by the Urban Institute of Washington, D.C., have found minimal cost savings in such an approach when conversion occurred from a totally unmanaged Medicaid system. With the success of the Colorado Primary Care Physician Program, we believe that additional cost savings might be negligible. Additionally, capitated HMO managed care has not had experience in caring for the disabled or nursing home populations, which combined, account for the majority of costs in the current Medicaid program. Concern also should be raised in breaking ongoing patient relationships with physicians and providers of ancillary services in a patient population that often finds it difficult to develop such relationships.

In addition, it is essential that state reforms are enacted that facilitate the purchase of private health insurance for Coloradans who do not qualify for Medicaid. Colorado should consider a buy-in program that allows low-income individuals to participate in the state Medicaid program.

The CMS supports the application of the following principles under any restructuring of Medicaid, whether by block grant program, a continuation of the current program, or any other alternative.

<u>Income-Based Eligibility with a State Floor</u>

Because of limited federal and state resources for Medicaid, Colorado will face difficult choices regarding who will be eligible for Medicaid coverage. An eligibility floor is essential to ensure that Colorado will not cut coverage for the poorest Coloradans, which would add to the growing numbers of uninsured and exacerbate cost-shifting and uncompensated care. At a minimum, Colorado must provide Medicaid coverage to those whose incomes fall below an eligibility requirement set at, or at some percentage of, the federal poverty level. Colorado should maintain current efforts in covering children to age 18, pregnant women and dual Medicaid-Medicare

eligibles. In addition, since there may be a large number of Colorado residents who have incomes which are higher than the established eligibility floor but still have no health care coverage, Colorado should allow those with low incomes that do not meet eligibility requirements to buy into Medicaid. In order to discourage Medicaid recipients from not earning income in order to retain eligibility, a mechanism should be created on a sliding scale dependent on the individual's income to provide proportionate partial funding for payment of such Medicaid premiums.

Minimum Adequate Benefits

Basic standards of uniform minimum adequate benefits should be established for Medicaid recipients. Without such standards, Colorado may see restructuring which results in inadequate coverage for recipients and increased uncompensated care costs for our state. Colorado should have the flexibility to provide additional benefits to recipients as we choose, using our own resources.

Access Standards

The desire to have the freedom to tailor our Medicaid program must be balanced against the necessity for more active legislative oversight if Colorado's management of the Medicaid program results in significantly diminished access and/or quality of care. To allow for this, the legislature should require the development of certain "access standards" by which to measure Medicaid eligibles' access to providers and covered health care services. These standards must include guidelines for adequate provider reimbursement levels, which have a demonstrated link to recipients' access to medical care. In addition to such guidelines, changes in uncompensated care which might reflect an inadequacy in the eligibility levels should be monitored.

An oversight process should be established whereby Medicaid should be required to rectify problem areas. This oversight authority should continue until Medicaid is in conformance with the access standards. Interested parties, including CMS, should have input at the state level into the development and implementation of access standards.

Promoting Patient Empowerment and Market Competition

Medicaid recipients should be empowered to utilize Medicaid funds in the most rational, efficient manner possible. Rather than a single health delivery system dictated by the state, which generates inefficiencies and stifles a competitive market, Medicaid recipients should be provided with as many choices of health delivery systems as possible, including managed care, traditional indemnity, and benefit payment schedule where available, within a defined contribution framework. This will achieve the twin goals of predictable Medicaid expenditures, and price and quality competition on the Medicaid market.

1. Vouchers

Colorado should issue publicly-financed vouchers for an actuarially determined amount of insurance to allow Medicaid eligibles to choose among private health insurance plans that provide required benefits. Colorado should ensure that Medicaid recipients are given a choice among types of health delivery systems. In order to ensure that Medicaid recipients obtain necessary care while purchasing health care services in a cost effective manner, Colorado should establish programs to educate Medicaid eligibles in the efficient use of health care services.

2. Provider Networks

Innovative states have recognized the benefits of creating incentives for providers to treat Medicaid patients by enacting laws that facilitate provider networks' ability to "manage" the care of Medicaid recipients. Allowing provider networks to contract to cover Medicaid recipients creates a competitive atmosphere for Medicaid business and promotes high quality for Medicaid recipients by placing medical decision making and quality assurance activities in the hands of those who are responsible for providing the care. Provider networks that contract directly with states to cover Medicaid recipients also are able to reduce the cost of the insurer "middleman,"

who diverts a layer of the Medicaid dollar from patient care. Eliminating barriers to provider networks ability to contract with Medicaid will result in enhancing competition in the commercial health care market.

3. The Primary Care Physician (PCP) Program

The PCP program is one program in Colorado, which has proven that it can control costs[1]. It is important to maintain this program. Colorado should create mechanisms for traditional Medicaid providers, who have been serving this population for decades, to continue to participate in Medicaid managed care.

4. Health Plan Standards

Regardless of the methods for financing or delivering Medicaid health care services, the paramount concern must be the quality of patient care. In an increasingly competitive market, and with fewer Medicaid dollars, health plans face incentives to ration patient care, reduce choices of physicians, deny treatment and base medication and other clinical choices on cost rather than quality considerations. Plans often apply similar pressures on providers as a condition of participating in the plans. Patients must be protected from practices that are unfair or impair the quality of care that they receive. Moreover, accountability standards and state oversight requirements must be established for health plans that contract to cover Medicaid recipients. These standards must address: coverage, marketing and enrollment, fairness, physician involvement in medical policy decision making, quality management/utilization review, administrative simplification, continuity of care, smooth transition into newly contracted health plans or providers, access to both primary and specialized care and incentive plans.

Quality Improvement Systems and Quality Performance Measures

Outcomes research and technology assessment are the preferred ways to measure quality improvement and quality performance. Good objective information fed back to physicians to improve their clinical decision making is invaluable. Quality performance measurements, if well done, can provide oversight to previously discussed utilization review or coverage decision making systems that review the medical decisions made or recommended by physicians.

Long Term Care

The long term care component of Medicaid consumes 35% of Medicaid spending. Since few Coloradans purchase long term care insurance, and instead, even middle-income Coloradans who require long term care often access Medicaid to cover their costs by sheltering and disposing of their assets and thus "spending down" for Medicaid coverage, taxpayers end up paying for the long term care of individuals who could afford to purchase the care and/or long term care insurance. This drains Medicaid money from intended recipients -- Colorado's poor.

Colorado must separate long term care from health care and establish incentives and mechanisms for individuals to plan for their long term care costs. Stronger state requirements should be implemented to limit individuals' ability to divest or transfer assets in order to qualify for Medicaid long term care coverage. Colorado should phase-in rules to allow individuals an opportunity to purchase long term care insurance and establish a spend down "offset" for

[1] The Colorado Department of Health Care Policy & Financing calculated PCP program savings at $10,386,904 for FY92-93. Savings projected for the federal waiver renewal period were projected at $8.49 per recipient month. The projected number of recipient months enrolled under the waiver during the renewal period will be 2,108,136. Therefore, savings under the renewal period should be $17,898,075.

individuals who purchase such insurance. CMS endorses the concept of transforming our current health care delivery system into an individually selected and individually owned system where the individual chooses the health plan which best meets personal and family needs. In such a system, individuals would be able to establish a medical savings account (MSA) for long term care when first entering the workforce. Accumulated unspent funds in such an account could be used to pay for long term care and other end-of-life medical care needs, and to plan for these financial needs in a prospective way similar to the planning that occurs for funding the educational needs of children, and for retirement.

Potential alternative methods of financing long-term care must be studied including, but not limited to, the use of the following devices: long term care insurance, including the possibility of Medicaid-funded stop loss coverage and tax incentives for employers to provide and individuals to purchase such insurance; and tax incentives for family caregiving. Investigations should also be conducted into an adjustment of the Diagnosis Related Grouping (DRG) system as applied to capitated long term care such that care of chronic morbidities is appropriately funded within a cost controlled model.

Guidelines for Provider Reimbursement

Medicaid has historically set provider reimbursement levels considerably below private sector and Medicare levels. As long as Medicaid reimbursement levels remain considerably below those of other payors, there is a disincentive for providers to participate in Medicaid, which ultimately impacts on recipients' access to quality medical care. Colorado needs flexibility in financing Medicaid and the ability to achieve equity in Medicaid provider reimbursement, therefore Colorado must urge the federal government to replace the Boren Amendment[2] with broader reimbursement/access standards for all Medicaid providers and standards for payment to plans that are aimed at ensuring access to care.

CMS supports basing provider reimbursement on the following:

- In the fee-for-service arena, Medicaid programs should utilize a resource based relative value scale with a single conversion factor for physician reimbursement.
- Any Medicaid payments or reimbursement based on capitation must be founded on sound actuarial and utilization assumptions.
- If plans utilize provider fee withholds or other financial incentives for providers to limit care, they must be equitable, particularly as compared to other payors. Financial incentives should not be linked to a provider's treatment decisions for a specific patient and should take into account a provider's "case mix" of patients.

Emergency Room Care

Inappropriate use of emergency rooms by Medicaid recipients is one component contributing to spiraling Medicaid costs. Colorado should create incentives for Medicaid recipients to use the most appropriate time and site of care. Such incentives might include a program for nominal copayments for emergency room visits. Additionally, provisions should be made to retain the current emergency room triage program which screens Medicaid recipients on entrance to the facility, and refers non-urgent problems to the most appropriate clinical setting.

Conclusion

Regardless of whether the federal mechanism for financing Medicaid is a block grant program, a continuation of the current program, or any other alternative, it is imperative that the function of Medicaid as a safety net for the state's poorest and most vulnerable populations be maintained.

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[2] 43 U.S.C. §1396a(a)(13) which requires that hospitals be reimbursed at 100% of reasonable costs.

Our proposal for transforming Medicaid attempts to achieve the necessary balance between flexibility and standards of accountability. Such safeguards are essential to ensuring that the Colorado Medicaid program fulfills the crucial objective of the Medicaid program -- to maintain and improve the health of Medicaid recipients.