Pre-Conference: Medicaid Reform Primer

Chiquita White

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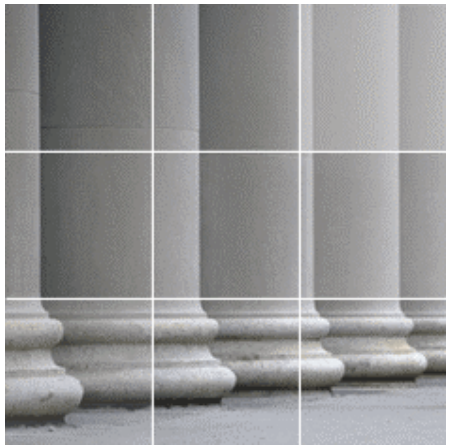
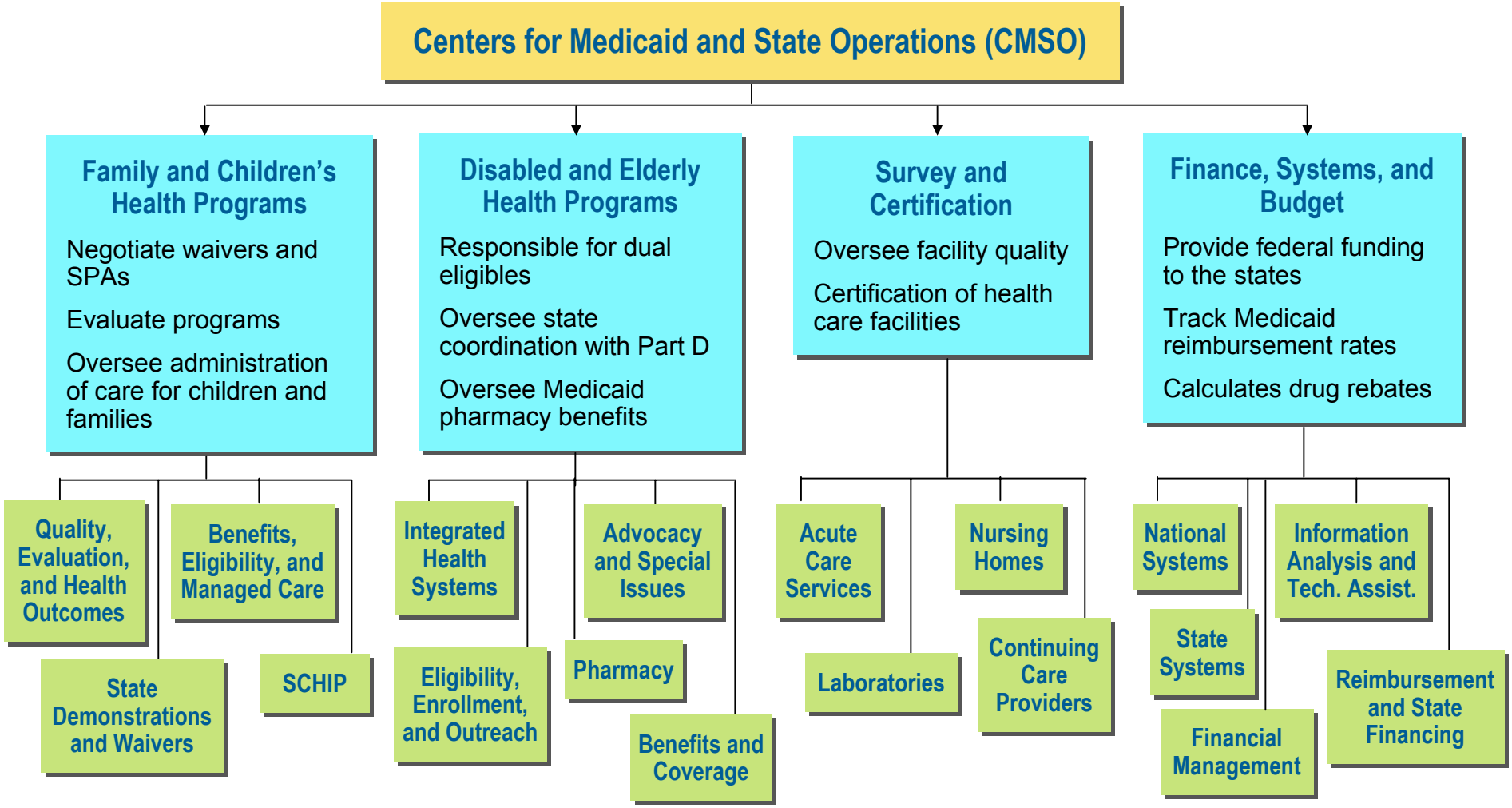


Methods to Implement State Medicaid Reform

States Have Multiple Options for Implementing Medicaid Reform

	State Plan Amendments	Waivers	Waiver Templates
Purpose	Permit states to implement program options that are allowable under federal Medicaid law	Permit states to waive sections of the Medicaid statute in order to implement reforms that are not possible under Medicaid law	HHS Secretary may release waiver guidance or templates, which are intended to direct states towards specific reform options and speed approval process
Speed of Approval	Fast – federal approval is procedural; must be completed within 90 days	Varies – often lengthy negotiation and Q&A process; no time limit (typically 9-12 months)	Moderate – templates speed waiver approval; no time limit (typically 2-6 months)
Ability to Negotiate	Low – states must adhere to federal limitations	High – Secretary can waive almost any provision of the statute, if supportive	Low – template sets parameters for application
Transparency	Low – no public process required for submission or approval	Higher – supposed to be a public process with opportunity to comment	Moderate – no public control over template design, but still subject to public process

CMS is Responsible for Reviewing and Approving Waivers & Overseeing Program Administration



Other Federal Agencies Also Play Important Roles in Medicaid Reform

CMS Regional Offices (ROs)

Act as initial point of contact for beneficiaries, providers, state & local governments

Involved in review of SPAs and waivers

CMS Office of Legislation (OL)

Provide technical assistance to Hill staff while drafting legislation

Assist CMSO with writing regulations and guidance

Department of Health and Human Services (HHS)

Oversee and manage CMS – Approve Medicaid waivers

Review CMS regulations

Reviews CMS regulations and state waivers

Publishes the FMAP

Office of the Inspector General (OIG)

Produce audit and evaluation reports

Recommend program offsets

Office of Management & Budget (OMB)

Oversee and manage CMS

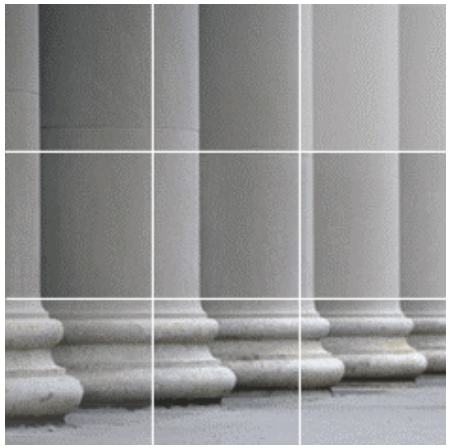
Make final decisions on proposals included in the President's Budget

Review Medicaid policy issues, including waivers and regulations

Coordinate comments on regulations

Medicaid Waivers are Required to be Budget Neutral

- Budget Neutrality means that a state may not spend more money under a Medicaid waiver than it would under the traditional Medicaid rules
  - » States negotiate with CMS to set a “trend rate” for the waiver financing
  - » It is difficult to project long-term program growth
  - » Demonstrating program savings can be administratively burdensome
- Impact on State and Federal Budgets
  - » Budget neutrality is intended to limit federal financial risk
  - » If state’s costs grow below trend rate, it may expand coverage to new populations – MassHealth
  - » Not all states have achieved their expected savings to pay for coverage expansions – TennCare



Sample Medicaid Reform Policies

States have Pursued Many Reforms that Seek to Contain Costs, Expand Coverage, and Alter Delivery Mechanisms

- **Cost-Sharing Increases:** Impose premiums or non-nominal cost-sharing for services
- **Preferred Drug Lists & Supplemental Rebates:** Shift beneficiaries to lower-cost drugs and negotiate additional rebates from manufacturers
- **Multi-State Purchasing Pools:** Increase state negotiating leverage by collectively purchasing prescription drugs
- **Limited Benefits and Benchmark Plans:** Provide slimmer benefits to targeted populations
- **Premium Assistance:** Medicaid pays premiums for beneficiaries to enroll in ESI
- **Coverage Expansions:** Provide Medicaid coverage for expansion populations (e.g. childless adults)
- **LTC Integration Projects & HCBS:** Improve coordination of care for dual eligible beneficiaries and Medicaid beneficiaries receiving LTC services
- **Medicaid Managed Care:** Provide some or all Medicaid services through capitated MCOs

Cost-Sharing Increases

	State Plan Amendment	Waiver (1115)	DRA Change
Example States	IL charges nominal cost sharing to eligible beneficiaries ($3/brand Rx; $2/physician visit)	UT charges an enrollment fee ($25-50) and non-nominal cost-sharing (25% cost of brand Rx) to beneficiaries in the Primary Care Network	KY will increase cost-sharing (Up to $15/non-preferred drug and $10/physician visit)
Flexibility	States may impose nominal beneficiary cost-sharing below federally-established limits	Some states have increased cost-sharing or imposed premiums on optional and expansion groups	Nominal cost-sharing limits to increase with inflation Cost-sharing for non-preferred drugs may exceed nominal limits for beneficiaries >150% FPL Cost-sharing will be enforceable
Requirements	Children, pregnant women, and other groups are excluded from cost-sharing requirements	Secretary has been unwilling to waive nominal cost-sharing limits for mandatory populations	Total cost-sharing may not exceed 5% of family income Children in foster care and women with breast and cervical cancer may not be charged cost-sharing

Preferred Drug List (PDLs) and Supplemental Rebates

	State Plan Amendment	Waiver (Pharmacy Plus)	DRA Change
Example States	FL first implemented a PDL in Jan 2002 FL maintains an aggressive PDL	WI used a pharmacy plus waiver to expand drug-only coverage to new populations	No Change
Flexibility	States can implement PDLs with prior authorization for all beneficiaries PDLs enable states to negotiate with manufacturers for supplemental rebates	States have used waivers to establish PDLs and apply supplemental rebates to beneficiaries not otherwise eligible for Medicaid	
Requirements	States must ensure that beneficiaries have access to all medically necessary drugs States are encouraged to provide relatively open access to drugs for vulnerable populations (HIV/AIDS, mental health)	States had to demonstrate savings to cover new populations for drugs Difficult to implement in the Part D environment	

Multi-State Purchasing Pools

	State Plan Amendment	Waiver	DRA Change
Example States	AK, MI, NV, NH, and VT formed the first multi-state pool, administered by First Health These states control their own PDL placement, but benefit financially from selecting the same preferred drugs	N/A	No Change
Flexibility	States may pool their purchasing power in order to negotiate deeper discounts on prescription drugs		
Requirements	CMS encourages states to form new pools and contract with different vendors		

Limited Benefit Packages and Benchmark Plans

	State Plan Amendment	Waiver (1115)	DRA Change
Example States	CO covers all mandatory and most optional services CO does not cover dental, chiropractic, or psychologist services	UT's Primary Care Network expanded limited coverage to uninsured residents Increased cost-sharing and reducing benefits for optional groups	KY will provide different benefit packages to different populations
Flexibility	Select which optional services to cover Determine the amount, duration, and scope of services	In 2001 & 2002, states sought to limit benefits for optional and expansion populations	Created SPA for states to enroll beneficiaries in benchmark plans with private-style benefit packages
Requirements	Comperability – States must cover the same services for all beneficiaries	Waivers have not permitted states to limit benefits for mandatory populations	Many populations may not be required to enroll Benchmark coverage must meet minimum requirements

Premium Assistance Programs

	State Plan Amendment	Waiver (1115)	DRA Change
Example States	IA covers full premium cost for beneficiaries enrolled in ESI Enrollment is mandatory for those with access to cost effective coverage Employers must to contribute to the cost of coverage	NJ's program is mandatory for eligible individuals – wraparound provided Employers must contribute at least 50% of premium cost Beneficiaries >150% FPL pay a fixed share of premium	None approved to date
Flexibility	States may provide premium assistance for beneficiaries to enroll in ESI Can provide premium assistance to non-Medicaid eligible family members	States may enroll beneficiaries into ESI without wrapping around benefits or cost-sharing requirements	States can enroll beneficiaries in ESI without wraparound coverage
Requirements	States must wraparound ESI to ensure beneficiaries receive all Medicaid-covered services and do not incur higher cost-sharing	HIFA template requires all waiver applications to include a premium assistance component or investigate such a program; plans must meet benchmark requirements	ESI coverage must meet the benchmark plan requirements

Coverage Expansions

	State Plan Amendment	Waiver (1115)	DRA Change
Example States	NY expanded coverage to parents up to 150% FPL, children up to 250%, and pregnant women up to 200% FPL	OR expanded limited coverage for parents and childless adults	No states
Flexibility	States may increase income eligibility requirements for categorically eligible groups	States can expand coverage to new populations, not traditionally eligible for coverage	States can provide limited benefit packages to new populations without demonstrating savings
Requirements	Newly covered optional populations must receive the same coverage as other beneficiaries	The cost of coverage expansions must be offset by demonstrated savings from other parts of the program	New coverage must meet benchmark requirements

Long-Term Care Integration Projects & Home and Community-Based Services (HCBS)

	SPA	Waiver (1915(c))	Waiver (1915(b)/(c))	DRA Change
Example States	N/A	OH has three waivers to provide HCBS and support services to aged and disabled beneficiaries	TX delivers acute and LTC services for dually eligible beneficiaries through MCOs Duals are encouraged to enroll in the MCO for Medicare services	No states
Flexibility		States may provide HCBS to beneficiaries who would otherwise need institutional care – including duals Can use more liberal income and resource requirements May use enrollment caps	States can deliver HCBS through managed care Can create a provider network for enrollees Can use more liberal income and resource requirements May use enrollment caps	Created an SPA for states to provide HCBS to beneficiaries <150% FPL No statewide requirement May use waiting lists
Requirements		Programs must be cost-effective	Must have freedom of choice for providers	Higher level of need required for institutional eligibility

Medicaid Managed Care

	State Plan Amendment	Waiver (1915(b))	Waiver (1115)	DRA Change
Example States	NY Medicaid MCOs are mandatory for some beneficiaries – same benefits as FFS	In VA, parents, children and aged beneficiaries must select a primary care physician (PCP) from which they will receive all primary care services and will receive a referral for all necessary specialty services	AZ was the first state to enroll almost all beneficiaries in managed care and not provide a FFS option	No change
Flexibility	States can enroll most beneficiaries* in mandatory managed care No statewide requirement Can limit provider choice	1915(b) – Permit mandatory managed care for dual eligibles	1115 – Permit managed care plans to provide tailored benefit packages to enrollees Permit states to virtually eliminate the FFS option	
Requirements	MCO enrollees must receive the same benefits and cost-sharing requirements as other beneficiaries	All beneficiaries in MCOs must have access to specific benefits established under the waiver	Beneficiaries must have access to mandatory benefits	

*Dual eligibles and special needs children may not be required to enroll in MCOs.