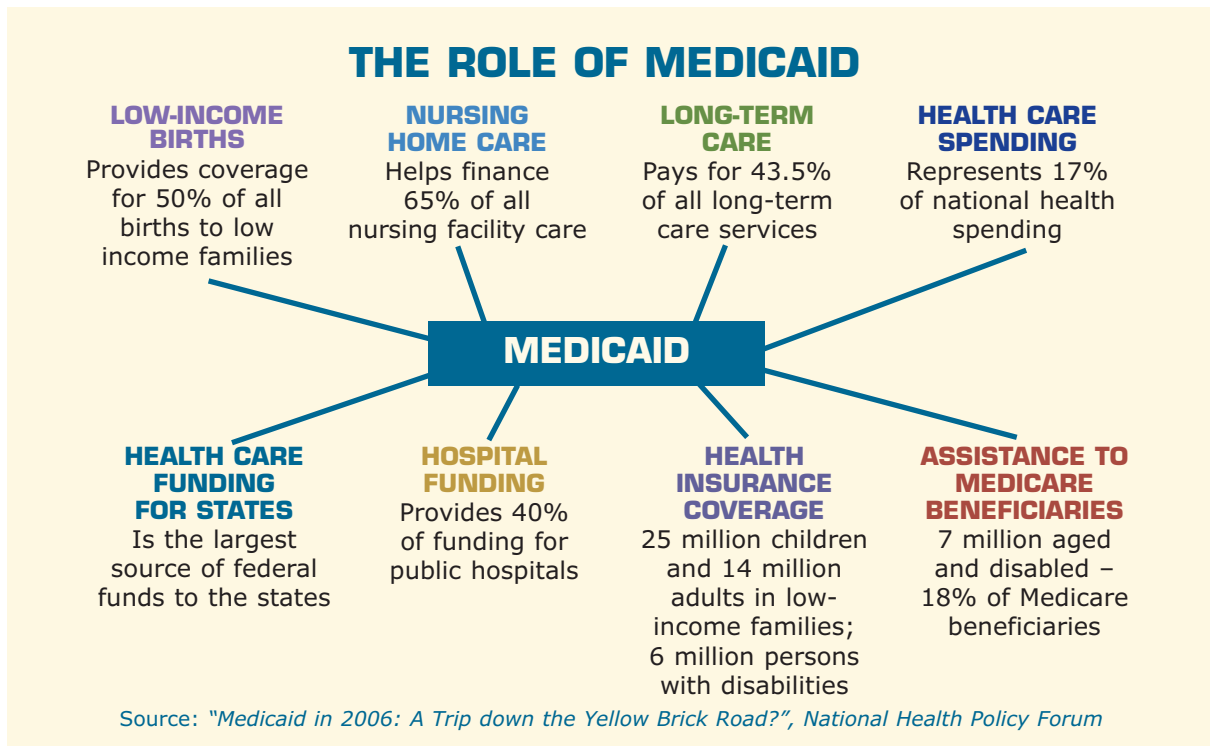


The Case For Medicaid Reform

Texas leaders face an important decision. In a state that already leads the nation in the number of uninsured, how do you sustain a \$17 billion program that provides primary healthcare to almost three million Texans without compromising other essential state priorities?¹

Medicaid expenditures currently comprise roughly a quarter of the state budget and have more than doubled during the last ten years.² To the roughly twelve percent of the state's population that uses the program, Medicaid is often the only means of access to healthcare. Without the access it provides, the state would face a healthcare collapse among some of its most vulnerable citizens. Without an effective Medicaid program, local government budgets would be overwhelmed by the costs of uncompensated care delivered through the emergency rooms of many of their safety-net hospitals.



As state leaders work to comprehensively address the growing uninsured population, clearly, the Medicaid program will be a critical part of that strategy. Fortunately for Texas, there are promising Medicaid reform options. One already proven option is the expanded use of managed care. Additionally, through the adoption of the Deficit Reduction Act of 2005 (DRA) and quicker approval of waivers, the federal government has provided states new tools and flexibility to help manage the costs of their Medicaid programs without reducing access to the healthcare it provides.

Faced with opportunities to increase efficiency, manage costs, and maximize access, state leaders have a strong case for Medicaid reform in Texas - reform that will allow the program to serve as a key tool in reducing the uninsured population without jeopardizing funding for other important state programs. The following is a summary of how other states are reforming their Medicaid programs as well as specific principles that might be helpful in guiding reform efforts in Texas.

The Path To Medicaid Reform

States currently have the ability to seek changes to their Medicaid programs through the approval of waivers from the federal government. In general, the waivers are intended to provide states flexibility in operating their Medicaid programs by utilizing innovative activities that are not otherwise permitted. The federal government limits funding for the proposed changes to current funding

levels to ensure it does not bear additional costs as a result of a waiver. Over the years, waivers have allowed states to use new programs and the savings they generate to keep pace with the changing and increasing needs of those served.

The recently approved **Deficit Reduction Act of 2005 (DRA)** also provides states new opportunities to reform their Medicaid programs. While the act was approved by the Congress to reduce spending on federal entitlement programs such as Medicaid, it also was a response to state concerns about antiquated regulations that prevented states from utilizing less cumbersome state plan amendments to implement reform measures aimed at reducing costs and improving quality of care. Enhanced DRA flexibility now enables increased cost sharing, customized benefit plans for targeted populations, expansion of Long-Term Care partnerships, and expanded use of home and community-based services. These changes, along with the use of managed care systems that integrate acute and long-term care services, provide states with the greatest potential of gaining control of Medicaid spending which has taken over many state budgets.

The Tools For Medicaid Reform

TARGETED BENEFITS PACKAGES

Prior to the DRA, states were required to provide certain mandatory benefits to eligible Medicaid populations. In addition to the mandated services, states could receive matching federal funding for certain optional benefits. The scope and duration of those non-mandated benefits were determined by the state, but once they were offered the state was generally required to provide them to all eligible Medicaid beneficiaries it served. The DRA provides states new flexibility in developing alternative benefit plans within its Medicaid program. This flexibility allows states to develop different benefit packages for target populations as long as certain mandatory services are covered. States are using this new flexibility to reduce costs associated with benefits by tailoring the services offered to meet the unique needs of those served and to more closely resemble typical employer-sponsored insurance benefits.

Idaho, West Virginia, Kentucky, Florida, Arkansas, and Vermont have each incorporated targeted benefit packages, offering enrolled Medicaid recipients with customized benefits. By modifying packages according to the age and health status of the recipient, these states plan to reduce excess spending and administrative costs without decreasing access to services and quality of care.

EXPANDED COST SHARING

The DRA now allows various forms of cost sharing by those served, without the need for a federal waiver. For example, the DRA allows a state to enforce “nominal” co-payments on certain families whose income exceeds 150 percent of the federal poverty level. It also allows the cost sharing to vary among beneficiary groups and areas of the state. The use of cost sharing is intended to promote responsibility, accountability, and perceived value of the program among Medicaid clients. Increasing the amount a client pays for certain services and prescriptions makes Medicaid more like private health insurance in which clients have financial incentives to make certain decisions, like opting for a generic drug rather than a brand name and avoiding inappropriate emergency room use. However, cost sharing may not be increased beyond the nominal amounts for mandatory populations of children, pregnant women, and disabled and elderly individuals living in institutional settings. Additionally, cost sharing is not permitted for preventive services for children, for prenatal care and other pregnancy-related services, and for services exempted under current law, including certain emergency room visits, family planning services, and hospice care.

States can impose cost sharing for inappropriate emergency room use as long as they are able to demonstrate the availability of alternative providers. The DRA also set aside grant funds for states to ensure that such providers are available.

DEFICIT REDUCTION ACT OF 2005: IMPACT ON MEDICAID

Provides states new flexibility to manage their Medicaid programs.

COST SHARING

- Allows premiums and co-payments by enrollees
- Cost sharing may be limited by family income
- Co-payments will rise with CPI
- Allows for higher co-payments for non-preferred drugs and inappropriate emergency room use
- Provides funding for states to provide alternatives to emergency room care

BENCHMARK BENEFITS

- Allows states to adopt certain benchmark benefit plans for Medicaid enrollees
- Benchmark plan options that may be chosen include:
 - Standard plan offered to federal employees
 - Plans offered to state employees
 - The benefit package of the largest commercial health plan in the state
 - Any benefit package approved by the Secretary of HHS
- Requires that children maintain access to Early and Periodic Screening, Diagnostic, and Treatment benefits (EPSDT)
- Authorizes Health Opportunity Accounts in pilot areas

MEDICAID TRANSFORMATION GRANTS

- Provides \$150 million in grants to states for improvements to their Medicaid programs
- Improvements could include:
 - Electronic Medical Records
 - Pay-for-Performance
 - Programs to reduce waste and fraud

LONG TERM CARE

- Allows state to expand long-term care partnerships
- Promotes the use of long-term care insurance by providing asset protection for those who purchase the coverage
- Extends the "look back periods" from three to five years for establishment of Medicaid eligibility
- Allows families with disabled children to "buy-in" the program
- Promotes community care through enhanced federal reimbursement for people moved from institutions into the community
- Simplifies the process by which states can expand community-based services to the disabled

FRAUD, WASTE, AND ABUSE

- Requires that providers receiving \$5 million or more in Medicaid reimbursement provide false claims training to employees
- Provides funding for a Medicaid Integrity Program that includes:
 - The creation of the Medicaid Integrity Group, consisting of auditors within CMS to crackdown on controversial state practices
 - The development of the Medicaid Integrity Contractors, who will audit Medicaid providers and health plans, educating them on proper claims, while identifying inappropriate payments
- Requires states to identify if third party (i.e. self-insured health plans, pharmacy benefit managers, etc.) liability exists for the payment of services to avoid the use of Medicaid funds
- Requires that citizenship be certified to be eligible for Medicaid benefits

INTERGOVERNMENTAL TRANSFERS AND PROVIDER TAX LIMITATIONS

- Clarifies what constitutes a legitimate (and illegitimate) intergovernmental transfer
- Limits the use of provider taxes

DEFINED CONTRIBUTION

Under a “defined contribution,” the state defines the amount it will pay per enrollee rather than defining the benefits to be offered. With this approach, a state pays a set or defined premium per enrollee based on their age, unique medical needs, and healthcare risks. With a defined contribution approach, states rely on health plans to design benefit packages that meet the diverse medical needs of their populations. The risk-adjusted premiums are linked to an array of benefit plans that meet certain state and federal standards. Florida has led the nation in experimenting with this new approach by implementing a defined contribution approach pilot program for two of its counties.

CONSUMERISM: PERSONAL HEALTH

The growing recognition of the link between our lifestyles and our health is changing the variety of health insurance products available to consumers. Many Medicaid reform initiatives are aimed at increasing the awareness of those served about preventive measures that can be taken while also elevating their level of interest in the delivery and cost of the medical care they seek. The Medicaid program is also impacted by the growing movement of consumerism as a number of states are offering individuals the option of choosing the health plan that best meets their medical needs. Florida, West Virginia, Kentucky, Idaho, and California are building upon the efforts to promote personal responsibility among their Medicaid beneficiaries through reform plans that encourage patients to take charge of their health care.

In Florida, Medicaid recipients who exhibit healthy behavior receive credits that can be used to assist with premium payments for their healthcare coverage. Credits can be earned for activities like keeping doctors appointments, complying with prescription directions, and enrolling in smoking and weight-management programs. West Virginia has instituted a Healthy Reward Account, which gives quarterly credits to be used towards medical and prescription co-payments or to purchase non-covered service to Medicaid patients who meet health goals. Idaho’s personal health account option and Kentucky’s KyHealth plan also focus on improving the all-around health and behavior of their Medicaid beneficiaries by rewarding healthy behaviors.

Florida’s Medicaid program, through state contracting with private entities, has created a Choice Counseling program which provides one-on-one counseling along with online information about health plan options and tips for selecting the best health plan for the patient and family. The Medi-Cal Education and Outreach program in California provides seminars, claims assistance, custom billing workshops, on-site visits, and online tutorials as educational support for its clients. West Virginia asks enrollees of their Enhanced Plan to sign a patient responsibility member agreement that outlines certain responsibility guidelines that they must follow to maintain coverage. Through these types of programs, clients obtain the knowledge to become personally responsible and active in managing their own care, while also helping control program costs.

Texas has also attempted to tie wellness and health to benefits for Medicaid enrollees in the past. While never fully implemented, state law offered an incentive for families who complied with scheduled well-child visits and attended health care orientation sessions. For those families, the state offered simplified re-enrollment that did not require full review every six months.

LONG-TERM CARE PARTNERSHIPS

One provision of the DRA allows for states to form Long-Term Care Partnership programs with the intent of reducing long-term care costs of the Medicaid program by increasing the use of long-term care insurance. Long-term care spending accounts for a disproportionate share of all Medicaid expenditures and represents an area where states have a strong interest in containing costs.

Often times individuals will spend down or transfer their assets to relatives in order to achieve levels of impoverishment that qualify them for long-term care services through Medicaid. By purchasing a long-term care policy, individuals are allowed to protect a level of their assets roughly equal to the amount of benefits they receive under the plan. Once the benefits are depleted, assuming they meet other program criteria, individuals may then qualify for Medicaid

MEDICAID REFORMS FROM SELECT STATES

ARKANSAS

PUBLIC/PRIVATE PREMIUM ASSISTANCE

- Established the Arkansas Safety Net Benefit Program aimed at offering coverage to small employers with under 500 employees who have not offered health insurance in the past 12 months.
- Program provides premium subsidies for participating employers.
- Program is voluntary, but the employer must cover all employees
- The goal of the program is to cover 50,000 low and moderate income individuals in five years
- The benefit package is limited and designed as a safety net.
- Provides for 6 physician visits, seven days of inpatient coverage, and 2 outpatient visits
- Competitive procurement to select one or more private insurers

EXPANDED COST SHARING

The Arkansas Safety Net Benefit Program includes cost sharing for recipients, such as:

- \$100 deductible
- 15% coinsurance for all services except pharmacy
- \$1,000 out-of-pocket maximum
- \$15/month premium

FLORIDA

TARGETED BENEFIT PACKAGES

- Risk-adjusted premiums for each enrollee
- Health plans develop competing benefit packages for enrollees to consider

CONSUMERISM: PERSONAL HEALTH

- Enrollees who participate in healthy activities can receive credits that can be used to assist with premium payments for their health care coverage. Credits are earned through various activities, such as:
 - Keeping doctors appointments
 - Complying with prescription directions
 - Enrolling in smoking-cessation and weight-management programs
- Through the Choice Counseling Program, Medicaid enrollees are provided one-on-one counseling, along with online information, about health plan options and tips for selecting the best health plan for the patient and the family

PUBLIC/PRIVATE PREMIUM ASSISTANCE

- Enrollees can opt-out and purchase private coverage, either individual or employee-sponsored

OTHER

- Wide-scale implementation of managed care
- State will set annual spending caps for adult enrollees, excluding pregnant women
- State accepts capped funding for providers treating the uninsured, and funding is subject to the state meeting certain milestones

IDAHO

TARGETED BENEFIT PACKAGES

- Idaho Medicaid reform plan developed three categories of coverage for its enrollees:
- Benchmark Plan: Serves healthy children and adults by providing standard Medicaid benefits, except long-term care, organ transplants, and intensive mental health treatment
 - Enhanced Benchmark Plan: Serves the disabled and elderly by providing standard Medicaid benefits including long-term care and institutional care
 - Coordinated Benchmark Plan: Serves dual-eligibles of the Medicaid and Medicare programs

CONSUMERISM: PERSONAL HEALTH

- Enrollees receive credit for healthy behaviors

OTHER

- Provides for simplified enrollment of children
- Removes the assets test for applicants
- Increased reimbursement for primary care and high-performance providers

KENTUCKY

TARGETED BENEFIT PACKAGES

- Establishes four benchmark plans based on health status

EXPANDED COST SHARING

- Develops new cost sharing requirements for enrollees, including a \$50 co-payment for inpatient hospital services
- Some member categories and services are exempt from cost-sharing requirements

CONSUMERISM: PERSONAL HEALTH

- Develops "Get Healthy Benefits" for compliance with disease management requirements

PUBLIC/PRIVATE PREMIUM ASSISTANCE

- Provides for premium assistance, where it is deemed cost effective

OTHER

- Develops individual budget plans for disabled enrollees who choose Consumer Directed Services (CDS)

WEST VIRGINIA

TARGETED BENEFIT PACKAGES

- Basic Plan: Contains the current Medicaid benefits
- Enhanced Plan: Includes a larger range of medical services, but requires recipients to sign a contract, stating:
 - They will engage in healthy lifestyles
 - Keep scheduled appointments
 - Comply with health screening requirements
 - Use the emergency room only for emergencies.
- Non-compliance could result in benefits being taken away, and health plans and providers will assist in determining compliance

CONSUMERISM: PERSONAL HEALTH

- Develops a Healthy Rewards Account, through which enrollees can gain credit for meeting health goals.
- Program gives quarterly credits to be used towards medical and prescription co-payments

while preserving the specified level of their assets. By encouraging the purchase of private insurance to help fund long-term care and delaying an individual's use of Medicaid for care, states are able to realize cost savings from long-term care expenses they might have otherwise incurred. As the population ages and medical technology keeps people alive longer, incentives for increased use of long-term care insurance could have major budget implications for states given the cost of such services.

Four states, California, Connecticut, Indiana, and New York, currently operate long-term care partnerships. As many as 21 other states have already enacted legislation authorizing the use of partnerships.

PUBLIC/PRIVATE PREMIUM ASSISTANCE

The rise in the number of uninsured citizens has placed a heavy burden on the Medicaid system. States like Arkansas and Massachusetts have established strategies to increase the number of insured residents in order to decrease the number of those dependent on state funded Medicaid.

In March 2006, Arkansas, which has an estimated 450,000 uninsured residents, introduced the Arkansas Safety Net Benefit Program with a goal to expand coverage to 50,000 low and moderate income individuals over a period of five years. The plan targets employers with fewer than 500 employees who have not offered health insurance coverage in the last year. The program will provide limited benefits to individuals employed by a participating employer and will be paid for by a combination of federal funds, state tobacco settlement funds, and fees from participating employers. Enrollees will be required to pay a monthly premium of \$15, a \$100 deductible, 15 percent coinsurance for all services (except pharmacy services), and a \$1000 out-of-pocket maximum per year.

Although participation is voluntary, if an employer signs on to the program the state is mandating that they achieve 100 percent coverage among their employees. Arkansas plans to focus this effort on small businesses, as only 26% of the state's small employers offer health insurance.

New Mexico has launched its own public/private partnership in hopes of providing health coverage to 40,000 uninsured adults age 19-65 with incomes below 200 percent of the federal poverty level. Through its program, a new insurance product for small businesses will be offered to low-income workers. Premiums will be paid for through combined contributions from the employee and employer as well as state and federal funds.

Oklahoma is implementing its Employer/Employee Partnership for Insurance Coverage (O-EPIC) with the goal of enrolling between 50,000 and 70,000 Oklahomans in the program. Employers with fewer than 25 employees are eligible to participate. Employees and their spouses whose income is at or below 185 percent of the federal poverty level will qualify for coverage under the program.

Utah's Covered at Work program combines state and federal funds with employer and employee contributions to offer health benefits to individuals who are not eligible for other public programs and who cannot afford the coverage offered by their employer.

In some states, premium assistance initiatives known as three-share programs are being explored. Through these programs, low cost health insurance is offered to small businesses and individuals who have been unable afford coverage. Premiums for the benefit package are split three-ways between the employer, employee, and the government.

The University of Texas Medical Branch has been the first to offer a "three-share" option in Texas. Its *Three-Share Program* provides limited benefits to the working uninsured in Galveston county. The coverage is offered through small employers who have not offered insurance to their employees within the last 12 months. Funding for the premium will be provided by the employer, employee, and government funds. Within certain criteria, the federal government allows for the use of CHIP funds to be used to provide coverage for family members of CHIP enrollees as well as other individuals. The state has submitted a program waiver to allow for the use of CHIP funds for the government portion of the premium payment. Private funds are currently being used until the waiver has been approved.

UNIVERSAL COVERAGE

Massachusetts has launched an ambitious plan to insure all Massachusetts residents over the next several years. The state approved a bill early this year that requires all Massachusetts residents to purchase some level of insurance coverage or face financial penalties. The plan is designed to increase statewide responsibility concerning health care and “to end an era in which 550,000 people go without insurance and their hospital and doctor visits are paid for in part with public funds.”³

As a part of its sweeping insurance reforms, the state of Massachusetts established the Commonwealth Health Insurance Connector. Through this program, individuals and businesses with 50 or fewer employees are eligible to purchase insurance that is certified by the connector as high value and good quality. Individuals whose income falls below 100 percent of the federal poverty level will receive the insurance for free but will be required to pay a small co-payment for certain benefits. Individuals whose income falls between 100 and 300 percent of the federal poverty level will pay a low premium based on their income level. The primary goal of the connector will be to link individuals with affordable health insurance that meets their medical needs.

Guiding Principles For Medicaid Reform In Texas

Texas is already working to streamline its Medicaid program through the increased use of managed care, disease management programs, preferred drug lists, and case management. These initiatives offer state leaders a strong foundation on which to achieve additional savings and efficiencies through Medicaid reform without reducing the quality and access currently available.

Following are a series of principles that may be helpful in guiding Medicaid reform efforts in Texas. These tenets are intended to further strengthen the Legislature’s ability to achieve budget certainty for its Medicaid expenditures, control costs of the program, and continue providing eligible Texans with access to needed healthcare.

TEXAS PROBLEM, TEXAS SOLUTION

There is a saying that “if you’ve seen one state Medicaid program, you’ve seen one state Medicaid program.” Each state has a unique population with substantially different demographics, varying rates of insured and uninsured, large employers and small employers, and different Medicaid programs. Texas’ Medicaid population consists primarily of children and pregnant women, populations that have much different needs than childless adults. Lawmakers should be sure to consider ideas and best practices from other states, but must remain focused on finding a solution that works for Texas.

CONTROLLING COSTS

The major reason motivating states to consider Medicaid reform is the unsustainable cost trends of the program. Recognizing managed care as the most effective model for controlling costs is essential. The broad application of fully capitated managed care strategies will provide the state the greatest possibility of generating substantial savings through efficient benefit administration, care coordination, and integration of acute and long-term care services. This model has been highly successful in providing both acute and long-term care benefits to the aged, blind, and/or disabled Medicaid recipients in targeted areas of the state and should be used as a basis for serving this and other populations throughout Texas.

PRESERVING FEDERAL FUNDING FOR SAFETY-NET PROVIDERS

Reform efforts must preserve funding for safety-net providers associated with delivering Medicaid services and indigent care. The pursuit of an 1115 Medicaid waiver can incorporate the use of “low income” or “uncompensated care” pools to preserve federal funding for providers and sustain the program through savings achieved through the expansion of fully capitated managed care.

MANAGING HIGH COST LONG-TERM CARE

Ensuring integrated services are available, recognizing the unique needs of special populations, promoting community care, and expanding the use of long-term care insurance are key to gaining control of the most costly area of the program. Managed care programs that integrate acute and long-term care services provide the greatest possibility to control long-term care costs. Increasing the use of long-term care insurance through incentives should be explored as well.

ENCOURAGING PERSONAL AND FINANCIAL RESPONSIBILITY

Promoting prevention, rewarding healthy lifestyles, and facilitating the management of chronic conditions will improve health outcomes. Engaging individuals as active participants in directing their health care will increase their accountability for their medical expenses and can be designed to help control costs of the program. Implementing a cost sharing program can provide additional funding for services and increase personal accountability. However, copayments, coinsurance, and premiums can discourage enrollment and may have an adverse impact on individuals obtaining and maintaining coverage. The use of such options should be carefully considered. It may be necessary to limit their application to specific problem areas such as non-emergent emergency room use and the purchase of "non-preferred" prescription drugs. Exemption of certain populations from cost sharing arrangements may limit their effectiveness in Texas.

USING INNOVATION TO INCREASE ACCESS

Savings from Medicaid reform can be invested in new and innovative solutions to address the problem of the uninsured and help reduce uncompensated care within the state. Market-driven alternatives and public/private partnerships can be pursued to increase access to healthcare. Programs such as the University of Texas Medical Branch's *Three-Share Program* can increase opportunities for healthcare coverage while spreading the cost among government, employers, and employees. Expanding the use of premium assistance not only can reduce costs, it can actually decrease the uninsured by taking advantage of untapped employer dollars.

OFFERING ALTERNATIVE BENEFIT PLANS

Making alternative benefit plans available to the Medicaid population will allow for the services offered to better match the needs of those served while providing savings to the state. Such customization of benefits can help states limit program costs by reducing excess spending and administrative costs without decreasing access to care.

The Future Of Medicaid In Texas

If Medicaid is to be an effective tool in addressing the state's uninsured challenges, it will be up to state leaders to put programs in place that will help contain its costs while maximizing the access to care it provides. This will not be an easy task but within the wave of Medicaid reform that is sweeping the country, options do exist. Texas is poised to join the movement to reform its largest health program and build on momentum already in place from efficiencies brought about by managed care and other innovative programs it has undertaken. Any reforms that are proposed must be carefully considered factoring in the low income and medically fragile nature of the populations served. There is, however, great promise that a retooled Medicaid program could be a central strategy of efforts to reduce the growing number of uninsured Texans without compromising the state's capability to fund other key state programs.

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*Information from the National Conference of State Legislatures (www.ncsl.org/programs/health/medicaid.htm) was used throughout this newsletter.