

The Fight Over the Future

State Priorities and Federal Policy Reforms



American Network of Community Options and Resources
Providers Offering Quality Supports to People with Disabilities

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Short Term

States **MUST** have a balanced budget each year. When Medicaid grows faster than expected (during economic downturn) states must act immediately.

Three short-term options:

- Price – what you pay for health care
- Eligibility – who can get health care
- Benefits – what health care they receive

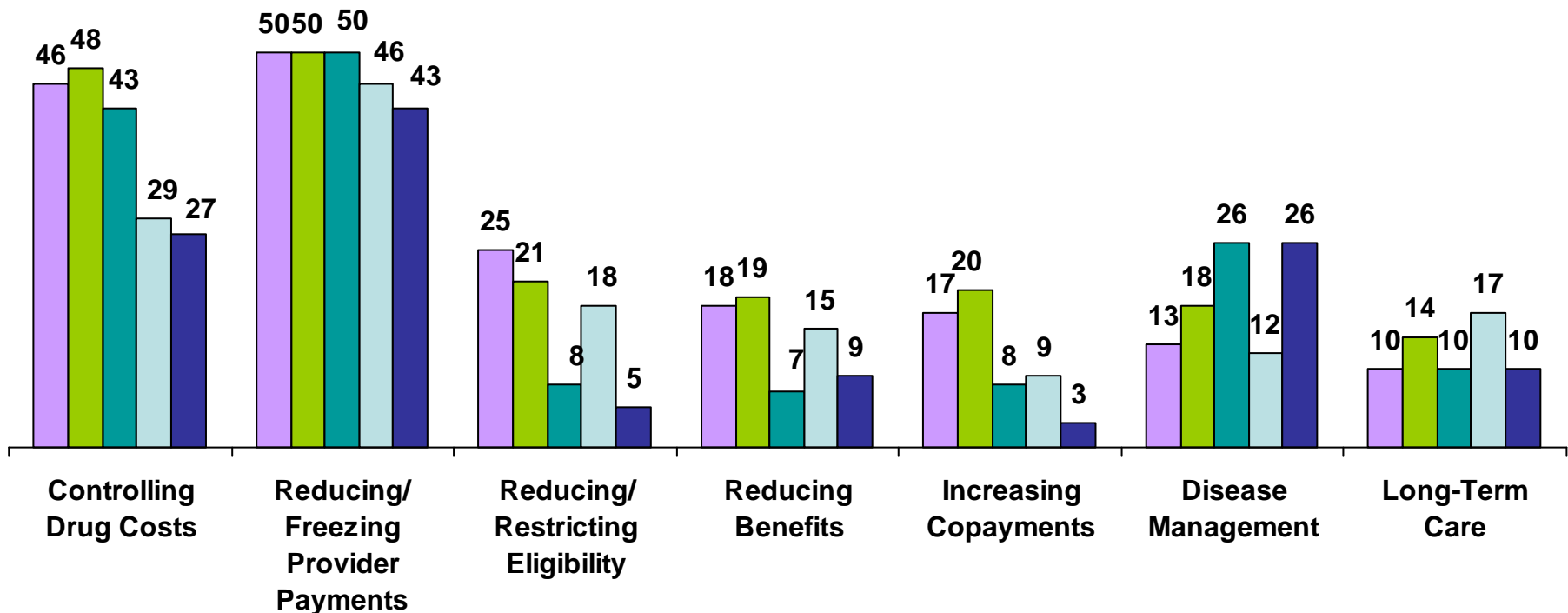
The Problem

- **Cost**
- **Financing**
- **Control**



State Medicaid Cost Containment Strategies FY 03–07

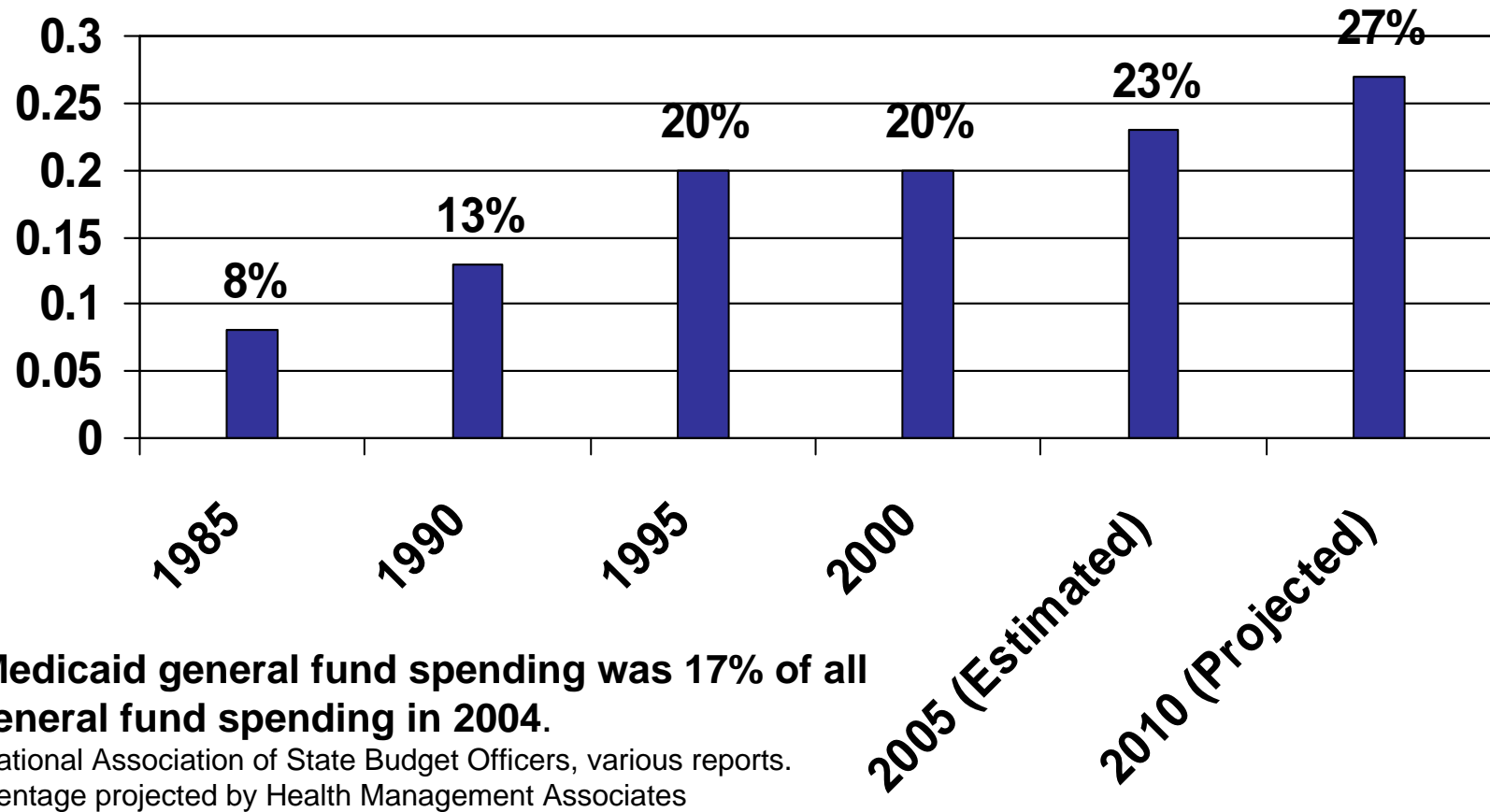
■ 2003
 ■ 2004
 ■ 2005
 ■ 2006
 ■ Adopted for 2007



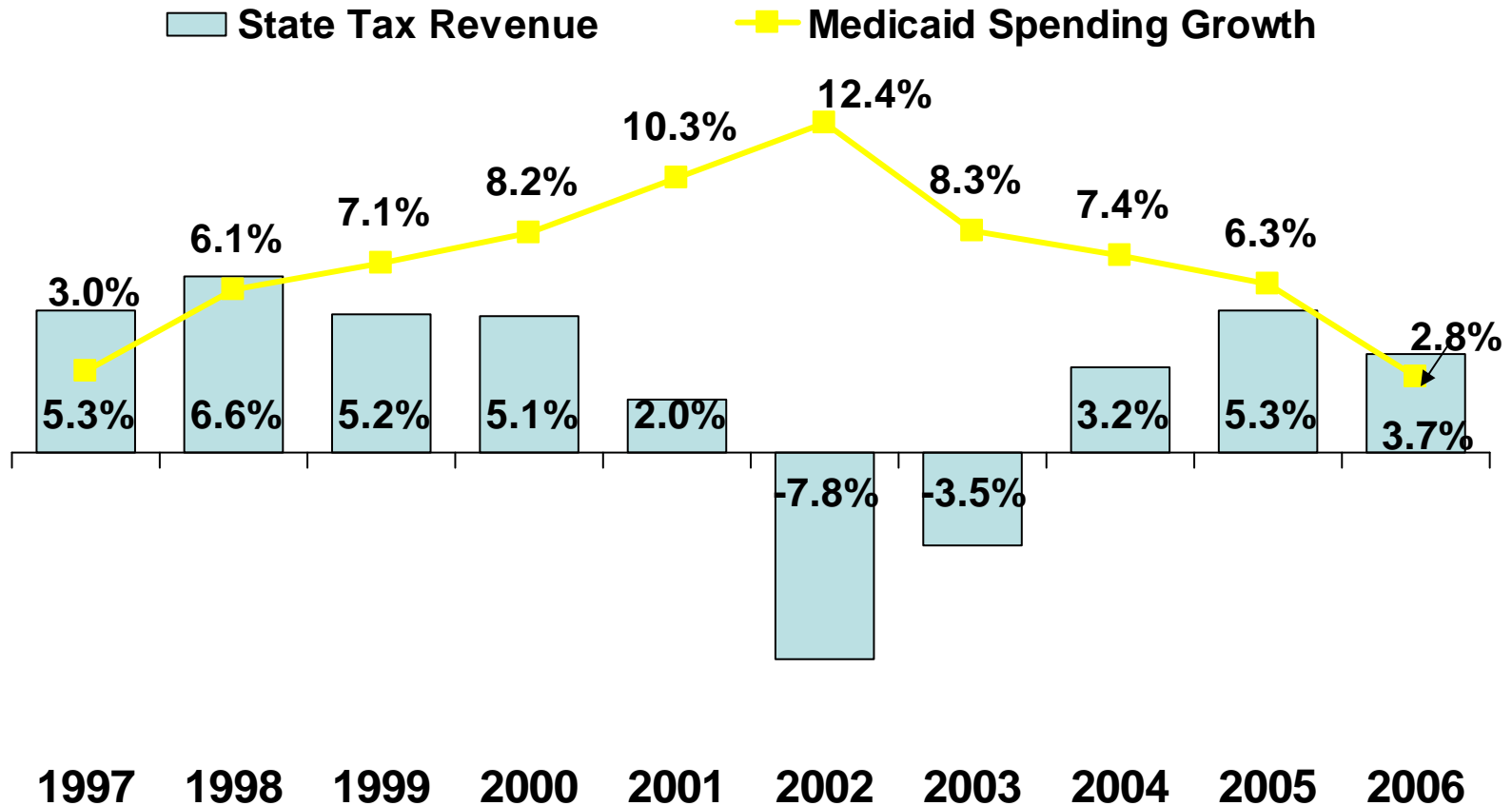
NOTE: Past survey results indicate not all adopted actions are implemented.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003, October 2004, October 2005, October 2006

Medicaid Projected to Increase as a Share of Total State Budgets



State Tax Revenue vs. Medicaid Growth 1997-2006

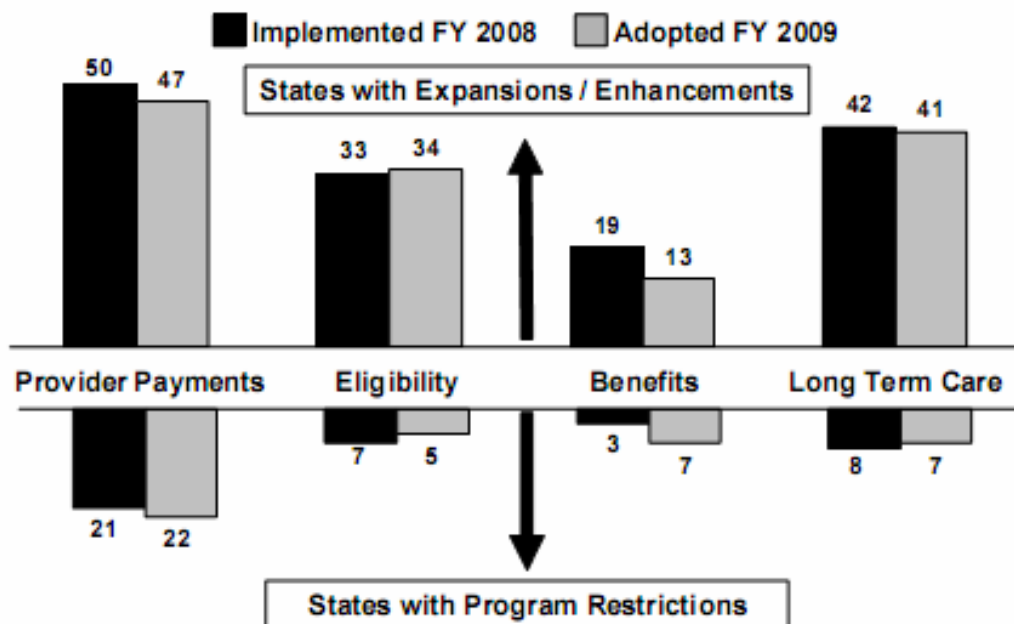


NOTE: State Tax Revenue data is adjusted for inflation and legislative changes.
Preliminary estimate for 2006.

SOURCE: KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates and KCMU / HMA Survey for 2006 Medicaid Growth Estimates; Analysis by the Rockefeller Institute of Government for State Tax Revenue.

Figure 17

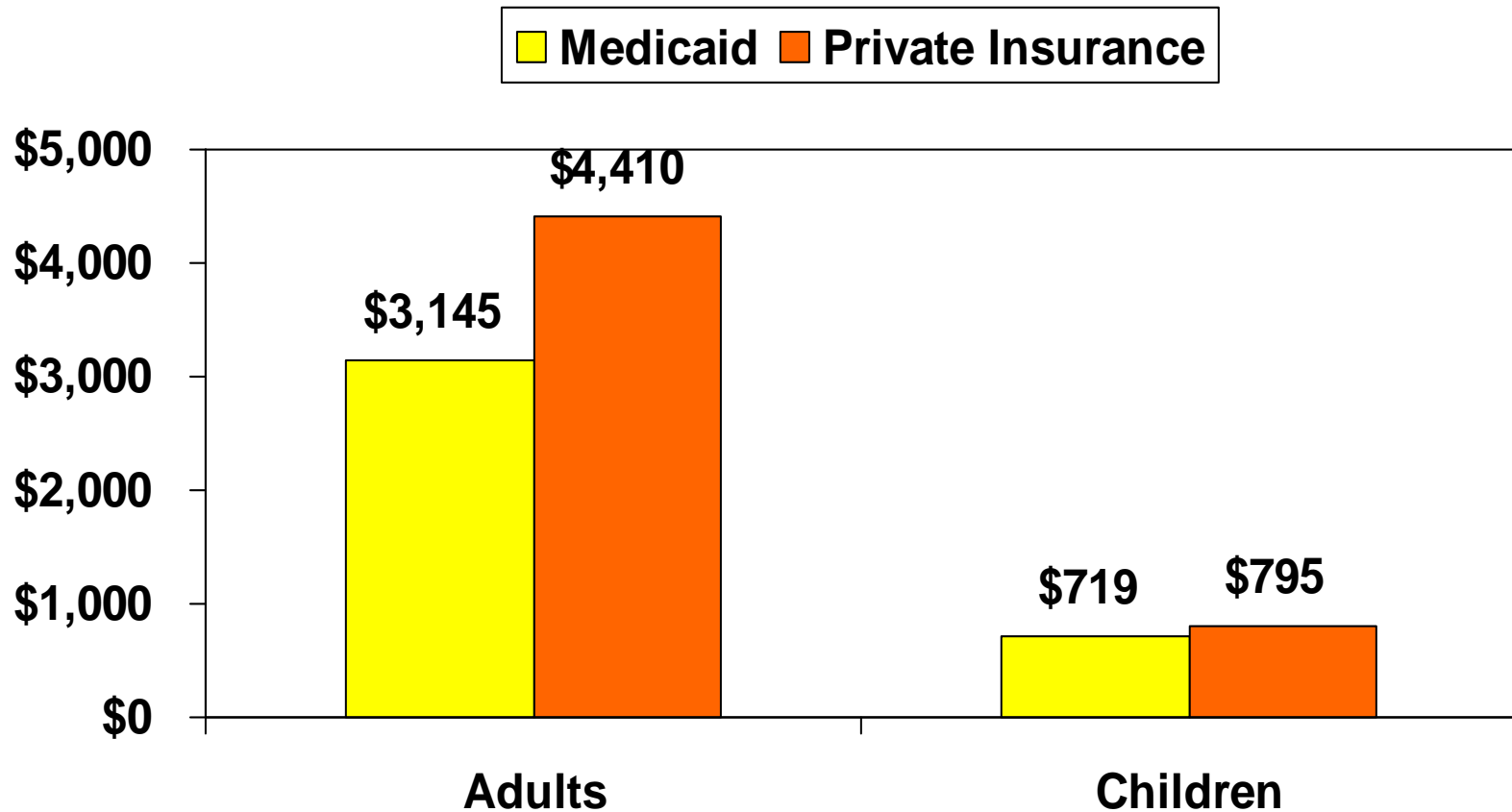
State Policy Actions Implemented in FY 2008 and Adopted for FY 2009



NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals. Eligibility includes eligibility and application expansions/restrictions.
 SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008.

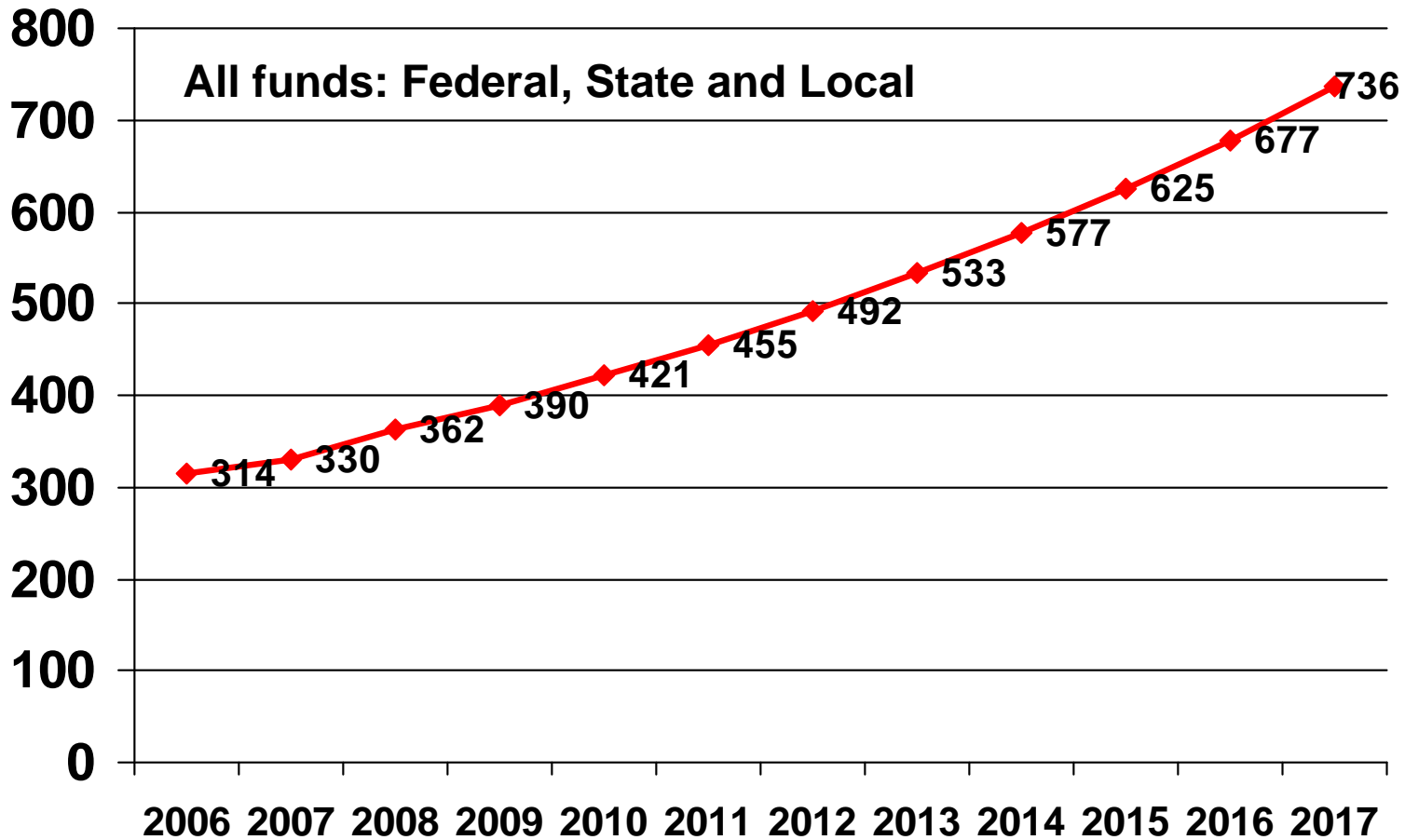
**Kaiser Commission on
 Medicaid and the Uninsured**

Medicaid *Per Capita* Costs Are Less Than Private Insurance



Note: Based on 2001 per capita costs, adjusted for health status.
Source: Hadley and Holahan, *Inquiry*, 2004.

Medicaid Total Spending Projected to Double to Over \$700 Billion in Ten Years: 2007 - 2017



Source: Health Management Associates estimates based on data from CBO and CMS, 2007.

State Priorities

- 1. Cover the uninsured (build on Medicaid)
- 2. Assure Medicaid fiscal sustainability
- 3. Increase value for public dollars
 - ✓ Quality
 - ✓ Health outcomes
 - ✓ Efficiency

Federal Priorities

- 1. Rein in Federal spending on health care
- 2. Assure Medicaid program and fiscal integrity
- States pay full matching share with “legitimate” public funds
- Closer scrutiny of provider claiming
- Closer scrutiny of rate setting
- A more “fundamentalist” approach to Medicaid benefit and eligibility definitions

Federal Response: Limit Role of Federal Financing

- Administration, through CMS action, began to resist use of new federal Medicaid funds in state expansion efforts
- New state efforts to match “unmatched” state or local dollars being rejected by CMS
- CMS unilaterally restricted SCHIP approvals over 250% FPL
- Obtained Congressional support to limit use of SCHIP waivers for adults (DRA)

Over 2/3 of All States in 2007 Offered New Proposals

Governors in 34 states offered plans to reduce the number of uninsured children, parents, adults, aged and disabled in their state through

- Medicaid expansions
- SCHIP expansions
- DRA waivers
- Comprehensive Section 1115 waivers
- Market-based approaches
- Improving quality through prevention and better management of chronic conditions

State Priority 2 - Sustainability

- Is it the “R” word yet?
- 18 states predicted fiscal shortfall in 2008
- 35-40 states expected to have shortfall in 2009
- Medicaid is countercyclical: state revenues drop just as Medicaid enrollment increases

2008 State Reaction

- Budget cutting, rather than health reform, is again the top priority in many states
- States once again freezing or cutting rates
- Expansion plans in jeopardy or delayed
- States and advocates continue to seek Medicaid fmap enhancement in a federal stimulus package

Increase Value

- Health Information Technology to improve outcomes and system performance
- Electronic Medical Records, e-prescribing
- Inter-operability
- Reduce administrative burdens
- Reduce errors
- Reduce unnecessary procedures

Federal Priority - Program Integrity

- Congress has been a driver
- GAO audits of federal agency oversight
- Critical of CMS
- Administration response: focus on federal/state fiscal relationship
 - Increased scrutiny of state fiscal arrangements (100 new auditors reviewing state financing): state “schemes” and “fraud and abuse” theme

Additional Federal PI Actions

- The Payment Error Rate Measurement
 - To comply with federal law to minimize improper payment in major federal programs
- Implemented 2006-8
- Detailed examination of Medicaid/SCHIP paid claims, capitation payments, reimbursement and premium policies, coding, eligibility processing and more

Bend the Trend: LTC Reform

- Medicaid is the nation's LTC insurance policy
- LTC = 1/3 total Medicaid spending
- Nursing homes = largest category LTC
- Reform elements:
 - Consumer-centered, choice and control
 - Least restrictive setting
 - Cost-effective
 - Personal financial responsibility encouraged

Who qualifies for Medicaid long-term care?

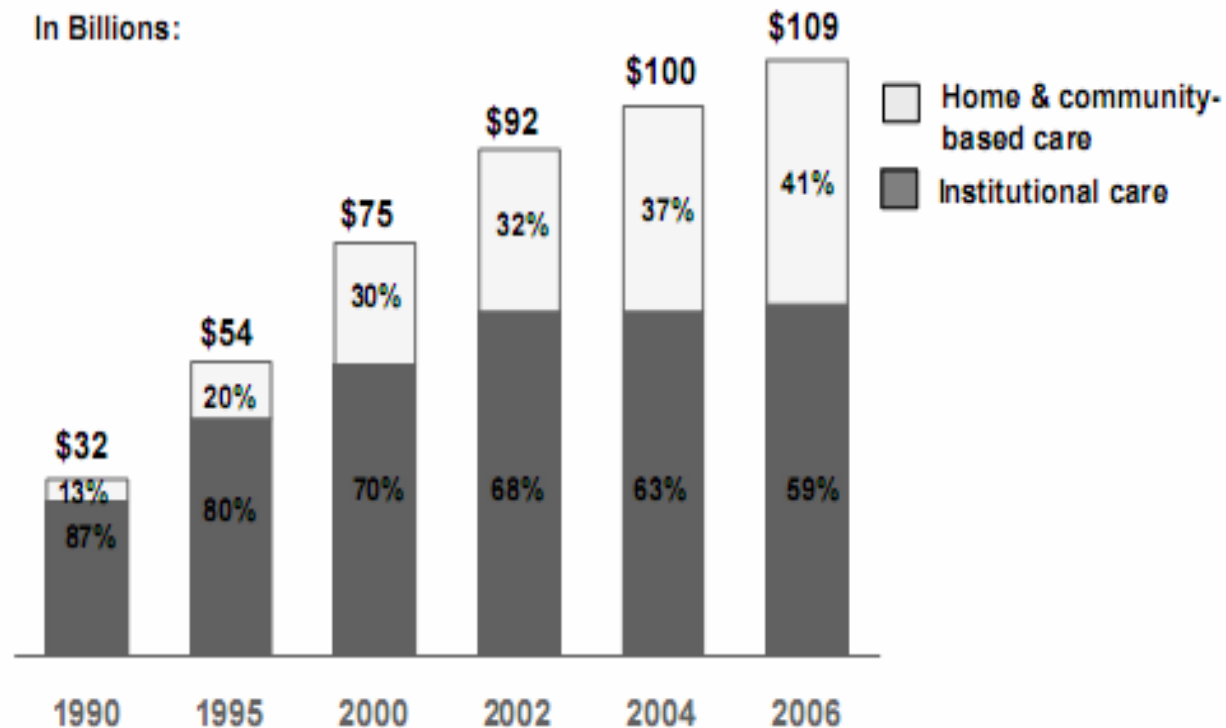
- Medicaid eligibility criteria is restrictive
 - Individuals need to fit into a category, such as over 65 or disabled to qualify.
 - Individuals must also have very low-incomes
 - AND limited assets (such as savings accounts) to qualify.
- Many individuals with long-term care needs are not eligible because they do not meet either financial or categorical criteria.
- For low-income Medicare beneficiaries who do qualify, Medicaid fills the gaps in Medicare coverage



Figure 5

Growth in Medicaid Long-Term Care Services Expenditures, 1990-2006

In Billions:



Note: Home and community-based care includes home health, personal care services and home and community-based service waivers.

SOURCE: KCMU and Urban Institute analysis of HCFA/CMS-64 data.

**KAISER COMMISSION ON
Medicaid and the Uninsured**

Medicaid Spending into the Future

On-going Medicaid spending pressures expected to persist

- Increasing health care costs
- Increasing uninsured / declines in employer coverage
- Increasing aged and disabled
- Tension in federal / state financing for Medicaid

A New Administration in '09

- States are eager for a new Administration– ***whoever it is!***
- Goal of many – “Don’t file anything until new Administration”
- Pent up demand from states:
 - Old filings that haven’t seen action
 - Routine updates
 - Waivers for reform
 - Response to regulations

Looking to the Future: Caution

- We want more from Medicaid.
- We don't know how to pay for growth.
- The tug of war over Medicaid's future will continue regardless of who gets elected in November.



What Happens Next?

- Congress and states “punted” regulatory issues to a new Administration
- New Administration will still be unpacking boxes by April 2009!
- Will they: Withdraw regs? Modify regs? Voluntarily extend moratorium? Start over?
- Congress likely to retain interest in outcomes
- Many issues raised by current Administration are viewed as having merit

Implications for Providers

- Some of the issues raised in proposed regulations won't just "go away"
- More standardization of service delivery and reimbursement being sought across states (CM, rehab)
- May force states to redesign services, some services may be lost or restricted (habilitation)
- Case management reforms could have greatest impact – single case manager, 15 minute units

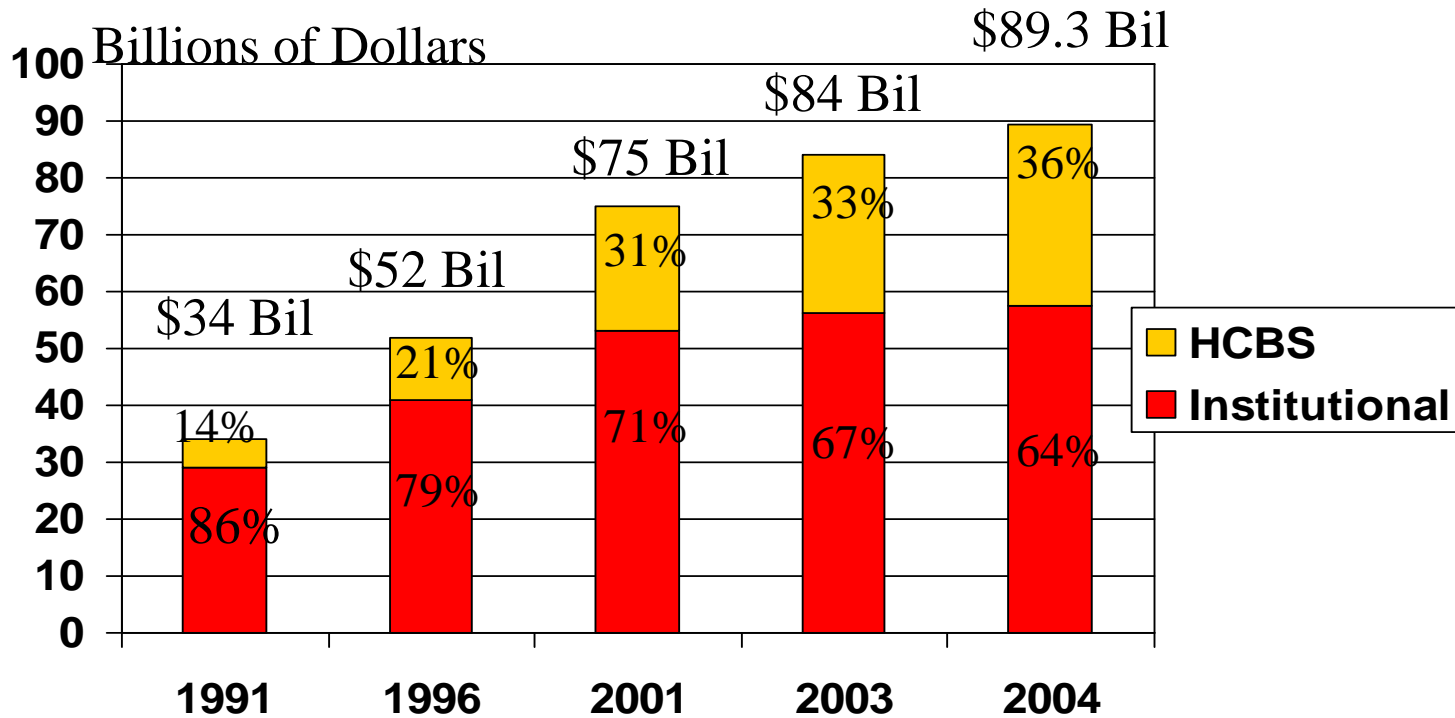
Implications for Providers

- Under DRA, States can target leaner or richer benefit packages, may exclude or include MRDD, MH services
- Cost-sharing can be enforced – a barrier to services for some?
- Some consumer/entitlement protections lost as states seek flexibility
- New options may be available

Implications for Providers

- Focus on performance and accountability will continue
- Federal Office of Inspector General (OIG) priority list targets local use of Rehab, TCM
- If Congress will remain unwilling to discuss financing, focus on “waste and abuse” likely to continue
- Continued focus on services to people with chronic or disabling conditions may create opportunities to improve Medicaid’s support of vulnerable populations
- IF covering the uninsured becomes a federal issue will needs of chronically ill/disabled be addressed?

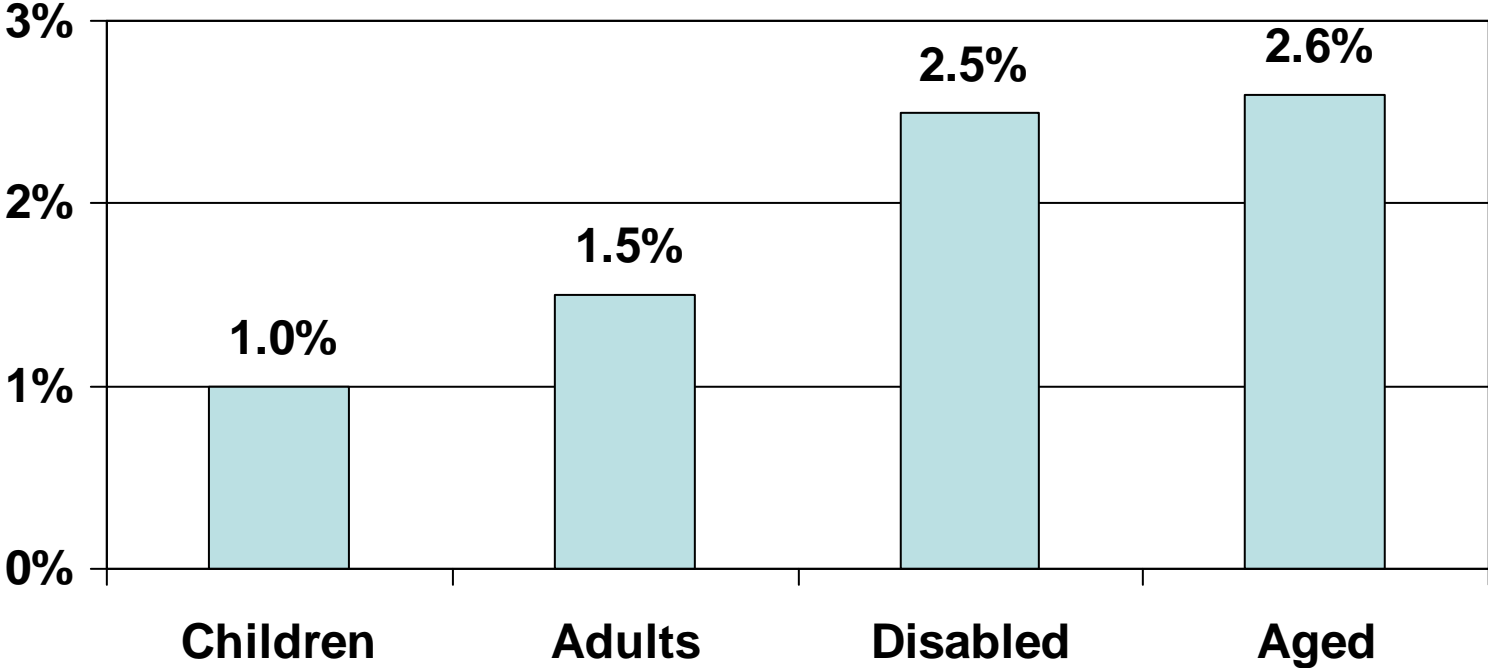
Medicaid LTC: Trend Continues Toward Home and Community Care



Source: Brian Burwell, Kate Sredl and Steve Eiken, Thomson Medstat, 2005.

Projected Growth in Medicaid Enrollees 2007 - 2017

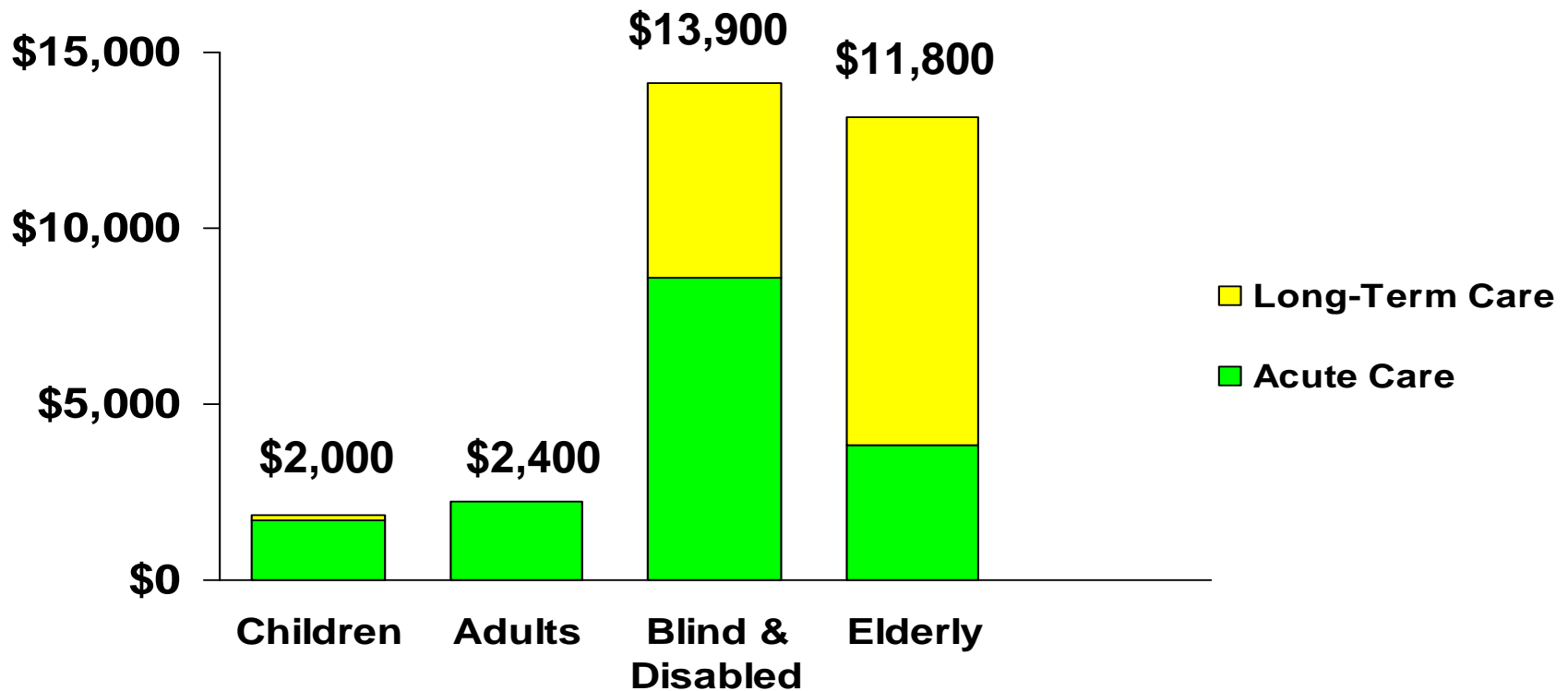
Medicaid Annual Growth by Category of Eligibility



Source: Calculations by Health Management Associates based on CMS historical data and Congressional Budget Office Projections through 2017, March 2007 Medicaid Baseline.

Medicaid Expenditures Per Enrollee

Annual, '06



SOURCE: Health Management Associates estimates, based on CBO March 2006 baseline. Expenditures do not include DSH, adjustments, or administrative costs. Long-term care and acute care shares represent historical data calculated by the Urban Institute.

State Priority 3 - Increase Value

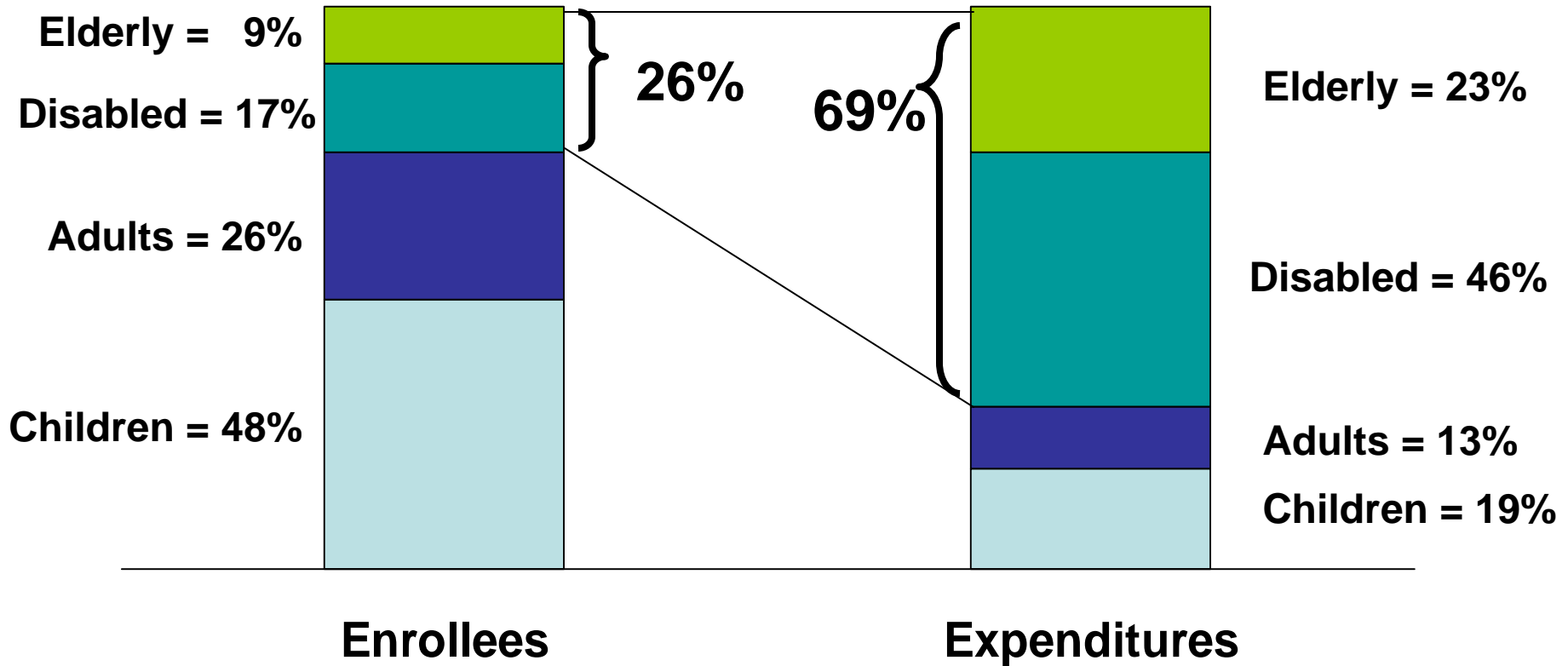
- Emphasis on personal behavior and responsibility
- Incentives, consumer education
- Cost sharing at higher incomes
- LTC Partnership program
- Pay for Performance
- Participation
- Process (medical home model)
- Outcomes (never events, improved health status)
- Promote Evidence Based Practices

Qualifying for Medicaid on the Basis of Disability

- Medicaid is the health coverage program for low-income people who fall into certain eligibility categories (*i.e. children, parents, seniors, and people with disabilities*) and who meet income, resource (assets), citizenship, and state residency requirements
- People with disabilities must meet the same Social Security standard for disability as Medicare
- 78% of people with disabilities qualify as recipients of SSI
- States can cover people with disabilities up to the poverty level and use other options to extend coverage;
 - medically needy coverage in which individuals start out with too much income, but “spend down” by incurring substantial medical expenses is an important pathway to Medicaid coverage in some states



Enrollment vs. Expenditures 2006



2006 U.S. Total = 59.7 million

U.S. Total = \$299 billion in 2006

NOTE: Expenditure distribution based on spending for medical services only and excludes DSH, supplemental provider payments, vaccines for children and administration.

SOURCE: Health Management Associates estimates based on CBO Medicaid Baseline, March 2006.

Medicaid Waivers

**Gaining state
exceptions to
Medicaid
Federal
requirements**



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Medicaid Long Term Care

- States are required to cover nursing facility benefits but also cover other ICF/MR and psychiatric inpatient facilities for individuals under 21
- Individuals with long-term care needs also receive medical and other supportive services
- 4 types of state Medicaid programs provide community-based long-term care services:
 - home health services (mandatory)
 - skilled nursing services
 - personal care services (optional: 32 states)
 - ADL and IADL assistance
 - home and community-based waiver services (254 waivers)
 - ADL & IADL assistance
 - varying other services: personal emergency response, respite, case management, counseling, adult or social day care
- New Home and Community-Based Services at state option (DRA 2005)
- 1915(b)(c) allows managed care to integrate HCBS waiver services with state plan services to provide coordinated array of services
- 1115 research and demonstration waivers are the most comprehensive
- 1115 waives used to authorize experimental, pilot, or demonstration projects to promote objects of the SSA Act (including Medicaid)
- 1115 requires public input



Key Federal Requirements

- **Statewideness**
1902(a)(1): in all political subdivisions
- **Comparability**
1902(a)(10)(B)
- **Income & Resources**
1902(a)(10)(C)(i)(III)
- **Fair Hearing:**
1902(a)(3)
- 1902(a)(23) **Freedom of Choice of All Qualified Providers**
- **Payments to Providers:**
1902(a)(30)(A) requires that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers
- **Provider Agreements:**
1902(a)(27) requires provider agreement between Medicaid agency and each provider furnishing services



Waivers

- Exception to federal requirement
- State request to waive specific statutory requirements
- May or may not require public input
- Feds (HHS Secretary through CMS) required to approve
- Initial time limit; then renewal limit



Types of Waivers

- 1915 (b) waives freedom of choice of providers (managed care); limit number of providers through selective contracting
- 1915(c) waives 3 requirements to provide services otherwise not otherwise available under SP as an alternative to institutional care
- 1915(b)(c) allows managed care to integrate HCBS waiver services with state plan services to provide coordinated array of services
- 1115 research and demonstration waivers are the most comprehensive
- 1115 waivers used to authorize experimental, pilot, or demonstration projects to promote objects of the SSA Act (including Medicaid)
- 1115 requires public input



1915(c) HCBS Waivers

Federal Medicaid Provisions Waived

- **Section 1902(a)(1)**, regarding statewideness
- **Section 1902(a)(10)(B)**, regarding comparability of services allowing state to make services available to people at risk of institutionalization, without being required to make waiver services available to the Medicaid population at large. States use this authority to target services to particular groups—elderly, MR/DD, and physical disabilities.
- **Section 1902(a)(10)(C)(i)(III)**, regarding income and resource rules applicable in the community. This allows states to provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent.

Program Requirements

States have the flexibility to develop HCBS waiver programs designed to meet the specific needs of targeted populations

- Demonstrating that providing waiver services to a target population is no more costly than the cost of services these individuals would receive in an institution.
- Ensuring that measures will be taken to protect the health and welfare of consumers.
- Providing adequate and reasonable provider standards to meet the needs of the target population.
- Ensuring that services are provided in accordance with a plan of care.



Medicaid 1915(c) Waivers

- **48 states and DC have 1915(c) waivers**
- **There are 287 active waivers**
- **No limit on number of waivers state can have**
- **Waiver initially granted for 3 years; renewal for 5 years**



Current Developments in Medicaid 1115 Waivers & DRA

- Impact of economic downturn on state budgets
- Update on state activity under DRA
- Update on Section 1115 waivers



What a Difference a Year Makes

- Last year the talk was about state coverage expansions
- This year:
 - ✓ 31 states and DC facing budget shortfalls
 - ✓ Shortfalls totaling \$48 billion
 - ✓ 3 other states project shortfalls for FY 2010 and beyond
 - ✓ Likely that some states will face mid-year shortfalls



Budget Deficits Affecting State Medicaid Programs

- A number of states have implemented or are considering cuts in Medicaid
 - ✓ At least 7 states cutting services for seniors and people with disabilities
 - ✓ At least 13 states making cuts affecting children and families
- Examples:
 - ✓ Florida provider cuts
 - ✓ California no budget – no provider payments since July
 - ✓ Alabama cutting homemaker services



Recent 1115 Waiver Activity

- GAO: 2 reports on 1115 waivers
- ✓ July 2007: Medicaid Demonstration Waivers: Lack of Opportunity for Public Input during Federal Approval Process Still a Concern
- ✓ January 2008: Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns Not much state activity under DRA this year
- Only one new 1115 waiver—Healthy Indiana Plan
- Several pending—RI, PA, TX



Healthy Indiana Plan

- Expands coverage for parents and adults without children
- Each participant has an \$1,100 POWER account
- Health plans provide coverage after deductible
- Benefits differ from Medicaid
- ✓ \$300,000 annual and \$1 million lifetime cap
- ✓ Limits skilled nursing to 30 days, no dental or vision care, limits therapy services

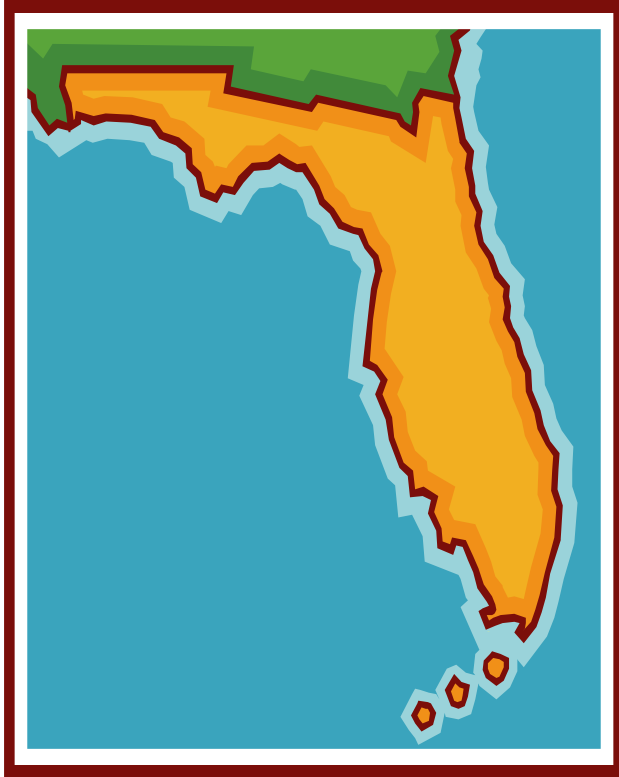


Rhode Island 1115 Proposal

- ✓ **Would change Medicaid's matching structure to a block grant**
- ✓ **Limits state funding for Medicaid to a percentage of the state budget**
- ✓ **Asks for unprecedented flexibility to make changes in eligibility & benefits**
- ✓ **Establishes tiered system of coverage**
- ✓ **If not in most intensive support needs tier, no entitlement to coverage**



Waiver Update—Florida



- Pilot program—5 counties (3 rural)
- HMO plans offered less generous benefits in second year
- ✓ People with disabilities more likely to enroll in provider-sponsored networks which cannot limit benefits in same way as HMOs
- Beneficiaries have only spent 20% of “enhanced benefits” they have earned
- Not clear whether state is saving money



Looking Ahead...

- **Will RI waiver be approved and, if so, would other states want to move in that direction?**
- **How will states respond to budget shortfalls?**
- **What approach will new Administration take on these waivers—regarding both process and substance?**
- **Possible Congressional legislation requiring Federal and state transparency and stakeholder input.**

