Background on the Medicaid Program: Requirements/Restrictions

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Medicaid Commission

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Road Map

- The Medicaid State Plan
- Flexibility under the State Plan
- Section 1115 waivers
- Is there a problem that requires statutory "reform" (or, why isn't an 1115 waiver enough)?
- What kinds of challenges in Medicaid cannot be completely resolved by reforming just Medicaid?

The Medicaid State Plan

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A Medicaid "state plan" is best understood as a contract between a state and the federal government . . .

- Title XIX is based on a contract which is called the approved "state plan": in exchange for federal funds, the state will operate its Medicaid program in accord with the state plan requirements in 42 USC Section 1396a et. seq.

- The federal government exercises oversight to ensure the state is meeting its end of the bargain in exchange for the federal funds

- Recent court decisions suggest that the overall terms of the state plan are enforceable by a state or the federal government against each other, but not in federal court by a Medicaid provider or Medicaid beneficiary

. . . that represents one attempt to balance state "flexibility" with a baseline "national" program . . .

- Title XIX should be understood as one attempt at balance in the federalism debate: certain things are mandatory (to create a national program), and certain things are discretionary to the states and to HHS (to allow variation across the states)
- A key issue for the Medicaid Commission will be to consider where it thinks this balance should be

. . . where some elements are mandatory "boilerplate" for a state, such as . . .

- Coverage of mandatory eligibility groups
- Coverage of mandatory benefits
- Paying proscribed provider rates to FQHCs and IHS
- "Statewideness"
- "Comparability"

. . . and where other elements are discretionary for a state.

- Optional eligibility groups
- Optional benefits
- Most private provider rates

“Flexibility” under the State Plan

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Domains to be discussed

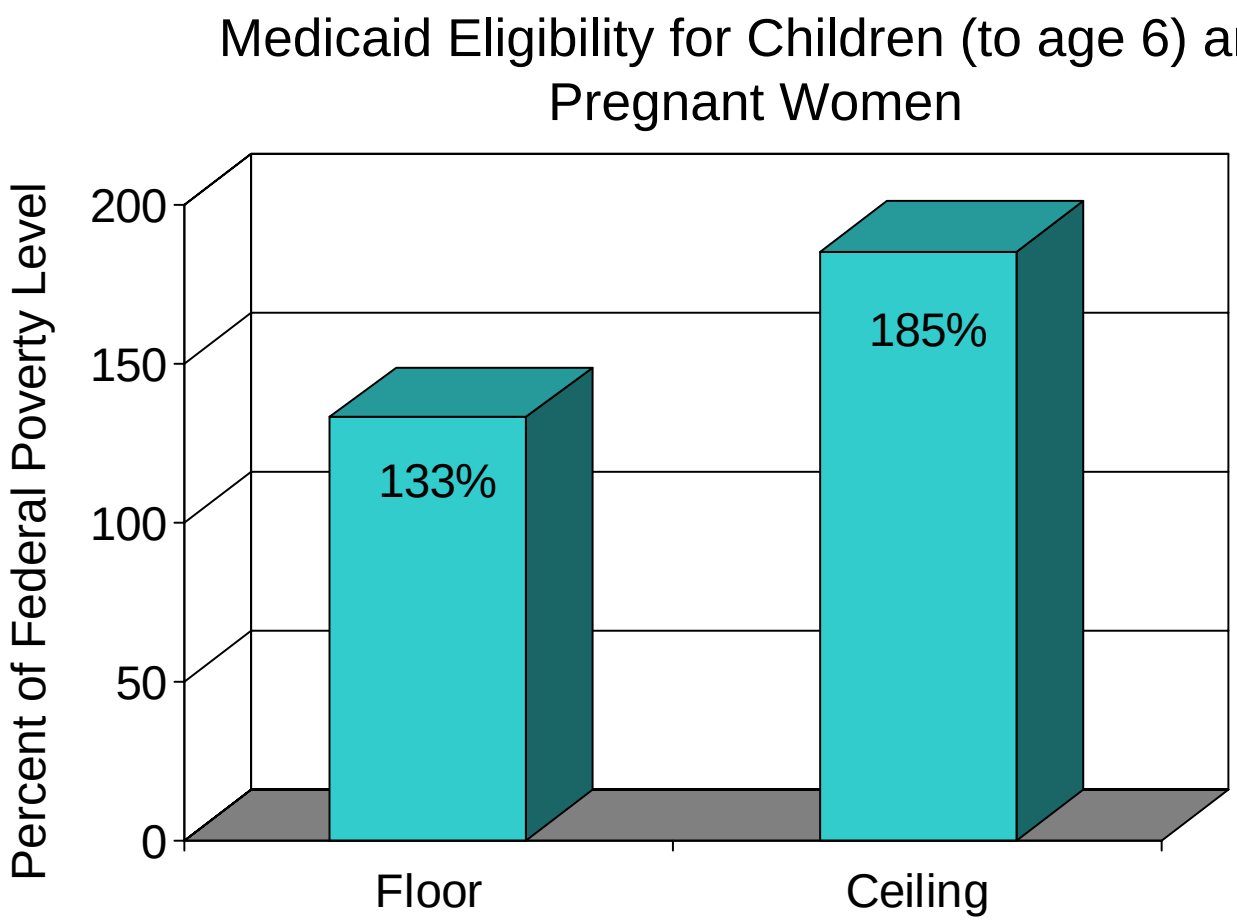
- Eligibility
- Benefits
- Provider rates
- Beneficiary cost sharing
- Utilization control

This discussion addresses state flexibility *in the absence of a waiver*

State flexibility in eligibility

- Whether to cover an optional eligibility group and, if so, up to what income level
- Whether to be less restrictive in how certain income and assets are counted (for some eligibility groups)

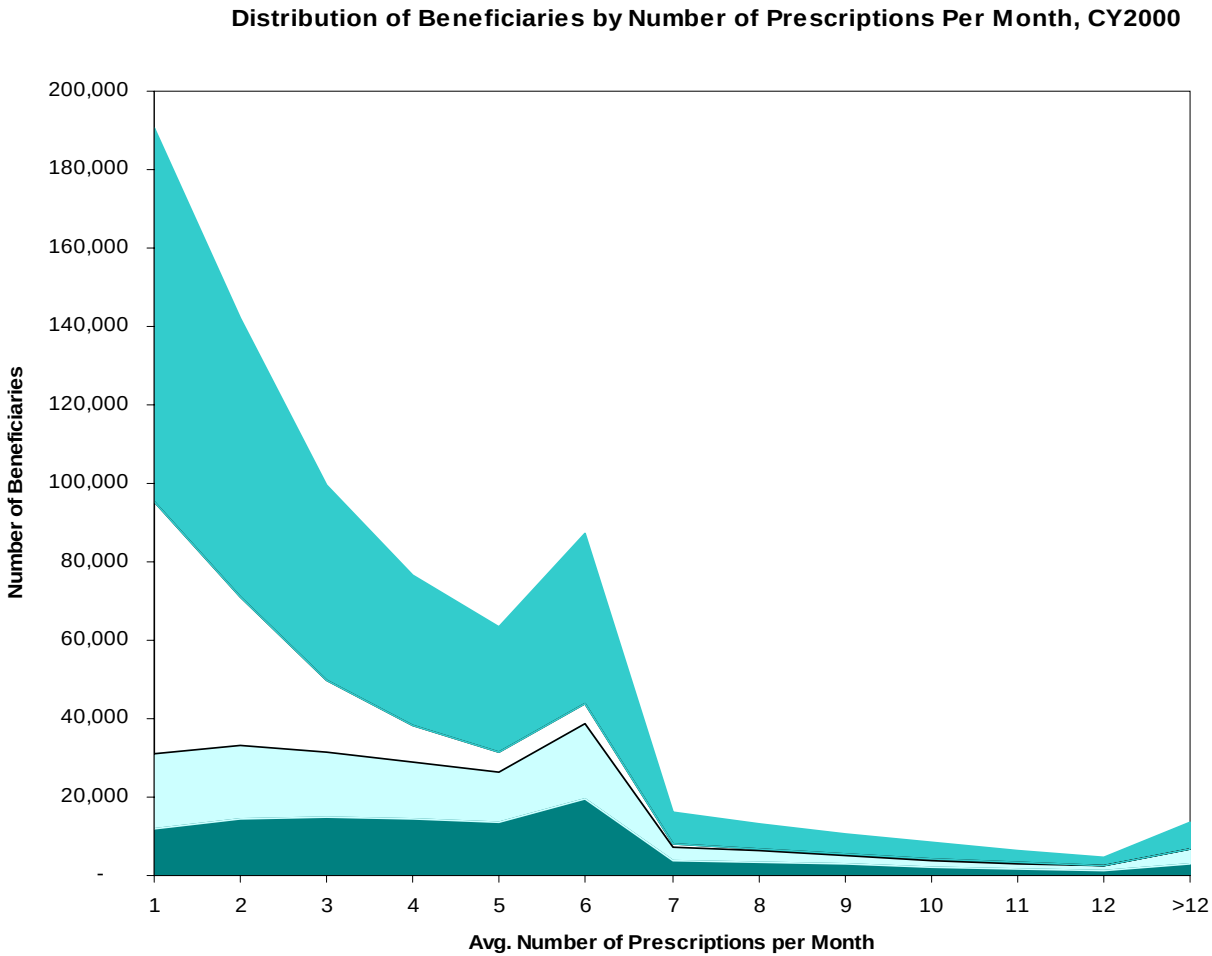
For example, a state can select optional coverage for children (to age 6) between 133%-185%



State flexibility in benefits

- Whether to cover an optional benefit at all
  - Yet, an optional benefit may become mandatory for children because of the requirement of “early and periodic screening, diagnosis and treatment” (EPSDT)
- And, if so, the “amount, duration and scope” of the benefit

For example, North Carolina limited adult prescriptions



Source: Lewin Group analysis of North Carolina Medicaid Data, CY 00

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State flexibility in provider rates

- States have significant flexibility in setting most private provider rates (as long as the rates provide access to the covered benefit).

- But CMS increasingly is unwilling to approve state plan amendments regarding payments to public providers (as CMS interprets what constitutes state and local matching funds, and what is necessary for the efficient administration of the Medicaid program).

State flexibility in setting private physician fees leads to great variation around the country.

CPT Code	*Description*	*DC*[a]	*VA*[b]	*PA*[b]	*DE*[b]	*W. VA*[b]	*MD*[c]	*Medi Care*[d]	*Min Private fee*[e]
99201	New Patient, Office Visit	25	29	25	38	35	29	36	56
99202	New Patient, expanded office visit	30	45	20	59	55	51	65	74
99203	New Patient, low complexity	30	63	20	83	77	77	96	97
99204	New Patient, intermediate complexity	35	91	20	120	110	109	136	142
99205	New Patient, high complexity	59	114	30	149	136	139	174	182
99211	Established Patient, Office Visit	15	14	20	19	19	17	21	29
99212	Establish. Patient, expanded office visit	18	24	20	32	29	30	38	45
99213	Established Patient, low complexity	18	34	20	44	39	42	53	62
99214	Establish. Patient, intermediate complexity	30	52	20	68	61	66	83	92
99215	Established Patient, high complexity	41	77	20	101	87	97	121	136

Note:
[a] American Academy of Pediatrics Survey of Medicaid Reimbursement (1998/1999)
[b] American Academy of Pediatrics Survey of Medicaid Reimbursement (2001)
[c] Fee schedule as of July 2002
[d] Medicare Fee schedule for March through December 2003
[e] 2003 Physicians Fee & Coding Guide, MAG Mutual Healthcare Consultants

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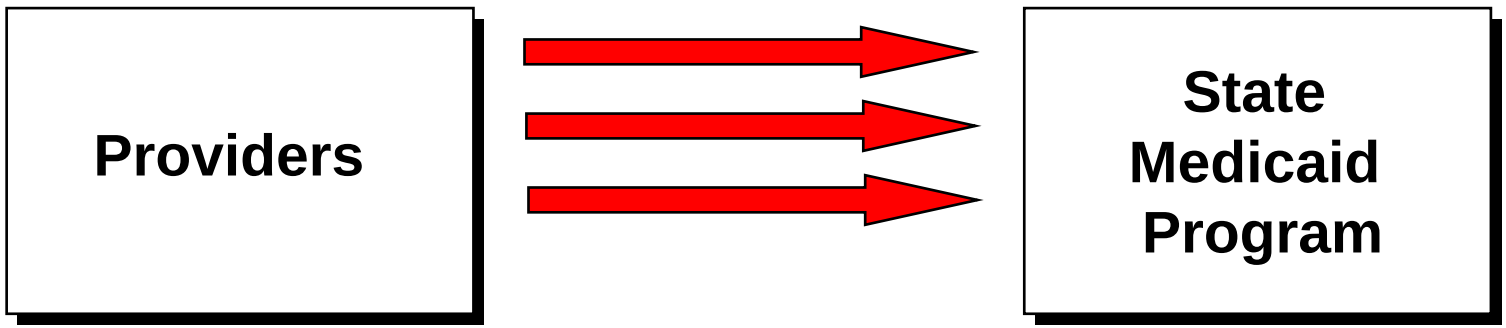
Yet, pressure is increasing on Medicaid provider rates . . .



1. **Cannot cost shift onto Medicare or private insurance (due to "prudent purchasing" by these purchasers)**

2. **Increase in Medicaid enrollment/patient load heightens the importance of Medicaid rates**

3. **Providers: "social mission diluted by Medicaid expansions"**

. . . and CMS's concerns about payments to public providers is the basis for current Administration budget proposals

- Upper payment limit
- Intergovernmental transfers
- Targeted case management
- Cap on administrative expenditures

State flexibility in beneficiary cost sharing

- Under the statute, cost sharing must be:
  - "Nominal"
  - Not imposed on services used by certain eligibility groups (e.g., pregnant women; children; people in institutions)
  - Cannot be enforced if the effect would be to deny a service
- Under regulations issued by then-HCFA in the early 80's:
  - Copays cannot exceed $3 per service
  - Premiums cannot exceed $19/mo. per family

State flexibility in utilization control

- States may impose prior authorization requirements in an attempt to avoid unnecessary care

State flexibility in utilization control: potential savings by prior authorizing of certain drugs in North Carolina

Drug Name	Total Expense 2000	Projected Potential Expense Reduction
Prilosec	$ 36,282,850	$ 25,500,000
Prevacid	$ 23,481,230	$ 13,800,000
Aciphex	$2,562,802	$1,500,000
Ranitidine 150mg	$6,371,835	($ 2,000,000)
Pepcid	$5,366,912	($ 1,700,000)
Axid	$2,308,959	($ 700,000)
Celebrex	$ 15,036,600	$ 11,200,000
Vioxx	$ 10,010,600	$ 7,750,000
"other branded NSAIDs"		neutral
Total		$55,350,000
Potential State Savings		$16.3 million

Source: Lewin analysis of North Carolina Medicaid Data, CY 00

Section 1115 Waivers

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An 1115 demonstration waiver permits the Secretary to waive otherwise required elements of the state plan

- An 1115 waiver specifically allows waiver of the terms of 42 USC Section 1396a (“Section 1902”)
- Must be budget neutral (cannot cost the federal government more money than the status quo)
- Theoretically, this governs many key elements. E.g.:
  - Mandatory eligibility groups
  - Mandatory benefits
  - Delivery system/managed care

. . . but many areas are not "waiveable" by the Secretary under the law (since they aren't in Section 1902) . . .

- FMAP rates
- Minimum level of Rx rebates
- Prohibition on charging copayments for services by pregnant women, kids, others
- Spousal impoverishment protections
- Estate recovery
- Payment rates to FQHCs and IHS
- Obligation to conduct third party liability

. . . and others have not been considered "waiveable" under longstanding policy from HHS.

- Provision of mandatory benefits to mandatory populations

- Entitlement nature of program for mandatory populations (i.e., the prohibition of an enrollment cap for these groups)

This reflects a view about federalism

Is there a problem that requires "reform" (or, why isn't an 1115 waiver enough)?

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Potential problem no. 1

- Components of Medicaid law that are not “waiveable” by the Secretary
  - This type of reform might be desired by both the Governors and HHS.
  - Examples: Minimum level of Rx rebates; spousal impoverishment rules

Potential problem no. 2

- Components of Medicaid law that are “waiveable”, but the Secretary might be reluctant to waive them
  - This type of reform might be desired by one or more Governors, but not necessarily by HHS.
  - Examples: Enrollment cap on eligibility groups; guarantee of EPSDT services for mandatory children; higher copayment levels for non-pregnant adults.

Potential problem no. 3

- Components of Medicaid law that are “waiveable”, but there is distrust about which states get approved waivers, and which states do not.
  - Potential goals: Equity and predictability
  - Examples: methodologies to achieve budget neutrality are allowed in some states, but not in others.

Potential problem no. 4

- The statute may be fine – but certain stakeholders want reform of the HHS regulations (i.e., they want to override the regulations by a statutory change)
  - This type of reform might reflect a view by some Governors that HHS will not voluntarily pursue a regulatory change
  - Example: raising the permissible copayment and premium levels (i.e., redefining what "nominal" means)

What kinds of challenges in Medicaid cannot be completely resolved by reforming just Medicaid?

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What kinds of challenges cannot be completely resolved by reforming just Medicaid?

- Enrollment growth related to substitution of coverage
- Costs related to dual eligibles
- Medicaid's institutional bias

Substitution: coverage for the non-elderly (age 0-64) has migrated into Medicaid/SCHIP since the 1997 BBA

Source of Coverage	1997 (per 1000)	1999 (per 1000)	2001 (per 1000)	2003 (per 1000)
Employer	651	660	670	634
Other Private	69	67	60	55
Public Insurance	76	83	89	119
Other Coverage	49	40	39	42
Uninsured	154	151	141	150

Source: *HSC Community Tracking Study Household Survey, Tracking Report No. 94* (August 2004)

From 1997-2001, children (ages 0-18) in families below 200% FPL dramatically migrated into Medicaid and SCHIP . . .

	Per 1,000 Children		
	1997	**2001**	**Change**
Access to Employer-Sponsored Insurance	697	697	None
Take-Up	518	480	-38
Insured	795[x]	845[y]	+50
Uninsured	205	155	-50
Sources of Insurance:			
ESI (Take-Up)	518	480	-38
Other Private	68	52	-16
Public	210	314	+104
Total	796[x]	846[y]	+50

x, y are not equal due to rounding.

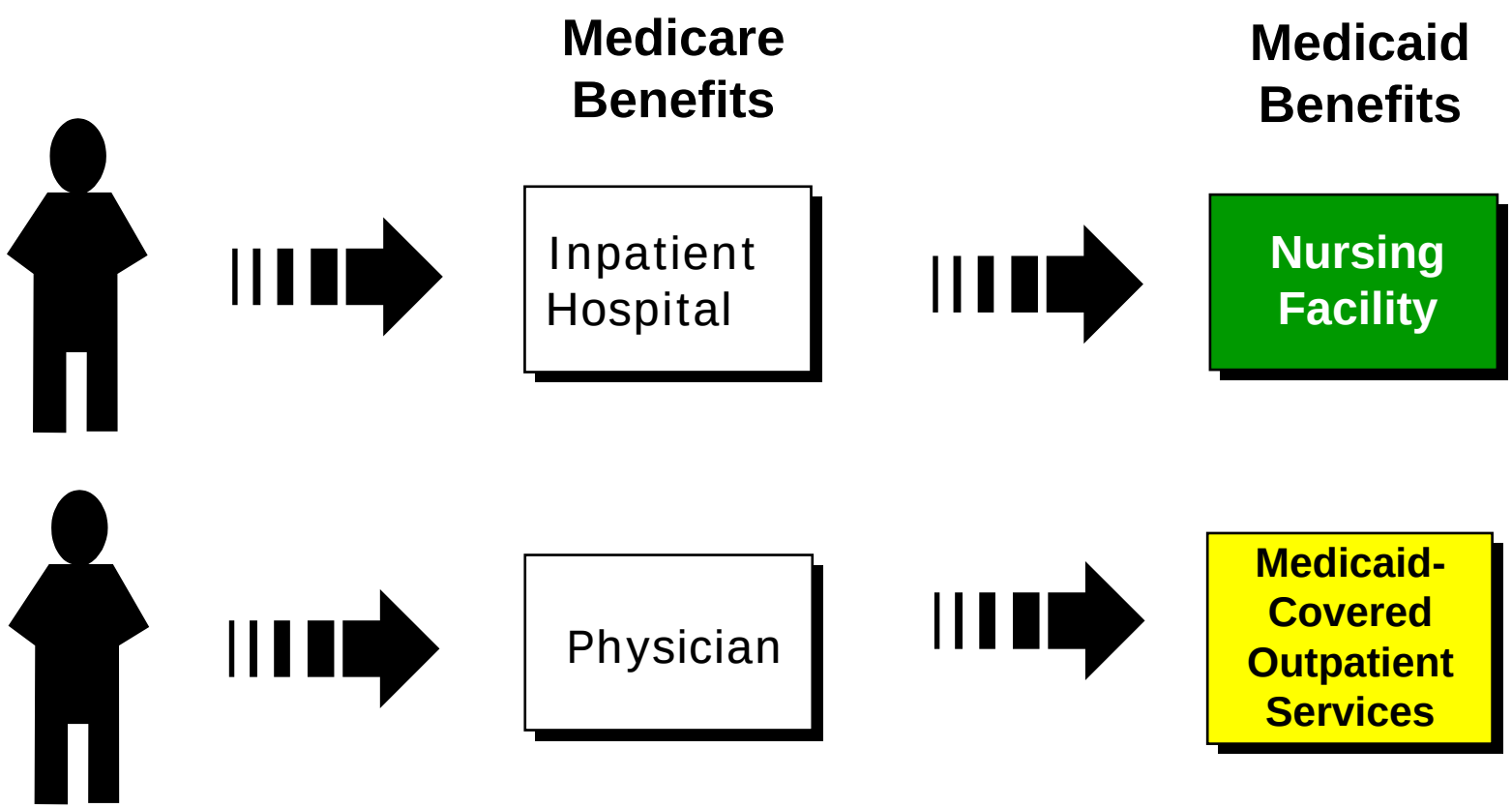
- Source: UMBC analysis of *HSC Community Tracking Study Household Survey, Tracking Report No. 4* (August 2002)

. . . and from 2001 to 2003, the non-elderly (age 0-64) in working families below 200% FPL also migrated into Medicaid and SCHIP

	Per 1,000 People		
	2001	**2003**	**Change**
Insured	723	728	+5
Uninsured	277	272	-5
For insured, source of Insurance:			
ESI	374	325	-49
Other Private	114	106	-8
Public	235	297	+62
Total	723	728	+6

Source: UMBC analysis of *HSC Community Tracking Study Household Survey, Tracking Report No. 94* (August 2004)

Dual Eligibles: Medicare serves as a gateway to Medicaid



Medicare access to a Medicaid outpatient service: pharmacy case study

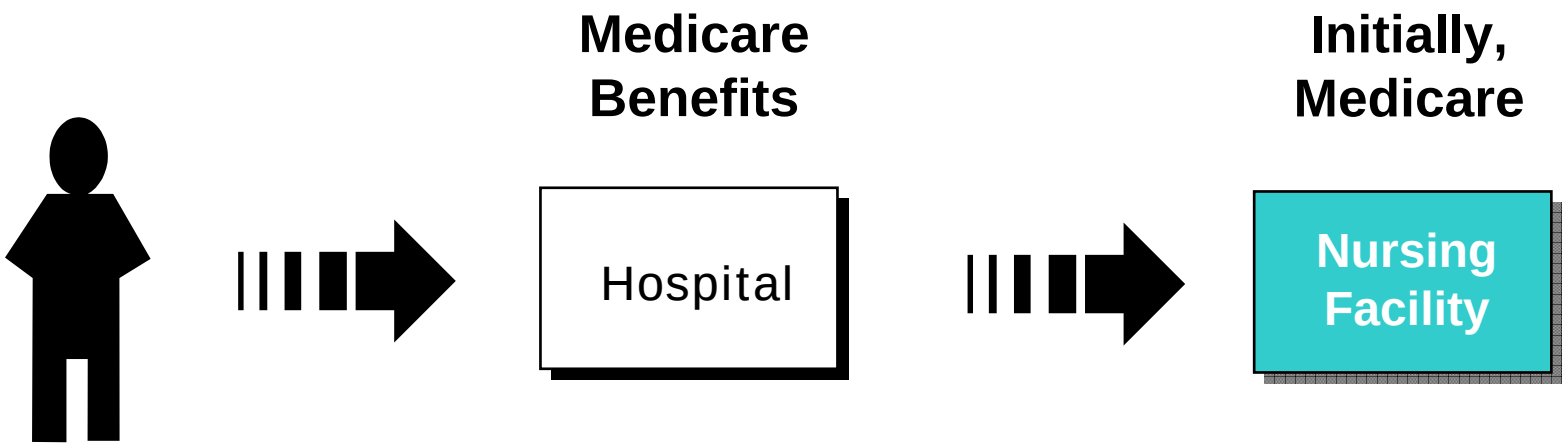
- In FY 04, Maryland had 3,147 dual eligibles in two home and community-based waivers. The top 10 Rx:

Top 10 Drugs	No. Beneficiaries
FUROSEMIDE	996
PREVACID	757
LISINOPRIL	666
NORVASC	568
LIPITOR	513
PLAVIX	467
CIPRO	426
ZITHROMAX	413
ZOLOFT	401
AMBIEN	394

Rx use by dual eligibles, example continued

- These 3,147 beneficiaries:
  - Received a total of 218,954 prescriptions in FY 04 (an average of 69.6 each);
  - Received 1,630 unduplicated medications; and
  - 399 separate medications were received by only ONE beneficiary each

Dual eligibles: most nursing home residents enter from a hospital, with Medicare paying the bill



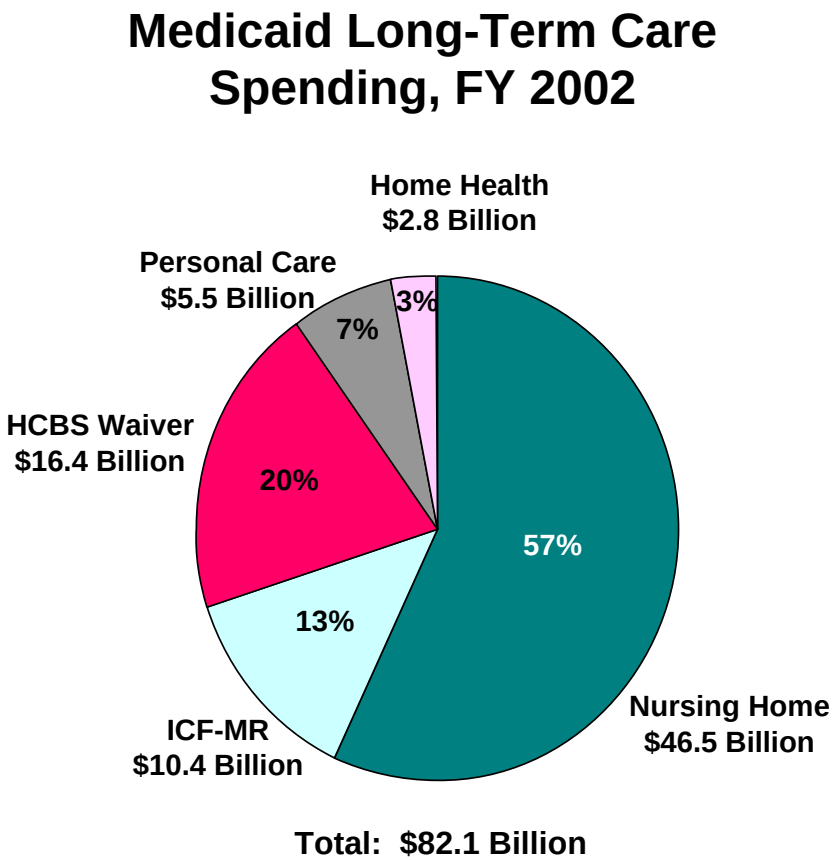
65.4% of all nursing home admissions come from a hospital.

Source: The National Nursing Home Survey: 1999 Summary

Other Medicare decisions impact Medicaid

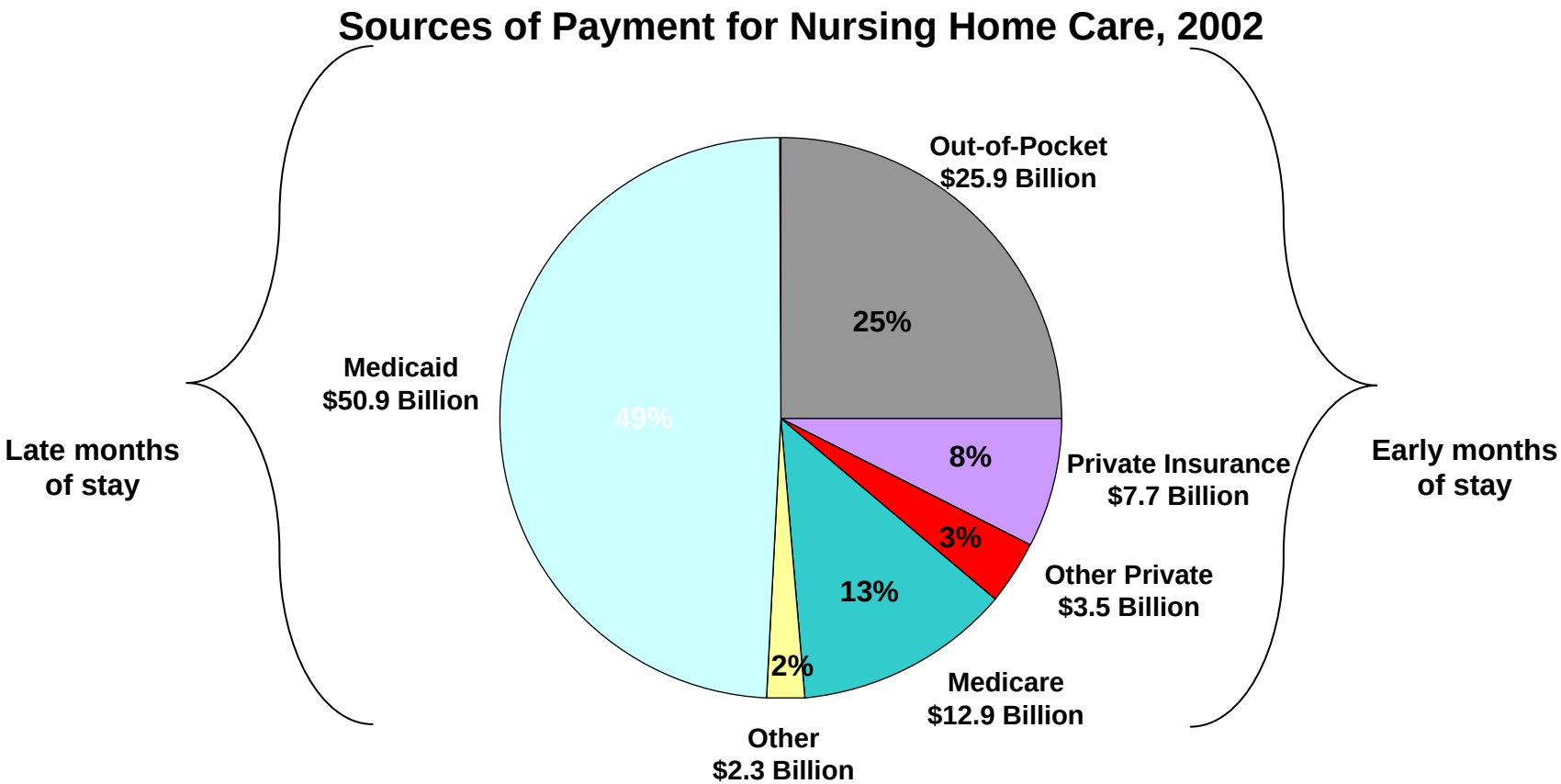
- Cost sharing levels in Medicare (e.g. Medicare Part B premiums)
- Utilization review decisions governing overlapping benefits
  - Skilled nursing
  - Home health
  - DME

Institutional bias: Medicaid spends the majority of its long-term care dollars on institutional care…



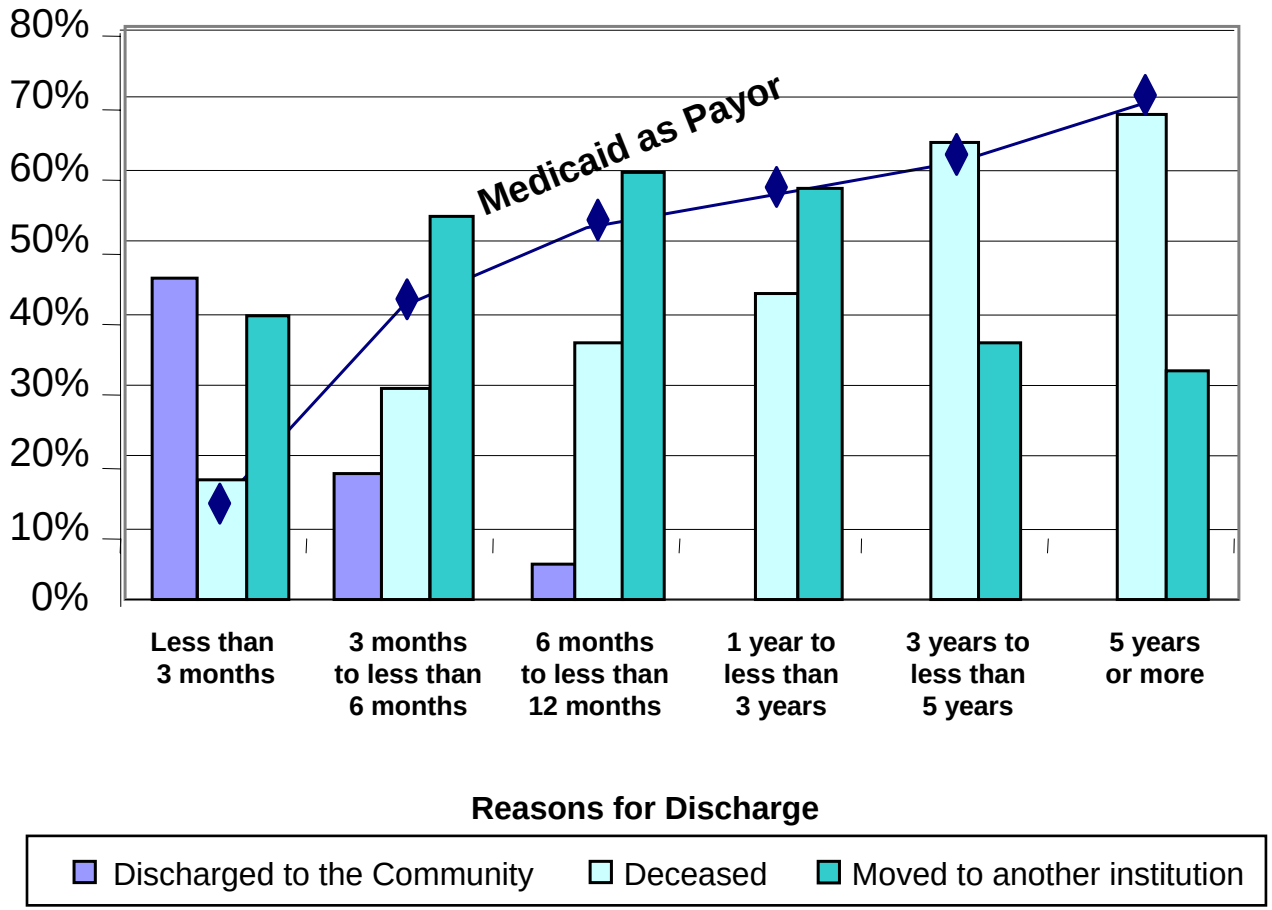
Source: The MEDSTAT Group, Medicaid HCBS Waiver Expenditures, FY 2002

. . . although other funding sources usually cover the early months of a person's stay . . .



Source: CMS, Office of the Actuary

. . . thus, individuals who move to the community do so after a short stay, before Medicaid is a major payor



Source: The National Nursing Home Survey: 1999 Discharge Data Summary

Conclusion

- Current Medicaid law is premised on a certain balance between restrictions/requirements and flexibility for both the states and HHS
- Major reform to Medicaid ultimately is a question of whether to redefine the existing balance in the federalism debate
- Certain types of challenges to Medicaid cannot be completely fixed just by changing the Medicaid statute alone

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