Chairman's Mark and Proposed Amendments

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Medicaid Commission Meeting

CENTER FOR HEALTH PROGRAM DEVELOPMENT AND MANAGEMENT

UMBC
AN HONORS UNIVERSITY IN MARYLAND

Sequence of Discussion

- A. Long-term care
- B. Benefit Design
- C. Eligibility
- D. Health IT
- E. Quality and Care Coordination

Long-Term Care

MARK A.1. Promote individual planning for long-term care

- **Public policy should promote individual responsibility and planning for long-term care needs.**
  - Provide federal and state tax incentives to encourage the purchase of private LTC insurance
    - Individuals and employers
  - Provide tax deductions/credits to family caregivers
  - Promote the use of home equity programs
  - Increase state participation in federal LTC Awareness Campaigns for public education

Amendment A.1. Include a study of "social insurance" options

- Proposed modification
  - **The Commission should recommend a study of options using a "social insurance" model for the provision of long-term care services.**

MARK A.2. Rebalance long-term care services

- **Changes in Medicaid LTC policy should reflect what most seniors and persons with disabilities say they want and need, which is to stay at home in their communities in the least restrictive or most integrated setting appropriate to their LTC needs with nursing homes as a last resort.**
  - Medicaid policy should respect beneficiary preferences
  - States should explore and build on LTC options authorized by the DRA and incorporate LTC services into their state plans
  - States should expand use of the Cash and Counseling model

Amendment #1 A.2. — Include federal responsibility and cost-neutrality

- Proposed modification (bullet #2) (Submitted by McCann)
  - **[In the second sentence] States, <u>CMS, and Congress</u> should be encouraged to <u>utilize existing Medicaid resources to maintain</u> and/or incorporate long-term care services within Medicaid State Plans that include…services <u>currently offered in state plans</u> and as HCBS.**
    - Adds CMS and Congress
    - Adds cost-neutrality
    - Recognizes that some LTC services are currently in state plans

Amendment #2 A.2. Offer dual entitlement to HCBS and institutional care

- Proposed substitution (Submitted by Gillenwater)
  - **Eliminate the institutional bias in long-term care.**
    - Individuals at risk of institutional care should have a choice of home- and community-based services or institutional care
  - **Amend the DRA regarding the HCBS state plan option**
    - Explicitly align income rules in Section 6086 of DRA to nursing facility eligibility
  - **Promote access to affordable and accessible housing**

Benefit Design

MARK B.1. Increase benefit flexibility

- **States should be given greater flexibility to design Medicaid benefit packages to meet the needs of covered populations. This flexibility should include the authority to establish separate eligibility criteria for acute and preventive medical care services from the eligibility criteria for long-term supports and services**

Amendment #1 B.1. — Make explicit the options for premium assistance and purchase of private coverage

- Proposed modification (submitted by Turner and Helms) (add to the end)
  - **"…and the option to offer premium assistance to allow buy-in to job-based coverage or to purchase other private insurance."**

Amendment #2 B.1. Add exemptions for people with disabilities

- **(Submitted by Gillenwater):**

  People with disabilities should not be subject to state flexibility, and they should not be required to enroll in private coverage. The current exemption for people with disabilities from the DRA benchmark provision should be maintained and strengthened by reversing CMS policy allowing states to voluntarily include people with disabilities in benchmark plans. States should not be able to limit eligibility for acute or long-term care services in a way that would affect current mandatory eligibility categories.

MARK B.2. Promote beneficiary rights and responsibilities

- **Federal Medicaid policy should promote partnerships between states and beneficiaries that emphasize beneficiary rights and responsibilities and reward beneficiaries who make prudent purchasing, resource-utilization, and lifestyle decisions.**

Amendment B.2.	**None submitted**

MARK B.3. Promote replication of successful state demonstration programs

- **States should have the flexibility to replicate demonstrations that have operated successfully for at least 2 years in other states, using an abbreviated waiver application process. These replications should be automatically approved 90 days after submission, unless the application does not meet the replication criteria.**

Amendment #1 B.3. — Require public involvement in Medicaid program changes

- Proposed substitution (Submitted by Christopher)
  - **Congress should enact legislation requiring public notice and establishing guidelines for public comment about Section 1115 waiver applications and State Plan Amendments.**

Amendment #2 B.3.	**Extend requirement for a successful waiver to five (5) years**

- Proposed modification (Submitted by Gillenwater)
  - **Change the length of time a waiver needs to be successfully operating from two (2) years to five (5) years.**

Eligibility

MARK C.1. Simplify eligibility

- **Medicaid eligibility should be simplified by permitting states to streamline eligibility categories without a waiver, provided it is cost-neutral to the federal government.**

Amendment #1 C.1. Encourage states to expand coverage to low-income adults

- Proposed modification (Submitted by Christopher)
  - **Medicaid eligibility should be simplified by <u>encouraging</u> states to streamline eligibility categories without a waiver <u>to expand coverage to include all adults with incomes below poverty levels</u>**

    - Eliminates cost-neutrality provision
    - Encourages states to expand coverage to adults below poverty levels

Amendment #2 C.1. — Protect current mandatory eligibility categories

- Proposed modification (Submitted by Gillenwater)
  - **Medicaid eligibility should be simplified by permitting states to streamline eligibility categories without a waiver, <u>as long as the state's action does not limit eligibility for individuals in current mandatory eligibility categories.</u>**
    - Eliminates cost-neutrality provision
    - Protects those in current mandatory eligibility categories

New Recommendation C.2.	**Federal match rate should vary based on population income**

- **(Submitted by Turner and Helms)**
- **To protect the ability of Medicaid to serve needy low-income patients and to preserve the program's core purpose of serving the most vulnerable populations, states should receive a Federal match that reimburses them at a higher rate for adding lower-income populations to the program, with the match rate scaling back as they expand to higher-income populations. Cost neutrality standards must be satisfied.**

New Recommendation C.3.	**Provide incentives for uninsured to purchase private coverage**

- **(Submitted by Turner and Helms)**
- **The Federal government should provide new options for the uninsured to obtain private health insurance through refundable tax credits or other targeted subsidies so they do not default into Medicaid.**

Health Information Technology

MARK D.1. Change the congressional scoring process for HIT investments

- **The Commission wants to emphasize the importance of investments in health IT. It recommends that the budget scoring process utilized by Congress amortize the cost of investments in health information technology over a period of five years, while also accounting for long-term savings.**

Amendment D.1.	**None submitted**

MARK D.2. HHS should provide incentives to promote HIT implementation

- **HHS should continue to promote and support the implementation of health information technology through policy and financing initiatives while ensuring interoperability.**

Amendment D.2.

Ensure accessibility

- Proposed modification (submitted by Gillenwater)
  - **HHS should continue to promote and support the implementation of health information technology through policy and financing initiatives while ensuring interoperability and accessibility.**
    - Adds a provision for ensuring accessibility

MARK D.3. Electronic Health Records

- **All Medicaid beneficiaries should have an electronic health record by 2012.**

Amendment D.3.	**None submitted**

MARK D.4. Promote interoperable HIT investment in Medicaid programs

- **State Medicaid agencies shall be required in contracts or agreements with health care providers, health plans, or health insurance issuers that as each provider, plan or issuer implements, acquires or upgrades HIT systems, it shall adopt, where available, HIT systems and products that meet recognized interoperability standards.**

Amendment #1 D.4. Adds accessibility standards

- Proposed modification (submitted by Gillenwater)
  - **State Medicaid agencies shall be required in contracts or agreements with health care providers, health plans, or health insurance issuers that as each implements, acquires or upgrades HIT systems, it shall adopt, where available, HIT systems and products that meet recognized interoperability and accessibility standards.**
    - Adds a provision for ensuring accessibility

Amendment #2 D.4. Eliminate unfunded mandate for states

- Proposed modification (Submitted by Manchin and Atkins)
  - **Either replace the word “required” with “encouraged” or include in the recommendation a mechanism for enhanced funding, so that it is not presented as an unfunded mandate for states.**

Quality and Care Coordination

MARK E.1. Require Medicaid beneficiaries to have a medical home

- **Federal law and regulations must be changed to require states to place all categories of Medicaid beneficiaries in a coordinated system of care premised on a medical home for each beneficiary, without imposing a burden on states to seek a waiver or any other form of federal approval.**

Amendment E.1. — Eliminate unfunded mandate for states

- Proposed modification (Submitted by Manchin and Atkins)
  - **Either replace the word “required” with “encouraged” or include in the recommendation a mechanism for enhanced funding, so that it is not presented as an unfunded mandate for states.**

MARK E.2. Promote integrated care options to improve care for dual eligibles

- The Commission recommends reform proposals to support the development and expansion of integrated care programs that would promote the development of a medical home and care coordination for dual eligibles
  - Allow states to integrate acute and LTC benefits/services through SNPs via the state plan
  - Allow states to operate an integrated care management program with universal (automatic) enrollment, and "opt-out" provisions, to preserve beneficiary choice
  - Reduce the administrative barriers by aligning Medicare and Medicaid's rules and regulations (marketing, enrollment, quality reporting, performance monitoring, etc.)
  - Authorize a *Medicaid Advantage* program to integrate Medicare and Medicaid services (see next page)

"Medicaid Advantage": A New State Option

- Modeled after Medicare Advantage, but managed by the states
- Federal Medicare support would continue through risk-adjusted, capitated payments
- Medicaid would still be jointly funded by federal and state government
- Integrated care model with a medical home for dual eligibles providing full spectrum of services
- Beneficiaries would have the ability to "opt-out"

Amendment E.2.

Increase consumer protections for managed care delivery systems

- Proposed modification (Submitted by Gillenwater)
  - **Dual eligibles (and all beneficiaries) should be exempt from mandatory and automatic enrollment in managed care**
  - **Increase consumer protections for all managed care enrollees regarding beneficiary choice, network adequacy, care coordination, grievance and appeals, accessibility standards, cultural competency, public input, etc.**
  - **Extensive suggested modifications found on pages 15-16 of Amendment package**

MARK E.3. Focus on purchasing outcomes not processes

- **Medicaid should focus on purchasing quality health care outcomes for its beneficiaries rather than reimbursing for health care processes.**

Amendment E.3. Federal funding should support investments in quality

- Proposed modification (Submitted by Bella)
  - **CMS/Congress should support state innovation to deliver value for taxpayer dollars by purchasing outcomes. The Commission therefore recommends that CMS/Congress provide enhanced match and/or demonstration funding, to be recouped from savings over 5 years, to support investments in quality improvement in targeted areas:**
    - **Development/enhancement of performance measures, particularly for children, persons with disabilities, and the frail elderly;**
    - **Implementation of care management programs for high-risk, high-cost co-morbid beneficiaries; and**
    - **Creation of provider-level pay-for-performance programs.**

MARK E.4. Support state innovations in health care reform

- **CMS should establish a National Health Care Innovations Program to 1) support the implementation of state-led, system-wide demonstrations in health care reform and 2) make data design specifications available to all other states for possible adoption.**

Amendment E.4.	**None submitted**

MARK E.5. Require price transparency

- **State Medicaid agencies shall make available to beneficiaries the prices that they pay to contracted providers for common inpatient, outpatient and physician services.**

Amendment E.5. Include payments from private insurers

- Proposed modification (Submitted by Gillenwater)
  - **State Medicaid agencies shall make available to beneficiaries the <u>payments</u> to contracted providers for common inpatient, outpatient and physician services. <u>In order to ensure transparency the government should include reimbursement from private insurers so beneficiaries could see the discrepancies</u>.**
    - **Would require transparency of different prices various payers pay, to show Medicaid's relatively low reimbursement rates compared to other payers**

New Recommendation E.6.	**Link Medicaid reimbursement with medical outcomes**

- **(Submitted by Turner and Helms)**
- **Payments to Medicaid providers should be tied to objective measures of medical outcomes. States must collect and mine data to determine which programs, providers and services are effective and which need improvement.**