

## Roadmap to Medicaid Reform

### New Options to Improve and Expand Insurance Coverage for Acute Care Needs

**States may use the DRA in a combination with options under titles XIX and XXI and other programs, as a strategy to align the Medicaid Program with today's health care environment to:**

- **Expand access to affordable mainstream coverage**
- **Promote personal responsibility for health and accessing health care**
- **Improve quality and coordination of care**

For more than a decade, States have been asking for the tools to modernize their Medicaid programs. With the enactment of the Deficit Reduction Act of 2005 (DRA), States now have new options to create programs that are more aligned with today's Medicaid populations and the health care environment. Cost sharing, benefit flexibility through benchmark plans, and the health opportunity accounts (HOA) demonstration provide the greatest opportunities to modernize Medicaid, make the cost of the program and health care more affordable, and expand coverage for the uninsured. States will be able to reconnect families to the larger insurance system that serves most Americans and promote continuity of coverage. The sweeping DRA provisions on Medicaid include 6 chapters and 39 sections. Through a combination of new options for States and new requirements related to program integrity, the DRA will help ensure the sustainability of the Medicaid program over time.

Today, 55 million people are served by Medicaid, the majority of whom are children and adults who need access only to preventive and primary acute care services similar to the health insurance coverage of the majority of Americans. Between 1999 and 2003, the fastest-growing Medicaid population was non-disabled adults. While total Medicaid eligibles grew 35 percent in this period, non-disabled adults grew 69 percent nationally. The DRA gives States greater control over the administration of their Medicaid programs by moving from waivers and demonstrations to State plans.

More than \$100 billion of Medicaid spending is currently delivered through waivers and demonstrations. The very nature of a waiver, candidly stated, is to demonstrate more modern approaches than those contained in the outdated rules of title XIX. But even with the success of waivers and demonstrations, they can be cumbersome to administer. Waiver and demonstration programs must show that they meet a variety of budget neutrality and cost-effectiveness tests, necessitating detailed analyses and lengthy discussions with the Federal government while putting States at risk for expenditures beyond the predetermined spending ceilings. State plan amendments (SPAs) do not have either feature and are administratively much more straightforward. As a result of DRA, the statute now gives States the tools they need to manage their programs without waivers or demonstrations in ways they have requested, tested, and proven over decades.

A State's 21<sup>st</sup> century health care Medicaid program recognizes the different needs of the different populations served under title XIX. By combining the new tools provided by

the DRA with the options available under titles XIX and XXI and other programs, a State can:

1. **Expand access to affordable mainstream coverage:**

- Offer benchmark benefit packages;
- Build public-private partnerships through premium assistance with employer coverage options; and
- Apply for High-Risk Pool Seed and Operational Grants

2. **Promote personal responsibility for health and in accessing health care:**

- Implement cost-sharing that is appropriate for an individual or family's income level; and
- Demonstrate the potential efficacy of Medicaid HOA and incentive-based approaches to health care delivery.

3. **Improve quality and cost effective coordination of care:**

- Expanding access to services through managed care;
- Re-aligning Medicaid prices on prescription drugs with other purchasers and protect community pharmacists;
- Reaping the benefits of disease management and similar strategies;
- Taking aggressive steps with generic drugs; and
- Implementing electronic transmission of prescriptions or "e-prescribing".

**To expand access to affordable mainstream coverage, States can:**

- **Offer benchmark benefit packages** to provide more flexible benefit packages that are more comparable to those in the private sector for non-disabled, non-elderly persons who are eligible for Medicaid. Following the success of the State Children's Health Insurance Program (SCHIP) and section 1115 demonstrations, the benchmark approach allows flexibility to extend four types of coverage to Medicaid beneficiaries: Blue Cross/Blue Shield standard Federal Employee Health Benefits Program coverage; State employee coverage; coverage of the largest commercial Health Maintenance Organization (HMO) in the State, or Secretary-approved coverage providing appropriate coverage for the population served.

States will be able to take greater advantage of marketplace dynamics within their State. Because States are no longer tied to statewideness and comparability rules for non-disabled, non-elderly populations, they will be able to offer individuals and families different types of plans consistent with their needs and available delivery systems. Families will gain continuity in coverage as family members move together from Medicaid to SCHIP to, eventually, private coverage. Today, one child may be in Medicaid, another in SCHIP, and the parent has access to

private coverage. Under DRA, families can be together in the same plan with the same providers and one set of administrative rules. Administrative simplification can help families maintain health insurance coverage and give them experience with private insurance coverage that will become important when their income rises above Medicaid and SCHIP eligibility levels.

States with strong employer-based coverage may emphasize family coverage and premium assistance. States may form larger pools by combining Medicaid enrollees with their public employees. The flexibility of benchmark plans and “wrap around” services should also create new opportunities for disease management and similar strategies for care management (further described below) so as to improve outcomes for individuals with chronic conditions.

- **Build public-private partnerships through premium assistance with employer coverage options.** States with strong employer-based coverage may emphasize family coverage and premium assistance. States may form larger insurance pools by combining Medicaid enrollees with their public employees, thus spreading risk and reducing costs.

Non-disabled, non-elderly adults make up the fastest growing population in Medicaid as States have expanded coverage to optional eligibility groups. The majority of these individuals are in the workforce and therefore present an opportunity to purchase cost effective “family coverage” through premium assistance where offered by employers. These programs represent successful efforts to integrate public and private dollars to make sure the dollars go as far as possible. They help keep individuals within the current employer-based system that serves most Americans and also assist promoting continuity of health care coverage. Individuals with ongoing access to private coverage are less likely to be “churned” between public and private coverage because of slight variations in income.

Multiple States with approved SPAs or Health Insurance Flexibility and Accountability (HIFA) demonstrations- including Arizona, Idaho, Illinois, Maine, Michigan, New Mexico, New Jersey, Oregon, Rhode Island, Virginia, California (not implemented) and now Arkansas – have the ability to use Medicaid and/or SCHIP funds to help pay insurance premiums for employer-sponsored insurance. Such strategies can help reverse trends in employers dropping dependent coverage and stabilize premiums for all those in the coverage pool.

- **Apply for High-Risk Pool Seed and Operational Grants** The State High-Risk Pool Funding Extension Act of 2006 establishes: (1) seed grants to States for the creation and initial operation of a qualified high-risk pool for those States that do not have one; (2) the continuation of grants to States to reimburse them for a percentage of losses incurred by their high-risk pools; and (3) new bonus grants for program innovation and supplemental consumer benefits. It also broadens the definition of a “qualified high-risk pool” to include an acceptable alternative

mechanism that includes a high-risk pool as a component. This new flexibility allows States to create opportunities to realign and reorganize their resources and funding streams to promote greater options and strategies for the uninsured.

**To promote personal responsibility for health and in accessing health care, States can:**

- **Implement alternate premium and cost sharing requirements for certain beneficiaries.** This new authority, which builds upon past CMS' experience with section 1115 demonstrations and SCHIP, provides States with options for premiums and cost sharing. It also enables States to implement alternative cost sharing for certain medical services, particularly non-preferred drugs and non-emergency care furnished in a hospital emergency department. Cost-sharing flexibility frees up State dollars to expand covered populations, improve benefits, promote patient responsibility, and encourage appropriate utilization of services. Furthermore, grant funding is available to assist States with the development of emergency room diversion programs to enable care to be provided by appropriate alternative non-emergency providers.

The DRA provides that the aggregate premium and/or cost-sharing amounts must not exceed 5 percent of the family's income for all family members for the month or quarter period, similar to cost-sharing limits that have proven successful with expanding coverage in SCHIP. For families with income between 100 percent and 150 percent of poverty, no premiums are permitted, but cost sharing up to 10 percent of the cost of services is permitted. Above 150 percent, premiums are permitted and cost sharing up to 20 percent of the cost of services is permitted. The DRA contains special rules on cost sharing for prescription drugs and non-emergency care provided in emergency rooms.

The DRA cost-sharing options reflect mainstream thinking and recognize that Medicaid now serves families in the work force. Today, only a minority of Medicaid eligibles are on welfare. Two-thirds of Medicaid enrollees live in families in the workforce and a majority (56 percent) has family income above the poverty level. In a survey, "What Families Think About Cost-Sharing Policies in SCHIP," the National Academy for State Health Policy found the majority of families in their focus groups of current and past SCHIP enrollees do not object to cost sharing and have found the cost sharing rules adopted by States are reasonable and affordable. In a recent report to Congress on SCHIP, researchers from Mathematica Policy Research Inc. and The Urban Institute report that: "In most of the study States, case study respondents reported that cost sharing was viewed as a positive feature of SCHIP constituencies - including advocates for families." In the Commonwealth Fund's October 2005 Health Care Opinion Leaders Survey, 61 percent of opinion leaders surveyed on the Future of Medicaid favored an option that provides for flexibility in benefit design and cost sharing for families above 100 percent of poverty.

- **Demonstrate the potential efficacy of Medicaid Health Opportunity Accounts (HOA) and incentive-based approaches to health care delivery.** The 5-year, ten-State HOA demonstration program under DRA is designed to combine the success of the Health Savings Accounts and Health Reimbursement Accounts. The demonstrations will provide States with the option of enrolling some Medicaid beneficiaries into flexible consumer-based accounts. Beneficiaries are given the means to take a greater role and responsibility in their health care. States can adjust contributions to the accounts based on the expected health needs of beneficiaries, to ensure that the HOA program works well both for healthier beneficiaries and those with chronic illnesses. Ten demonstrations will be approved to operate for 5 years, after which the HOA feature could become an option for any State through the SPA process.

**To improve quality and coordination of care States can:**

- **Expand access to services through managed care.** Managed care has proven its role in improving access to services for Medicaid beneficiaries. Under the DRA, benefits provided by the State’s largest commercial HMO is one of the benchmark plans, so States have another option to utilize managed care without a waiver. A State may also implement alternative, cost-effective delivery systems such as Managed Care Organizations or PCCMs through State plan or waiver authorities. Section 1932(a)(1) of the Social Security Act (the Act) permits mandatory enrollment of many Medicaid beneficiaries in those delivery systems *without* the need for a waiver of the provisions in section 1902 of the Act pertaining to statewideness, comparability, or freedom of choice. Additional groups of beneficiaries may be included in mandatory managed care under existing 1915(b) waiver authority. Finally, a State can be deemed to be in compliance with the statewideness, comparability, or freedom of choice requirements if it utilizes the authority in section 1915(a) of the Act to competitively procure laboratory services or medical devices.
- **Re-align Medicaid prices on prescription drugs with other purchasers and protect community pharmacists.** It has been widely recognized that Medicaid has been paying more for prescription drugs than have other purchasers. The DRA will lower the overall spending on drugs by limiting payment for drugs on the Federal Upper Limits (FULs) in the aggregate to 250 percent of the Average Manufacturers Price (AMP). However, States retain the overall authority for pharmacy reimbursement and may target reimbursement to providers, for example, through higher dispensing fees for independent pharmacies, pharmacies serving a large share of low-income beneficiaries, or pharmacies in rural areas to assure access. States can also adjust payments to provide more financial support to pharmacists that improve quality and reduce costs of drug coverage and chronic disease management, as described in more detail below.
- **Reap the benefits of disease management and care management strategies.** Disease management as “wrap around” benefits complements benchmark plans.

Disease management programs are an emerging strategy for States to improve care and are designed to reduce overall expenditures, including drug expenditures, through more appropriate medication use for Medicaid beneficiaries with chronic illnesses. These programs usually include adherence to evidence-based medical practice guidelines, providing support services to assist physicians in monitoring their patients, more closely managing patient care including the proper use of drugs (for example, through medication therapy management programs), and promoting patient adherence to an individual treatment plan, which includes improved medication compliance. While pharmacy costs may increase, overall expenditures usually decrease as a result of disease management programs by reducing the number of emergency room visits and hospitalizations.

- Examples of successful disease management strategies include the following:
  - Washington has adopted a disease management program for categorically needy Medicaid beneficiaries in fee-for-service who have asthma, congestive heart failure, diabetes, and End Stage Renal Disease or chronic kidney disease, later extending the program to include Chronic Obstructive Pulmonary Disease (COPD). The State anticipates savings of 5 percent of the overall medical costs for program participants.
  - North Carolina's disease management program began by providing disease management services to children with asthma, later adding diabetic children. Results have been positive. Participants in the asthma disease management program show a 46 percent increase in appropriate use of inhaled corticosteroids, 35 percent lower hospitalizations, and 34 percent lower emergency department visits. Under the Diabetes Disease Management program, eye care referrals have increased by 22 percent and flu vaccinations by 12 percent. Community Care also has a program to reduce emergency department use through care management follow-up with frequent users that has reduced use by 13 percent and costs by 30 percent.
  - Florida: A Healthy State is a public/private partnership between the State of Florida's Agency for Health Care Administration (AHCA) and Pfizer Inc. The program began in 2001, and has been providing hands-on, community-based disease management education, treatment, and empowerment to Florida's neediest Medicaid patients with diabetes, hypertension, asthma, and heart failure. A Healthy State brings a level of understanding of the barriers patients face, as well as local and cultural norms. The program has reached nearly 150,000 Medicaid beneficiaries and improved their health while providing the State savings and investment of \$61.1 million over the past 2 years.
- **Take aggressive steps with generic drugs.** Some States are achieving additional savings by promoting the use of generic drugs. Minnesota has had a mandatory generic substitution policy in place for nearly a decade. Even if a practitioner has written "Dispense as Written – Brand Necessary" on the prescription,

authorization from the State Medicaid agency is required before a brand name drug is dispensed. Previously, the generic substitution mandate could be overridden if the practitioner specified on the prescription that the brand name drug was medically necessary. This change in Minnesota is expected to save \$10 million annually. Idaho's mandatory generic substitution policy, in place since 2000, requires prior authorization for brand name drugs under Medicaid when an acceptable generic form is available. Specifically, the State requires a patient to fail on two generic products before consideration is given to most brand name products. This policy has served as a deterrent to unnecessary brand name requests and has resulted in an increase in generic utilization from 46.7 percent in fiscal year (FY) 2002 to 53 percent in FY 2003. As of September 2004, this mandate for generic substitution has saved over \$12 million in State and Federal funds. Pharmacy-based education programs can also help promote beneficiary use of generics.

- **Implement electronic transmission of prescriptions or "e-prescribing."** Electronic transmission of prescriptions is a means for improving medical care by providing information alerts to physicians to adverse drug interactions and patient drug allergies while reducing costs, fraud, and abuse.

In 2001, Florida initiated a pilot project to provide hand-held devices to physicians that displayed the Medicaid preferred drug list in order to make it easier for the physician to prescribe a medication that is on the preferred list. In 2002, the device was expanded to provide clinical information about prescription drugs and to allow for the inclusion of patient medical histories. Eventually, the State anticipates e-prescribing for 80 percent of drugs, with consequential improvements in medical care (less inappropriate and duplicative prescribing), cost, and fraud and abuse prevention.

## **Conclusion**

In adopting the new options available under the DRA, States will assist families and individuals in their goals of independence by maintaining access to affordable mainstream health insurance coverage over time and make their Medicaid programs more sustainable.