Medicaid Expansion — The Soft Underbelly of Health Care Reform?

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Expanding health insurance to cover Americans who are currently uninsured, with the ultimate goal of improving access to care, is arguably the most critical objective of the recently enacted health care reform legislation. In large part, the success or failure of health care reform will hinge on the achievement of this goal.

The Patient Protection and Affordable Care Act (ACA) incorporates two strategies for expanding coverage. First is a mandate for all individuals to purchase insurance, coupled with the creation of state-based insurance "exchanges" and subsidies to help individuals whose incomes are below 400% of the federal poverty level to purchase coverage from private companies. Second is an expansion of Medicaid, underwritten by the federal government, to cover all adults whose family income is below 133% of the federal poverty level; children of families with incomes below this cutoff are already eligible for public coverage.

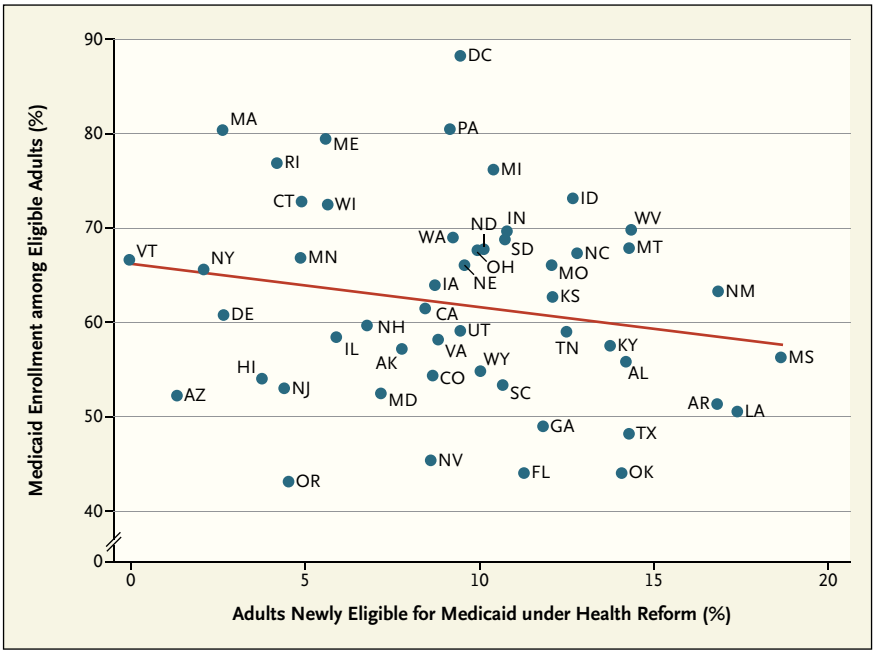
Estimates from the Congressional Budget Office (CBO) suggest that each of these approaches will add 16 million enrollees, for a total of 32 million newly insured Americans. However, there is obvious cause for uncertainty about the estimates of how many will obtain coverage through the insurance exchanges. Debate is already under way about the effectiveness of the mandate, what constitutes a sufficient subsidy, and how the exchanges will be implemented.

By comparison, the effect of the Medicaid expansion would appear to be easier to predict. Because expanded coverage will be free to the states (at least through 2016) and to uninsured persons whose income qualifies them for it, it is tempting to assume that almost all individuals who are eligible will enroll. But eligibility for health insurance does not always translate into actual enrollment — as evidenced by the millions of uninsured adults who are already eligible for Medicaid under current law. Moreover, the apparent simplicity of expanding Medicaid uniformly to include people in a given income category belies the tremendous heterogeneity among the 50 state Medicaid programs, which vary in terms of enrollment procedures, demographics of the target population, and state politics. These differences will complicate any attempt to implement such a broad expansion and cast serious doubt on the precision of predictions about its outcome.

Medicaid is currently characterized by highly variable participation rates among eligible adults in different states. We used data from the 2007 through 2009 Current Population Survey (CPS), a nationally representative survey conducted by the Census Bureau, to estimate state participation rates among U.S. citizens 19 to 64 years of age who are currently eligible for Medicaid and have no other health insurance. The eligibility rules come from public data sources,[1-4] and our estimates were adjusted for previously documented underreporting of Medicaid coverage in the CPS.[5] The scatter plot shows the Medicaid participation rates by state on the vertical axis. The horizontal axis indicates the percentage of each state's adult population that will become newly eligible for Medicaid in 2014 under the ACA. In other words, the vertical axis measures how well states currently perform in enrolling eligible adults and the horizontal axis measures the extent of the new task each state will face come 2014.

Three key results emerge from this analysis. First, participation rates are far from ideal, with a national average of 61.7% of eligible individuals. Second, Medicaid participation is highly variable, with rates ranging from just under 44% in Oklahoma, Oregon, and Florida to 80% in Massachusetts and 88% in the District of Columbia. Third, the states that will have the greatest number of newly eligible adults under health care reform have, if anything, been historically worse (but not significantly so) at finding and keeping eligible adults enrolled in Medicaid (regression coefficient, -0.46; 95% confidence interval, -1.13 to 0.21).

Our knowledge of the factors affecting Medicaid enrollment and retention among eligible adults is incomplete. Administrative obstacles almost surely play a key role. Unless they complete the multipage application and provide documentation of income and residency, eligible individuals sim-



Medicaid Enrollment among Currently Eligible Adults (2007 through 2009) and Percentage of Adults Who Will Become Eligible in 2014 under Health Care Reform, by State.

The population sample was restricted to eligible adults with no other form of health insurance; noncitizens were excluded from the analysis. Results are based on an analysis of data from the Current Population Survey of 2007 through 2009. The red line shows the regression equation: Enrollment = 0.66 − 0.46 × Newly Eligible (P = 0.17).

ply never get enrolled. Maintaining enrollment also poses a challenge, since federal law requires that states verify an enrollee's eligibility annually, and some states choose to do so more frequently. The prevalence and quality of Medicaid managed care, provider reimbursement rates, and outreach efforts may also play a role in enrolling and retaining eligible adults.

Official projections regarding Medicaid enrollment under the ACA come from the CBO, which does not release the details of its calculations. These projections require numerous assumptions about population growth and economic conditions over time, as well as about how many adults will switch from private coverage to Medicaid, and results vary depending on the data source. That said, on the basis of the CPS data, we predict that enrolling 16 million people by 2019 will require substantial increases in participation among uninsured adults and children who are already eligible, plus a takeup rate among newly eligible adults that will be much higher than the current level of 61.7%. Our estimates suggest that participation rates among all eligible individuals who are not privately insured would need to be in the range of 80%.

Such a scenario would require a fundamental shift in Medicaid implementation, although such a shift is plausible, given the dramatic changes brought about by health care reform — in particular, implementation of the individual mandate. Massachusetts, which has such a mandate, has achieved Medicaid take-up rates of roughly 80%. Other factors, such as the media attention that will surround the expansion and simplification of eligibility rules, may also lead to higher rates of participation than the program currently enjoys.

However, other factors suggest that takeup rates under the ACA may not even reach current levels of participation, let alone far exceed them. As the regression line on the scatter plot shows, the national average is skewed by higher levels of Medicaid enrollment in states in which the expansion will have less impact because so many of the adults in question are already eligible. Furthermore, newly eligible, higher-income adults may be less familiar with welfare procedures or more sensitive to the stigma of enrolling in a public program than are those who are currently eligible. Adults with disabilities make up a disproportionate share of current Medicaid enrollees, with a traditionally higher participation rate (79% in our sample), whereas the overwhelming majority of adults who will become eligible for Medicaid under the ACA do not have a disability. Finally, the federal mandate does not apply to adults with incomes below the Internal Revenue Service tax-filing threshold ($9,350 for single adults and $18,700 for married adults filing jointly, according to the 2009 rules); in our sample, this group accounted for slightly more than half of all uninsured adults who will be eligible for Medicaid.

The good news is that implementation of the ACA's Medicaid expansion is still more than 3 years away. This window creates a critical opportunity for states to evaluate their Medicaid enrollment procedures and lay the groundwork for a successful expansion. An important issue will

be how states approach the interactions between the insurance exchanges and Medicaid; adults with incomes close to 133% of the federal poverty level may not know which program they should apply to, and states should take steps to prevent uninsured adults from falling through the cracks. Other approaches to streamlining Medicaid enrollment will also need to be considered. The natural experiment of having 50 different states with highly variable participation rates offers ample opportunity for exploring the policy options.

The impending Medicaid expansion will be the single biggest change in the program since its inception in 1965. The success of health care reform in improving access to care will largely depend on whether newly eligible individuals enroll in Medicaid and remain enrolled. Though the details of enrollment outreach, application processes, and renewal procedures may not be glamorous, they hold the key to success in expanding health insurance coverage to millions of needy Americans.

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1. Where are states today? Medicaid and state-funded coverage eligibility levels for low-income adults. Washington, DC: Kaiser Family Foundation, 2009. (http://www.kff.org/medicaid/upload/7993.pdf.)
2. Medicaid financial eligibility: primary pathways for the elderly and people with disabilities. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2010. (http://www.kff.org/medicaid/8048.cfm.)
3. Ross DC, Horn A, Marks C. 2008. Health coverage for children and families in Medicaid and SCHIP: state efforts face new hurdles. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2008. (http://www.kff.org/medicaid/7740.cfm.)
4. Ross DC, Cox L, Marks C. 2007. Resuming the path to health coverage for children and parents: a 50-state update on eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and SCHIP in 2006. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2007. (http://www.kff.org/medicaid/7608a.cfm.)
5. Call KT, Davidson G, Davern M, Nyman R. Medicaid undercount and bias to estimates of uninsurance: new estimates and existing evidence. Health Serv Res 2008;43:901-14.

Sebelius outlines state flexibility and federal support available for Medicaid - Full Letter

February 3, 2011

Dear Governor:

As the new year begins, officials at the Federal and State level are looking ahead to a period full of opportunities and challenges. I have had the opportunity to speak individually with many of you over the past few weeks, including many who are now assuming their new positions. Having served as a Governor, let me welcome you to one of the best jobs you will ever have.

In these conversations, I have heard the urgency of your State budget concerns. I know you are struggling to balance your budget while still providing critical health care services to those who need them most. I want to reaffirm the Obama Administration's commitment to helping you do both.

I also know that as you prepare your budget, your attention will turn to Medicaid. Medicaid is a major source of coverage for children, pregnant women, seniors and people with disabilities in every State. It has a unique role in our health care system, covering a diverse group of beneficiaries, including some of the most frail and vulnerable Americans. And it is the nation's primary payer for long-term care in nursing homes and outside of institutions. Medicaid is a Federal-State health partnership. The Federal government pays a fixed percentage or matching rate and sets minimum standards. States fund their share of program costs and have the lead on designing their programs beyond these standards, including what benefits are covered, how providers are paid, and how care is delivered.

In the last two years, the Administration has worked to ensure adequate support for States to manage their Medicaid and the Children's Health Insurance Programs (CHIP). One of the first actions taken by President Obama was to work with Congress on legislation to increase Federal support for the States in the form of an enhanced Federal match for Medicaid (known as the Federal Medical Assistance Percentage or FMAP). This enhanced FMAP was part of the American Recovery and Reinvestment Act and lasted through December 31, 2010. However, last year, at the request of many Governors, we worked with Congress to extend the enhanced FMAP policy through June 2011. Approximately $100 billion has been provided to States, and in 2009 alone, due to the enhanced FMAP, State Medicaid spending fell by ten percent even though enrollment in Medicaid climbed by seven percent due to the recession. In addition to this financial support, we have taken many other administrative steps to open up lines of communication with States, lower the paperwork burden States face in administering the program, and accelerate our review process for State plan amendments.

We recognize that many States are re-examining their Medicaid programs and looking for opportunities to meet the pressing health care challenges and better cope with rising costs. In light of difficult budget circumstances, we are stepping up our efforts to help you identify cost drivers in the Medicaid program and provide you with new tools and resources to achieve both short-term savings and longer-term sustainability while providing high-quality care to the citizens of your States. We are committed to responsiveness and flexibility, and will expedite review of State proposals.

Starting immediately, the senior leadership from across the Department will be available to meet individually with your staff about plans that you may already have in mind. My team stands ready to come to your State to discuss your priorities and how we can help achieve them.

In the meantime, recent conversations suggest a lack of clarity about what flexibility currently exists in Medicaid. Some of you have asked whether I can "waive" the maintenance of effort requirements for people who a State has covered under Medicaid's "optional" eligibility categories and waivers. I note that the Affordable Care Act gives a State the flexibility to reduce eligibility for non-disabled, non-pregnant adults with incomes above 133 percent of the Federal poverty line ($14,500 for an individual) if the State has a budget deficit, although prior to June 30, this would mean the loss of the enhanced FMAP under the Recovery Act. I continue to review what authority, if any, I have to waive the maintenance of effort under current law.

However, States have substantial flexibility to design benefits, service delivery systems, and payment strategies, without a waiver. In 2008, roughly 40 percent of Medicaid benefits spending – $100 billion – was spent on optional benefits for all enrollees, with nearly 60 percent of this spending for long-term care services. The enclosed paper identifies a range of State options and opportunities to more efficiently manage Medicaid, many of which are underway across the country. Some of the key areas of potential cost savings are described briefly below:

- **Modifying Benefits.** While some benefits, such as hospital and physician services, are required to be provided by State Medicaid programs, many services, such as prescription drugs, dental services, and speech therapy, are optional. States can generally change optional benefits or limit their amount, duration or scope through an amendment to their State plan, provided that each service remains sufficient to reasonably achieve its purpose. In addition, States may add or increase cost sharing for services within limits (see attachment for details). Some States have opted for more basic benefit packages for higher-income enrollees (e.g., Wisconsin provides benefits equivalent to the largest commercial plan offered in the State plus mental health and substance disorder coverage for pregnant women with income between 200 and 250 percent of poverty). A number of States charge beneficiaries $20 for non-urgent emergency room visits or use cost sharing for prescription drugs to steer individuals toward generics or preferred brand-name drugs. To the extent States scale back low-value benefits or add fair cost sharing that lowers inappropriate use of care, savings can be generated.
- **Managing Care for High-Cost Enrollees More Effectively.** Just one percent of all Medicaid beneficiaries account for 25 percent of all expenditures. Initiatives that integrate acute and long-term care, strengthen systems for providing long-term care to people in the community, provide better primary and preventive care for children with significant health care needs, and lower the incidence of low-birth weight babies are among the ways that States have improved care and lowered costs. For example, children's hospitals adopting a medical home model to manage the care of chronically ill children have accomplished impressive improvements in health and reductions in cost. One Florida children's hospital reduced emergency room visits by more than one-third, and reduced hospital days by 20 percent.

These delivery models and payment strategies can be implemented by hospitals and States without seeking a Federal waiver, and we are exploring ways that we might provide further support for such initiatives.

In addition, the Affordable Care Act offers new Medicaid options that provide States with additional Federal matching funds. For example, States can now benefit from a 90 percent Federal matching rate for coordination of care services provided in the context of a health home for people with chronic conditions. Additionally, the Community First Choice Option, available in October, will offer States a six percent increase in the Federal matching rate to provide certain person-centered long-term care services and supports to enhance your efforts to serve beneficiaries in community-based settings.

- **Purchasing Drugs More Efficiently.** In 2009, States spent $7 billion to help Medicaid beneficiaries afford prescription drugs. States have broad flexibility to set their pharmacy pricing. We are committed to working with States to ensure they have accurate information about drug costs in order to make prudent purchasing decisions. As recommended by States, the Department is undertaking a first-ever national survey to create a database of actual acquisition costs that States may use as a basis for determining State-specific rates, with results available later this year. Alabama, the first State to adopt use of actual acquisition costs as the benchmark for drug reimbursement, expects to save six percent ($30 million) of its pharmacy costs in the first year of implementation. We will also share additional approaches that States have used to drive down costs, such as relying more on generic drugs, mail order, management relating to over-prescribed high cost drugs, and use of health information technology to encourage appropriate prescribing and avoidance of expensive adverse events.
- **Assuring Program Integrity.** According to the Department's 2010 Financial Agency Report, the three-year weighted average national error rate for Medicaid is 9.4 percent, meaning that $33.7 billion in combined Federal and State funds were paid inappropriately. The Federal government and States have a strong, shared interest in assuring integrity in every aspect of the program, and there are new options and tools available to States. Our Medicaid Integrity Institute is preparing a series of webinars for States to share best practices, learn about the potential cost savings created by the new program integrity provisions in the Affordable Care Act, and hear about initiatives underway in Medicare and the private sector that could be replicated in Medicaid. For example, to help your State identify providers who were terminated elsewhere, States will have access to a new Federal portal starting in mid-February to obtain this information from other States and the Medicare program. In addition, States will be able to use Federal audit contractors to save State funds and consolidate auditing efforts. States will also benefit from new, cutting-edge analytics, like predictive modeling, being developed to prevent fraud in the Medicare program. In 2010, the Departments of Health and Human Services and Justice recovered more than $4 billion in taxpayer dollars – the highest annual amount ever – from people who attempted to defraud seniors and taxpayers, and we want to continue to work closely with you to prevent and fight waste, fraud and abuse in Medicare, Medicaid and CHIP. The President is committed to cutting the error rate in half by 2012.

Beyond these areas of flexibility that could produce short-term savings, we are actively moving forward in areas that could lower costs in the long run. In particular, we are focused on how to help States provide better care and lower costs for so called "dual eligibles," seniors and people with disabilities who are eligible for both Medicaid and Medicare. These individuals represent 15 percent of Medicaid beneficiaries but nearly 40 percent of all Medicaid spending. This population offers great potential for improving care and lowering costs by replacing the fragmented care that is now provided to these individuals with integrated care delivery models. The new Federal Coordinated Health Care Office has already released a solicitation for up to 15 States to receive Federal support to design new models for serving dual eligibles. We also plan to launch a Department-wide effort to reduce the costs of health care by improving patient safety in Medicare, Medicaid and throughout the private health care system, and States will be critical partners in this effort. We welcome other ideas on new models of care, including new ways to deliver care that encourage investment and yield savings.

To expedite these 2011 efforts, we will host a series of "virtual" meetings with State health policy advisors and Medicaid directors. In these sessions, we will share information about promising Medicaid cost-saving initiatives underway in one or more States that we are prepared to support and approve in other States on a fast-track basis.

This is just the beginning of a discussion on how we can help you better manage your Medicaid programs and navigate your budget crises. Please be assured that I am committed to working with you toward a sustainable and vibrant Medicaid system in ways that are responsive to the current challenges you are facing every day.

Sincerely,

/s/

Kathleen Sebelius

Enclosures

Medicaid Cost-Savings Opportunities

February 3, 2011

Overview

Medicaid is a large and diverse health care coverage program. Jointly financed by the States and the Federal government, in 2010, Medicaid covered nearly 53 million people and accounted for about 16 percent of all health care spending.[1] It accounts for 17 percent of all hospital spending and is the single largest source of coverage for nursing home care, for childbirth, and for people with HIV/AIDS.[2] It covers one out of four children in the nation as well as some people with the most significant medical needs.[3] While children account for most of the beneficiaries, they comprise only 20 percent of the spending. By contrast, the elderly and people with disabilities account for 18 percent of enrollees but 66 percent of the costs.[4]

Over the past three years, despite rising enrollment due to the economic recession, nationwide State spending on the Medicaid program dropped by 13.2 percent (equivalent to a 10.3 percentage point decline in the State share of the total costs of the program) as a result of the added Federal support provided to State Medicaid programs through the American Recovery and Reinvestment Act of 2009 (the Recovery Act).[5] In 2009 alone, due to this action, State Medicaid spending fell by 10 percent even though enrollment in Medicaid climbed by 7 percent due to the recession.[6] However, this enhanced Federal Medical Assistance Percentage (FMAP) support is set to expire on June 30, 2011. While State revenues are beginning to show signs of recovery, the upcoming State fiscal year could be especially difficult for States.

Against this backdrop, States are beginning to plan for 2014 when Medicaid will be simplified and expanded to adults and children with income up to 133 percent of the Federal Poverty Level (FPL) ($26,645 in annual income for a family of three in 2011). Benefits for most newly eligible adults will be comparable to that of typical private insurance. Significantly, almost all of the new Medicaid coverage costs will be borne by the Federal government. The Medicaid changes in the Affordable Care Act will also bring about major improvements in the program for States, health care providers, and low-income individuals. The Department of Health and Human Services (HHS), in collaboration with States, has been engaged in a multi-faceted process to accomplish these changes by 2014. The objective is to ensure that Medicaid functions as a high-performing program serving the needs of America's most vulnerable citizens and is a full partner with the Health Insurance Exchanges in achieving the coverage, quality and cost containment goals of the new law. Recent reports have found that the increased support for Medicaid, lower uncompensated care costs, and other provisions of the new law to tackle health care costs will produce savings to States as they become fully effective. In the short term, however, State budget pressures are forcing an immediate focus on this program whose enrollment has grown as job-based insurance declined due to the recession.

Now HHS is stepping up its efforts to help States consider policies that will improve care and generate efficiencies, in the short term and over time, as part of the larger imperative to tackle health care cost growth throughout the health care system. This paper identifies existing flexibility in the Medicaid program and new initiatives, many of which can be accomplished under either current program flexibilities or the new options under the Affordable Care Act.

Existing Areas of Program Flexibility

Over time, Medicaid has evolved to offer States considerable flexibility in the management and design of the program. States set provider payment rates and have considerable flexibility to establish the methods for payment, to design the benefits for adults, and to establish other program design features. In addition, States have the ability to apply for a Section 1115 waiver of other Federal requirements to adjust coverage and payment rules.[7]

1. **Cost Sharing**

   In the Deficit Reduction Act of 2005, Congress gave States additional flexibility to impose cost sharing in Medicaid in the form of copayments, deductibles, coinsurance, and other similar charges without requiring States to seek Federal approval of a waiver. Certain vulnerable groups are exempt from cost sharing, including most children and pregnant women, and some services are also exempt. However, States may impose higher cost sharing for many targeted groups of somewhat higher-income beneficiaries, above 100 percent of the poverty level (the equivalent of $18,530 in annual income for a family of three), as long as the family's total cost sharing (including cost sharing and premiums) does not exceed five percent of their income.

   States may impose cost sharing on most Medicaid-covered services, both inpatient and outpatient, and the amounts that can be charged vary with income. In addition, Medicaid rules give States the ability to use cost-sharing to promote the most cost-effective use of prescription drugs. To encourage the use of lower-cost drugs, such as generics, States may establish different copayments for non-preferred versus preferred drugs. For people with incomes above 150 percent of the poverty level, cost sharing for non-preferred drugs may be as high as 20 percent of the cost of the drug. The following table describes the maximum allowable copayment amounts for different types of services.

   MAXIMUM ALLOWABLE COPAYMENTS

	Eligible Populations by Family Income [b,c]		
Services and Supplies (Cost Sharing Subject to a Per-Beneficiary Limit)[a]	**<100% FPL**	**101-150% FPL**	**>150% FPL**
Institutional Care (inpatient hospital care, rehab care, etc.)	50% of cost for 1st day of care	50% of cost for 1st day of care, 10% of cost	50% of cost for 1st day of care, 20% of cost

Non-Institutional Care (physician visits, physical therapy, etc.)	$3.65	10% of cost	20% of cost
Non-emergency use of the ER	$3.65	$7.30	No limit
Preferred drugs	$3.65	$3.65	$3.65
Non-preferred drugs	$3.65	$3.65	20% of cost

a. Emergency services, family planning, and preventive services for children are exempt from copayments. Cost sharing is subject to a limit of five percent of income.

b. Some groups of beneficiaries, including most children, pregnant women, terminally ill individuals, and most institutionalized individuals, are exempt from copayments except nominal copayments for non-emergency use of an emergency room and non-preferred drugs. American Indians who receive services from the Indian Health Service, tribal health programs, or contract health service programs are exempt from all copayments.

c. Under certain circumstances for beneficiaries with income above 100 percent of FPL, States may deny services for nonpayment of cost sharing.

Because Medicaid covers particularly low-income and often very sick patients, Medicaid cost sharing is subject to an overall cap. The Medicaid cost for one inpatient hospital visit averages more than $5,700 for blind and disabled beneficiaries.[8] Someone in very frail health, such as a beneficiary with advanced Lou Gehrig's disease, likely requires multiple hospital visits each year. If such an individual has four hospital stays per year and income amounting to 160 percent of poverty (about $23,000 for a family of two), without the cap he could be charged hospital cost sharing averaging up to $1,140 per visit. Total cost sharing is capped at five percent of income, so this beneficiary would not be required to pay the full 20 percent copayment for such a costly hospital stay, but could still face more than $1,100 in cost sharing per year.

2. **Benefits**

States have various sources of flexibility with respect to the design of Medicaid benefits for adults. For children, any limitations on services (either mandatory or optional) must be based solely on medical necessity; States are required to cover their medically necessary services.

"Optional" benefits. Medicaid-covered benefits are broken out into "mandatory" services, which must be included in every State Medicaid program for all beneficiaries (except if waived under a Section 1115 waiver), and "optional" services which may be covered at the State's discretion. Below is a table listing mandatory and optional services. While considered "optional," some services like prescription drugs are covered by all States. In 2008, roughly 40 percent of Medicaid benefits spending – $100 billion – was spent on optional benefits for all enrollees, with nearly 60 percent of this spending for long-term care services.[9]

MEDICAID COVERED SERVICES

Mandatory Services (60% of Spending)	Optional Services (40% of Spending)
◦ Inpatient hospital services	◦ Prescription drugs
◦ Outpatient hospital services	◦ Clinic services
◦ Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services	◦ Physical therapy
◦ Nursing facility services	◦ Occupational therapy
◦ Home health services	◦ Speech, hearing and language disorder services
◦ Physician services	◦ Respiratory care services
◦ Rural health clinic services	◦ Other diagnostic, screening, preventive and rehabilitative services
◦ Federally qualified health center services	◦ Podiatry services
◦ Laboratory and X-ray services	◦ Optometry services
◦ Family planning services	◦ Dental services
◦ Nurse Midwife services	◦ Dentures
◦ Certified Pediatric and Family Nurse Practitioner services	◦ Prosthetics
◦ Freestanding Birth Center services (when licensed or otherwise recognized by the State)	◦ Eyeglasses
◦ Transportation to medical care	◦ Chiropractic services
◦ Smoking cessation for pregnant women	◦ Other practitioner services
	◦ Private duty nursing services
	◦ Other services approved by the Secretary[a]

a. This includes home and community-based care and other community-based long-term care services, coverage of organ transplants, Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) services and other services.

Amount, duration and scope of a benefit. States have flexibility in the design of the particular benefit or service for adults, so long as each covered service is sufficient in amount, duration and scope to reasonably achieve its purpose.

"Benchmark benefits." States have broad flexibility to vary the benefits they provide to certain adult enrollees through the use of alternative benefit packages called "benchmark" or "benchmark-equivalent" plans. These plans may be offered in lieu of the benefits covered under a traditional Medicaid State plan. A benchmark benefit package can be tailored to the specific medical conditions of enrollees and may vary in different parts of a State.

Benchmark benefits coverage is health benefits coverage that is equal to the coverage under one or more of the following standard commercial benefit plans:

◦ Federal employee health benefit coverage – a benefit plan equivalent to the standard Blue Cross/Blue Shield preferred provider plan offered to Federal employees;

- State employee health benefit coverage – a benefit plan offered and generally available to State employees in the State; or
- Health maintenance organization (HMO) coverage – a benefit plan offered through an HMO with the largest insured commercial non-Medicaid enrolled population in the State.

States may also offer health benefit coverage through two additional types of benchmark benefit plans, Secretary-approved coverage or benchmark-equivalent plan coverage. Secretary-approved coverage is any other health benefits coverage that the Secretary determines provides appropriate coverage to meet the needs of the population provided that coverage. Benchmark-equivalent coverage is a plan with different benefits, but with an actuarial value equivalent to one of the three standard benchmark plans. Benchmark-equivalent packages must include certain services such as inpatient and outpatient hospital services, physician services, and prescription drugs.

States have the option to limit coverage for generally healthy adults to benchmark or benchmark-equivalent coverage. Other groups, including blind and disabled, medically frail, and institutionalized individuals can be offered enrollment in a benchmark plan, but they cannot be required to enroll in such a plan. To date, 11 States have approved benchmark coverage. States generally have used this option to provide benefits to targeted groups of beneficiaries, rather than having to provide these services to a broader group of people. For example, Wisconsin provides benefits equivalent to the largest commercial plan offered in the State plus mental health and substance disorder coverage for pregnant women with income between 200 and 250 percent of poverty.

Opportunities for Medicaid Efficiencies

Medicaid costs per enrollee, like those in the health system generally, are driven by utilization and payment rates, including rising prices, and to some degree by waste, fraud, and abuse. Medicaid costs are also uniquely driven by increased utilization associated with the complex cases and chronic illness prevalent among those enrolled in the program. The initiatives below aim to help States improve care and lower costs largely through changes in care delivery systems and payment methodologies focused on the costs drivers in the program. We are developing a portfolio of approaches that would be combined with technical support and fast-track ways for States to implement the new initiatives and we remain open to other ideas that can improve care and efficiency. Most of these initiatives can be accomplished under current flexibilities under the program.

1. **Service Delivery Initiatives and Payment Strategies for Enrollees with High Costs**

   Because Medicaid serves people with significant medical needs (including but not limited to "dual eligibles") and is the largest single payer for long term care, Medicaid expenditures are driven largely by the relatively small number of people with chronic and disabling conditions. For example, in 2008, five percent of beneficiaries accounted for more than half of all Medicaid spending and one percent of beneficiaries accounted for 25 percent of all expenditures.[10] Working to develop better systems of care for these individuals holds great promise not only to improve care but to reduce costs. Reducing the average cost of care by just ten percent for the five percent of beneficiaries who are the highest users of care, could save $15.7 billion in total Medicaid spending and produce a significant positive impact on longer term spending trends.[11]

   Some initiatives focusing on high-need beneficiaries include:

   - **Care and payment models for children's hospitals** to reorganize and refinance the way care is delivered for children with severe chronic illnesses. A number of children's hospitals are working to coordinate all primary care and specialized care needs of these children through a medical home model. For example, St. Joseph's Children's Hospital of Tampa reduced emergency room visits by more than one-third, and hospital days by 20 percent. The Arkansas Children's Hospital model is projected to reduce annual per child costs by more than 30 percent and reduce hospital admissions by 40 percent.[12] Even more importantly, the overall quality of life for these children can be dramatically improved through a medical home model of care.
   - **The "Money Follows the Person" demonstration grants** extended and expanded under the Affordable Care Act. Currently, 43 States and the District of Columbia are using or planning to use these funds to help transition people from costly nursing home settings to more integrated community settings. HHS is currently exploring innovative ways for States to use these funds and welcomes State ideas. Promoting alternatives for home and community-based services reduces dependence on institutional care, improves the quality of life, and enhances beneficiary choice.
   - **Initiatives to change care and payment models to reduce premature births**. Given that Medicaid currently finances about 40 percent of all births in the U.S., it has a major role to play in improving maternity care and birth outcomes. Early deliveries are associated with an increase in premature births and admissions to neonatal intensive care units (NICUs), which carry a high economic cost.[13] One factor contributing to premature births is an increase in births by elective cesarean section. Promising models to reduce premature births and medically unnecessary cesarean sections include adopting new protocols and using mid-level providers in an integrated care delivery setting to improve care coordination. In New York, one model of coordinated prenatal care reduced the chances of a mother giving birth to a low-birth weight infant by 43 percent in an intervention group as compared with a group of women receiving care under standard practices.[14] In Ohio, a focus on lowering the rate of non-medically necessary pre-term cesarean deliveries has led to reductions in pre-term cesarean births and NICU admissions.[15] According to some analyses, a NICU admission increases costs ten-fold above normal delivery costs. These service delivery and payment initiatives can be accomplished without a waiver or demonstration.
   - **Promoting better care management for children and adults with asthma**. About a quarter of all asthma-related health care spending is for hospital care, much of which could be avoided with better care management.[16] Successful models exist that involve nontraditional educators and patient self-management. A New York initiative focused on patient self-management and tailored case management reduced asthma-related emergency room visits by 78 percent.[17] A similar project in California reduced hospital admissions by 90 percent.[18]
   - **Initiatives to reduce hospital readmissions**, which could improve care and lower costs. A recently published analysis shows that 16 percent of people with disabilities covered by Medicaid (excluding the dual eligibles) were readmitted to the hospital within 30 days of discharge. Half of those who were readmitted had not seen a doctor since discharge.[19] There is a significant body of evidence showing that improving care transitions as patients move across different health care settings can greatly reduce readmission rates. Interventions such as using a nurse discharge advocate to arrange follow-up appointments and conduct patient education or a clinical pharmacist to make follow-up calls has yielded dramatic reductions in readmission rates. One Colorado project, for example, reduced its 30-day readmission rate by 30 percent.[20] These practices can continue to be expanded in Medicaid, where the average cost of just one hospital admission for an individual with disabilities (excluding dual eligibles) is more than $5,700.[21]
   - **Implementing the new Health Homes option** in the Affordable Care Act. This option offers new opportunities – and Federal support – to care for people with chronic conditions by providing eight quarters of 90 percent Federal match for care coordination services. Guidance to States has been issued (http://www.cms.gov/smdl/downloads/SMD10024.pdf), and HHS is establishing an intensive State-based peer-to-peer collaborative within the new Centers for Medicare & Medicaid Services (CMS) Innovation Center to test and share information about different models. The option, which was effective January 1, 2011, could result in

immediate savings, given the enhanced match, as well as a path for learning how to establish effective care coordination systems for people with chronic conditions.

- **Promoting Accountable Care Organizations (ACOs)** that include Medicaid by bringing States into the planning and testing of ACO models that include, or even focus on, Medicaid plans and providers. CMS will work with States to ensure that States have ample opportunity to participate in these new models of care and benefit from any savings.
- **Continuing to integrate health information technology.** Health information technology (health IT) and electronic health information exchange are also key to driving down health care costs. Medicaid-financed incentive payments to eligible providers began in several States in January. HHS-funded health IT initiatives are underway in every State, providing implementation assistance and supporting improved care coordination. Additional Federal grants from the Office of the National Coordinator for Health Information Technology to support State-level initiatives will be awarded in February. (http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__hitech_and_funding_opportunities/1310).

2. **Purchasing Drugs More Efficiently**

Pharmacy costs account for eight percent of Medicaid program spending, with States spending $7 billion on prescription drugs in 2009.[22] While States have taken steps to reduce their pharmacy costs over the past decade, there is still strong evidence that many State Medicaid agencies are paying too high a price for drugs in the Medicaid program.[23] Recent court settlements have disclosed that the information most States rely upon to establish payment rates is seriously flawed. As a result, the major drug pricing compendium used by Medicaid State agencies will cease publication before the end of 2011, and States must find a new basis for drug pricing. We will work with States to help them manage their pharmacy costs and ensure their pharmacy pricing is fair and efficient:

- **Provide States with a new, more accurate benchmark to base payments**. A workgroup of State Medicaid directors and State Medicaid pharmacy directors has recommended a new approach to establishing a benchmark for rates, namely, use of actual average acquisition costs.[24] Alabama, the first State to adopt use of actual acquisition costs as the benchmark for drug reimbursement rates, expects to save six percent ($30 million) of its pharmacy cost in the first year of implementation. However, it is difficult and costly for each State to create its own data source for actual acquisition costs. States have recommended a national benchmark. In response, CMS is about to undertake a national survey of pharmacies to create a database of actual acquisition costs that States may use as a basis for determining State-specific rates. The data will be available to States later this year.

3. **Dual Eligibles**

There is great potential for improving care and lowering costs by ending the fragmented care that is now provided to "dual eligibles" – people who are enrolled in both Medicaid and Medicare. While only 15 percent of enrollees in Medicaid and Medicare are dual eligibles, four out of every ten dollars spent in the Medicaid program and one quarter of Medicare spending are for services provided to dual eligibles.[25] Fragmented care, wasteful spending, and patient harm are significant risks with two programs serving some of the most frail and medically needy people, each with its own sets of rules and disparate financial mechanisms. Just a few examples can explain the problem and suggest some of the solutions:

- When Medicaid programs invest in health homes and similar initiatives that can help people who are dually eligible avoid hospitalizations, Medicare realizes most of the savings since it is the primary payer for the cost of hospital care for these people.
- If Medicare seeks to reduce hospital costs and avoid preventable hospital readmissions, extensive discharge planning relying on the availability of community-based long-term care may be required. Those long-term care services, however, are largely driven and financed by Medicaid, not Medicare.

Except in a very small number of specialized plans covering only about 120,000 of the 9.2 million dual eligibles, people do not have a team of caregivers that direct and manage their care across Medicaid and Medicare and States do not have access to information about the care delivered across the two programs.

The Affordable Care Act establishes a new Federal Coordinated Health Care Office to focus attention and resources on improving care for dual eligibles. The Office, which was formally announced on December 29, 2010, will work with States, physicians and others to develop new models of care. In the short term, the Office will focus on the following initiatives that will have an immediate impact on States' ability to better manage care:

- **Support State Demonstrations to Integrate Care for Dual Eligible Individuals**. The Federal Coordinated Health Care Office recently announced that it will award contracts to up to 15 States of up to $1 million each to help them design a demonstration proposal to structure, implement, and evaluate a model aimed at improving the quality, coordination, and cost-effectiveness of care for dual eligible individuals. Through these initiatives, we will identify and validate delivery system models that can be rapidly tested and, upon successful demonstration, replicated in other States. Further investments from the new CMS Innovation Center are under review; this is a priority area for States and HHS. Additional areas of focus and opportunity are demonstrations to decrease transfers between nursing homes and hospitals and developing accountable care organizations to serve dual eligibles and other populations with complex health problems.
- **Provide States with access to Medicare Parts A, B and D data.** For several years State Medicaid agencies have been requesting access to Medicare data to support efforts to: (1) improve quality; (2) better coordinate care; and (3) reduce unnecessary spending for their dual eligible beneficiaries. CMS will make these data available to States in early 2011.

4. **Improving Program Integrity**

States and the Federal government share a common interest in ensuring that limited dollars are not wasted through fraud. According to the 2010 HHS Financial Agency Report, the three-year weighted average national error rate for Medicaid is 9.4 percent, meaning that $33.7 billion in combined federal and State funds was paid inappropriately. Our work on developing new ways to prevent fraud as well as some of the new tools created by the Affordable Care Act will bring additional options and resources to States to help them with their fraud prevention and detection efforts. No waiver or special demonstration is needed to move ahead on these initiatives.

- **The Medicaid Integrity Institute** provides free training to State Medicaid agency staff—it conducted 38 courses last year and trained 1,900 staff since February 2008. States participate as faculty, receive training, and help shape the curriculum. We are planning a special series of web-based trainings for State Medicaid agencies to share best practices and inform States about new provisions of the law aimed at preventing fraud.
- **The Affordable Care Act requires the screening of providers** and provides States with new authority to help keep problematic providers from enrolling in Medicaid. The vast majority of Medicaid providers and suppliers

participate in both Medicaid and Medicare, so Medicare provider screening actions in Medicare will also benefit Medicaid and CHIP programs. A significant value for States is expected. CMS will provide active support and assistance to States, including training of State Medicaid and CHIP program staff and best practice guidelines.

- **New, cutting edge initiatives are being developed to prevent fraud in the Medicare program** and will be shared with States to ensure that Medicaid gets the full benefit of Medicare advances in this area including analytics such as predictive modeling to identify patterns and examine high-cost problem areas across all types of care.
- CMS will be organizing new **Payment Accuracy Improvement Groups** with States grouped based on their shared interest in particular program integrity vulnerabilities. States with similar interests will work with CMS, as well as Federal contractors and other experts, to target issues and problem solve.

[1] *2010 Actuarial Report on the Financial Outlook for Medicaid*. Office of the Actuary, Centers for Medicare & Medicaid Services (for enrollment data). *National Health Expenditure Projections 2009-2019.* Office of the Actuary, Centers for Medicare & Medicaid Services (for expenditure data).

[2] Kaiser Family Foundation 2010.

[3] Kaiser Family Foundation 2010.

[4] 2010 Actuarial Report on the Financial Outlook for Medicaid. Office of the Actuary, Centers for Medicare & Medicaid Services.

[5] CMS analysis of FY 2008-2010 Medicaid Budget and Expenditure System (MBES) data.

[6] Martin A. et al, "Recession Contributes To Slowest Annual Rate Of Increase In Health Spending In Five Decades," *Health Affairs,* 30(1): 11-22, January 2011.

[7] Section 1115 of the Social Security Act authorizes the Secretary of HHS to waive compliance with certain specified provisions of the law or to permit expenditures not otherwise allowed under the law in the context of an "experimental, pilot of demonstration project" that the Secretary determines is "likely to assist in promoting the objectives" of the program.

[8] CMS Analysis of Inpatient Hospital Spending for Blind/Disabled Non-Dual Medicaid Beneficiaries, FY2008, MSIS (Medicaid Statistical Information System), FFS only. Inpatient claim count is used as a proxy for inpatient admission count.

[9] ASPE Analysis of the Medicaid Statistical Information System (MSIS) data for 2008. Spending for mandatory and optional populations.

[10] CMS analysis of FY 2008 CMS MSIS data.

[11] CMS analysis of FY 2008 CMS MSIS data.

[12] November 2010 presentation by the National Association of Children's Hospitals.

[13] Tita, A., et.al. *The New England Journal of Medicine*. January 8, 2009 volume 360, No. 2, pages 11-120.

[14] Eunju Lee, et al. *American Journal of Preventive Medicine* 2009; 36(2):154–160).

[15] The Ohio Perinatal Quality Collaborative Writing Committee. A statewide initiative to reduce inappropriate scheduled births at 360/7–386/7 weeks' gestation. Am J Obstet Gynecol 2010;202:243.e1-8.

[16] American Lung Association. Trends in Asthma Morbidity and Mortality, January 2009.

[17] Hoppin, et al, August 2010. Asthma Regional Council.

[18] Hoppin, et al, August 2010. Asthma Regional Council.

[19] *Hospital Readmissions among Medicaid beneficiaries with Disabilities: Identifying Targets of Opportunity*. Center for Health Care Strategies, December 2010.

[20] Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med*. 2006 Sep25;166(17):1822-8.

[21] CMS Analysis of Inpatient Hospital Spending for Blind/Disabled Non-Dual Medicaid Beneficiaries, FY2008, MSIS (Medicaid Statistical Information System), FFS only. Inpatient claim count is used as a proxy for inpatient admission count.

[22] National health expenditures, historical tables. Includes state and local spending on Medicaid prescription drugs for 2009. https://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp.

[23] See for example, OEI-05-05-00240, Medicaid Drug Price Comparisons: Average Manufacturer Price to Published Prices, June 2005.

[24] *Post AWP Pharmacy Pricing and Reimbursement: Executive Summary and White Paper*. American Medicaid Pharmacy Association and the National of Medicaid Directors, June 2010. Accessed at: http://www.nasmd.org/home/doc/SummaryofWhitePaper.pdf.

[25] Kaiser Family Foundation. *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007*, December 2010. Accessed at: http://www.kff.org/medicaid/upload/7846-02.pdf.

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Thursday, February 24, 2011

Daily News

Budget 2012

Sources: White House 'Struggling' With Decision On Medicaid Rebates; Accelerated Home Health Cuts On Table

Posted: February 11, 2011

House Democrats have asked the White House to include in its budget a policy that would extend the Medicaid rebates into the Medicare Part D dual eligible population, but administration officials are struggling with the idea, several sources tell *Inside Health Policy*. Although the Congressional Budget Office has previously said that the move could bring a good amount of money, including it in the budget could undermine the relationship the White House built with the drug industry during the health reform debate, says Dan Mendelson of Avalere Health.

Other sources have confirmed the same information, and PhRMA issued a statement saying it opposes "price controls" in Medicare Part D.

In general, the White House has the difficult task of showing that it it can be fiscally disciplined while also ensuring there is enough funding for the implement of the affordable care act, Mendelson and other source say. To that end, Mendelson expects the budget request for CMS will be relatively flat.

The president has already said that he will impose a five-year freeze on discretionary spending. This means some programs could see increases, while others could see dramatic cuts, a source stresses.

Adding to the difficulty for the White House, is that the reform law already slashed a half trillion dollars from Medicare and there are few places left to go.

One option likely to be considered is accelerating scheduled payment cuts, Mendelson says. It's unclear if the proposed expedited cuts would hit only certain sectors , or hit all providers. Several sources expect the home health industry cuts to be expedited. Hospice and skilled nursing facilities could see faster reductions as well under the proposal, sources say. Accelerating the home health cuts was including as a solution in the president's bipartisan fiscal commission.

Hospitals, which face the largest cuts, may be another story. Sources suggest that administration officials would be unwilling to go after hospitals so soon after their agreement to take a $155 billion hit for the reform effort.

Yet, Mendelson says that the payments hospitals receive to help with graduate medical education (GME) could be a target. Another source says that hospital "bad debt limits" is also likely to appear in the budget.

Increased investment in fraud, waste and abuse is also very likely to appear in the budget, sources say.

The hospital source notes that going after GME funding would send the wrong message as the administration has been focused on boosting the workforce. For the same reason, it's hard to see the White House proposing cuts to the National Institutes on Health or other agencies that focus on innovative research.

But, perhaps the most challenging decision for the White House will be the Medicaid rebates. The House had included the policy, which the Congressional Budget Office estimated could save $63 billion over 10 years, in its health reform bill. However, the policy was taken off the table after the Senate Finance Committee and the drug industry struck

a deal that would require drugmakers to pay 50 percent of the costs of brand-name drugs for seniors who have fallen into the Part D coverage gap.

Rep. Henry Waxman (D-CA), then-chairman of the House Energy and Commerce Committee and a long time advocate of extending the rebate, was not shy about his position on the "deal," saying House members were not involved and therefore not obliged to follow it. A staffer did not reply to a query on whether Waxman, now ranking member of the committee, has approached the White House about adding the provision to the budget.

The deal ultimately held and the drug industry has since been a solid backer of the reform law.

Now that health reform is over several sources have had varying opinions on whether the White House or Congress is still bound to the deal it reached with PhRMA, but there's no doubt that PhRMA would be displeased to see the policy in the budget.

"PhRMA opposes implementing price controls in the Medicare prescription drug program. Such policies would likely lead to increased premiums on other beneficiaries in the program, by up to 20 percent, according to the Congressional Budget Office," says PhRMA Deputy Vice President Karl Uhlendorf in a statement. "Already negotiations between biopharmaceutical research companies and Part D plans are leading to significant rebates on medicines, " he adds. " In fact, the latest Medicare Trustees report found that savings from these negotiations have been higher than expected, resulting in Part D spending for beneficiaries and taxpayers far below expected levels. Many brand-name prescription medicines carry substantial rebates, often as much as 20-30 percent, the report stated." -- *Amy Lotven* *(altotven@iwpnews.com)*

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Thursday, February 24, 2011

Inside CMS - 02/17/2011

Sebelius Pushes ACOs As Medicaid Cost-Cutting Option

Posted: February 16, 2011

As CMS gets closer to issuing its much-anticipated proposed rule on health reform's Accountable Care Organizations (ACO), increasingly more attention is being given to the idea of states promoting ACOs and incorporating Medicaid into the model. HHS Secretary Kathleen Sebelius wrote in her recent letter to governors, which suggests ways states can make Medicaid more efficient without slashing eligibility, that states should promote ACOs that include Medicaid by bringing states into the planning and testing of ACO models that include or even focus on Medicaid plans and providers. HHS has already been given the authority under the Affordable Care Act to pilot ACOs with Medicaid pediatric care, but sources say Sebelius now is also urging states to promote ACOs that include Medicaid because of the future possibility that ACOs could share savings across multiple payers, once the concepts are fully developed.

Chet Speed, vice president for public policy at the American Medical Group Association, and other sources said this is the first time they've seen Sebelius explicitly encourage ACOs with Medicaid. The letter also says HHS will also focus on developing ACOs to "serve dual eligibles and other populations with complex health problems."

CMS Administrator Donald Berwick said earlier this week that the ACO regulation is in the review stage and could be out by the end of the month.

The Commonwealth Fund and National Academy for State Health Policy also released a joint report on Feb. 4 about states and ACOs, saying states have an important role to play in the development of the models.

"The ACO model holds promise as a new and flexible structure for the promotion of value in health care systems. Supported by mature data systems and using a shared-savings model that recognizes the importance of health care outcomes, ACOs can incentivize what states want - controlled costs and better health outcomes - while addressing health care in a longitudinal and population-based way," the report stated.

In her letter, Sebelius writes that "CMS will work with states to ensure that states have ample opportunity to participate in these new models of care and benefit from any savings." Toby Douglas, director of the California Department of Health Care Services, said California is in the very early stages of developing ACOs for its Medicaid population. The best approach to have shared savings in ACOs, Douglas said, would be to share them across Medicare and Medicaid.

"The only true way to test this out is to integrate the payment," Douglas told *Inside Health Policy*. CMS has not outlined anything in particular for shared savings in ACOs, but CMS is considering sharing Medicare savings with states that are designing programs for dually eligible beneficiaries.

Sources say it would be all the better for Medicaid to participate in the ACOs that provide care to Medicare beneficiaries and private payers, because the extent to which providers could receive savings would be much greater. Speed said aligning Medicare and Medicaid is key ,and if ACO care management techniques are applied to a Medicaid patient population there could potentially be improved care and reduced costs like in the Medicare population.

"Care alignment is critical," Speed said.

Several states are in the beginning stages of ACO development - including Colorado, Oregon and North Carolina. The Commonwealth Fund report lists engaging Medicare as a payer as a new payment method that could be designed and

promoted in ACOs. One source familiar with Medicare and state Medicaid programs said Medicare, as a buyer, wants to use the ACO model to influence cost efficiencies across the marketplace, and Medicare is not the only buyer.

Yet the source said it is unlikely states will really move forward with ACOs until CMS comes out with the proposed rule that sets regulations for Medicare. It will be easier for Medicaid health plans to figure out what best to do with ACOs, the source said, once it is more evident how Medicare is going to about it and CMS signals how some key decisions surrounding ACOs will be made.

At a Feb. 8 forum on ACOs, Stan Dennis, senior vice president of Texas Health Resources, made similar remarks about CMS' pending proposed rule, saying it would be a catalyst for states to adopt similar rules and regulations for Medicaid populations. Texas Health Resources is a faith-based nonprofit health system and is part of the Premier Accountable Care Implementation Collaborative. - *Rachana Dixit*

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Thursday, February 24, 2011

Inside CMS - 02/17/2011

HHS Offers New Ways To Contain Medicaid Costs Without Cutting Eligibility

Posted: February 16, 2011

HHS Secretary Kathleen Sebelius on Feb. 3 offered states new ways to contain Medicaid costs without cutting eligibility, including a new federal portal that states can access later this month to identify providers that have been terminated in other states, using information culled from states and Medicare. The portal was mentioned as one of several ways states could potentially reduce Medicaid costs - along with using federal audit contractors to save money and taking advantage of the first national survey underway by HHS to create a database of actual drug acquisition costs that states can use to determine specific reimbursement rates.

In a Feb. 3 letter to the nation's governors, Sebelius said HHS will step up its efforts to help states identify cost drivers in Medicaid and provide them with new tools to achieve short- and long-term savings in the program while still providing quality care to beneficiaries.

Other measures, such as encouraging states to look at limiting optional benefits and increasing cost-sharing for beneficiaries, were also outlined as options to avoid cutting back eligibility, something prohibited by health reform's maintenance of effort requirement. Sebelius said she would "continue to review what authority, if any, I have to waive the maintenance of effort under current law," but she focused most of the letter on ways states could cut costs without seeking an eligibility waiver.

"We recognize that many States are re-examining their Medicaid programs and looking for opportunities to meet the pressing health care challenges and better cope with rising costs," Sebelius wrote.

A CMS official said the federal audit contractors that will be available for widespread use by states are Medicaid Integrity Contractor audits. States have used MICs before, the agency said, but only on a small scale. With regard to the database that will allow states to give and find information on providers, CMS said some states have shared exclusion data on providers but most to date have not.

Bruce Lesley, president of child advocacy organization First Focus, said in a statement that the organization commended Sebelius' efforts to work with states to find Medicaid savings without excluding people from health coverage. "As our nation's economy struggles to recover, the proper role of the federal government is to ensure our most vulnerable citizens are not left worse off and to offer assistance to state governments," Lesley said.

The MOE requires states to maintain Medicaid eligibility levels as they were in March 2010. There is an exemption to the rule that some officials have pointed to (see related story) - states are exempt from the eligibility requirements for non-pregnant, non-disabled adults with incomes greater than 133 percent of the federal poverty level if states have a budget deficit - but sources have said that few states are likely to qualify for it.

JoAnn Lamphere, AARP's director of state government relations for health and long-term care, said Sebelius' letter shows the federal government's unprecedented commitment to work with states to "bring Medicaid into the 21st century." AARP is delighted to see that Sebelius toed the line on the MOE requirement, Lamphere said, and thought the letter provided several ideas to change Medicaid in terms of how care is delivered and achieve cost-savings without cutting eligibility.

Earlier this year, 33 Republican governors sent the administration and congressional leaders a letter asking them to lift some of the federal mandates required by health reform, particularly noting their concern with the

Medicaid MOE requirements that were found in health reform and in the federal stimulus bill. Largely because of stimulus money, most states maintained or expanded eligibility and enrollment in Medicaid and the Children's Health Insurance Program last year.

In a statement, Sen. Orrin Hatch (R-UT) said Thursday, "States should be able to manage their programs without excessive interference from Washington. Lifting these unreasonable restrictions and reforming Medicaid is an absolute necessity and is key to fixing not only state budget shortfalls, but our federal government's as well."

Arizona is the first state to have asked the federal government for a waiver from the maintenance of effort requirement. Gov. Jan Brewer (R) is seeking the exemption to drop an estimated 280,000 residents off Arizona's Medicaid rolls. Brewer's office did not return a request for comment Thursday.

The generic drug lobby lauded Sebelius' letter encouraging states to go after solutions to purchase drugs more efficiently and reduce drug costs, and pointing to relying on more generic drugs as a way to potentially realize those results.

"Public reliance on affordable generics and confidence in their effectiveness has never been higher," the Generic Pharmaceutical Association said in a statement. "Now is the time to optimize the savings that generics can achieve instead of considering misguided initiatives such as therapeutic carve-out laws to restrict the use of generic pharmaceuticals."

Sharon Treat, the executive director of the National Legislative Association on Prescription Drug Prices, said a central database would also be helpful to states that have had to negotiate rebates with drug manufacturers and wholesalers without access to good information. Only a few states, she said, have laws requiring reporting on a wide range of price points and penalties for misstating prices.

"I think that could be very helpful to the states," Treat said. - *Rachana Dixit*

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Thursday, February 24, 2011

Inside CMS - 02/17/2011

HHS Encourages States To Use AAC For Rx Reimbursement

Posted: February 16, 2011

Community pharmacies say HHS' options for reducing states' Medicaid pharmacy costs could have the unintended effect of reducing generic drugs use, which would drive costs up. The National Community Pharmacy Association is writing a letter to HHS Secretary Sebelius to outline the industry's concerns, and NCPA plans to lobby state governors and Medicaid directors to raise concerns with use of "average acquisition costs" and mail order pharmacies. Conversely, pharmacy benefit managers are lobbying states to use mail order pharmacies and move away from the current system that they say sets artificially high reimbursement and is beholden to community pharmacies.

Most states use the average wholesale price of drugs to set pharmacy reimbursement. However, recent court settlements disclosed that the AWP is flawed, and that compendium will no longer be published after the end of this year. Most states are in the process of looking for a new benchmark - as well as looking for savings to deal with tight budgets - and Sebelius' Thursday letter to the states outlining Medicaid cost-cutting options touts the actual acquisition costs. The actual acquisition cost (AAC) was but one suggestion in her letter that outlined several ways that states could lower Medicaid costs without cutting Medicaid eligibility (see related story).

NCPA is wary of using the AAC to determine pharmacy reimbursement, suggesting the level could end up lower than the average wholesale price (AWP). NCPA favors using "an appropriately-determined state Maximum Allowable Cost" for generics, a source says. If reimbursement is too low, community pharmacies say they will not be able to participate in the Medicaid program, and community pharmacies serve more Medicaid beneficiaries than other pharmacies. Also, community pharmacies use more generic drugs than other pharmacies, so if the government wants to contain Medicaid costs and maintain pharmacy access to the expanding Medicaid population, it must ensure that states maintain incentives for dispensing generics, they say.

Not only did the Sebelius letter encourage the use of AAC, it suggested that states use actual "average" acquisition costs. NCPA prefers using a "median" reimbursement benchmark as smaller pharmacies tend to purchase at a higher price than large publicly traded self-warehousing chains.

Sebelius' letter touts CMS' plan to undertake a national survey of pharmacies to create a database of AACs that states would use to determine pharmacy reimbursement rates, which is also a bone of contention with community pharmacists. The Deficit Reduction Act of 2005 (DRA) states CMS may have a contractor conduct a "nationwide survey of consumer purchase prices" for drugs, and the Affordable Care Act clarifies which transactions should be included in retail survey program and authorizes the disclosure of average retail survey prices for certain multiple source drugs. NCPA says CMS does not have the authority to collect prices that pharmacies pay for drugs. (The National Association of Chain Drug Stores agrees, according to a letter to Sebelius.)

Rather, the retail survey price program was created to survey the price that pharmacies charge consumers, according to NCAP. However, NCPA says states have the right to collect prices that pharmacies pay for drugs, if they choose to use the AAC.

Alabama was the first state to use AAC as the benchmark for drug reimbursement, and it expects to save 6 percent, or $30 million, on its pharmacy costs in the first year, according to the Sebelius letter to states. (Oregon began using AAC this year and other states are considering it.)

Community and chain pharmacies say it is important to note that both states calculated the comprehensive cost of dispensing and adjusted state dispensing fees so that they were also reflective of pharmacies' costs.

Sebelius goes on to list mail order as another option for reducing pharmacy costs. "We will also share additional approaches that States have used to drive down costs, such as relying more on generic drugs, mail order, management relating to over-prescribed high cost drugs, and use of health information technology to encourage appropriate prescribing and avoidance of expensive adverse events," her letter states.

NCPA dislikes mail order pharmacies, which typically are used by pharmacy benefit managers. NCPA argues that community pharmacies use 10 percent more generic drugs than mail order pharmacies because brand-name drug makers pay pharmacy benefit managers rebates to use the more expensive branded drugs. Mail order pharmacies take away business from community pharmacies, and without that extra generic drug use, the cost of pharmacy benefits will increase, the group says.

The National Association of Chain Drug Stores also states that beneficiaries should be allowed to "use the pharmacy of their choice." NACDS points to the Massachusetts fee-for-service Medicaid program, which has the

highest generic dispensing rate in the nation, 79.3 percent. If all other states were to match that rate, Medicaid would save $5.14 billion, NACDS states.

The Pharmaceutical Care Management Association, which represents PBMs, says mail order saves Medicaid money, and the trade association is encouraging states to contract with PBMs to increase the use of mail order.

"Most state Medicaid programs use an old-school fee-for-service approach in which state officials arbitrarily decide how much Medicaid will pay pharmacies," PCMA states in a release. "This approach exposes state governments to political pressure from the independent drugstore lobby to set artificially high payment levels. On the other hand, most non-Medicaid drug benefits programs - like those offered by Medicare, employers and unions - use independent, third-party pharmacy benefit experts to negotiate more competitive rates with pharmacies. These programs also use cutting-edge, market-proven strategies to increase the use of generics." - *John Wilkerson*

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Thursday, February 24, 2011

Inside CMS - 02/17/2011

Sebelius Grilled On State Reform Flexibility At Senate Hearing

Posted: February 16, 2011

The debate between the Obama administration and Republicans over state flexibility in implementing the health reform law heightened on Tuesday (Feb. 15) as HHS Secretary Kathleen Sebelius was grilled by members of the Senate Finance Committee over states' requirement to meet the maintenance of eligibility requirement for Medicaid. A Senate GOP memo circulated that day also comes out against Sebelius' assertion in a recent op-ed piece that the reform law "already gives states most of the resources and flexibility they're asking for."

The GOP memo counters HHS claims that states have discretion to offer a wide variety of plans through their exchanges, instead saying that the reform law has restrictions on deductibles and cost-sharing that would prevent a health savings account from being offered. Also, the memo states that the reform law does not give states the flexibility to decide what benefits plans might offer, highlighting that the law states that "the Secretary shall define the essential health benefits" necessary. Lastly, HHS has claimed that the federal government will cover 96 percent of the Medicaid expansion, while the GOP memo claims the federal government will pay 90 percent of the costs beginning in 2020 and states will not get an enhanced match on any currently eligible Medicaid individuals who enroll in the program.

The crux of the GOP criticism during the hearing was the lack of state flexibility in both the reform law and provisions in the president's budget proposal. Both Sen. Orrin Hatch (R-UT), the committee's ranking minority member, and Sen. Chuck Grassley (R-IA) highlighted the reform law's "maintenance of effort" provision, which calls for states to maintain eligibility levels as they were in March 2010 for Medicaid until the health exchanges are operational in 2014. Republican governors have written to lawmakers urging them to remove the requirements, and Arizona has requested for a waiver to block the requirement. GOP senators told Sebelius that keeping the mandate in place blocks a state's ability to manage its own finances.

"It's a mistake for the federal government to pick and choose what tools states have available to deal with trying budget times," Grassley said.

Sebelius responded that her agency "does not have the authority to blanket waive what is a congressional law," but that HHS is working "diligently" with governors across the country to help them address their Medicaid woes. She said that states still have enhanced FMAP funds to use, though they will expire in June.

The hearing marked Sebelius' first appearance in front of the committee since the debate on health reform, and though the hearing was billed as a discussion on the president's new budget proposal, senators took the opportunity to address concerns about the health reform law and its implementation. "There has been next to no opportunity of public oversight by this committee," Hatch said. "The process of implementing could have been helped along by some oversight."

Also at the hearing, Committee Chair Max Baucus (D-MT) agreed with Sebelius and Hatch that there must be a permanent fix to the Medicare physician payment formula, and also pushed the secretary for more delivery system reforms. Baucus said it will be a priority for him and that Sebelius should "light a fire under" those who are working on delivery system reforms.

Grassley also continued to press for more information on activities by the new Center for Consumer Information and Insurance Oversight, asking the secretary to post on the center's website the criteria each entity must meet to obtain a waiver from certain health reform requirements, the list of entities that have applied or been denied a waiver and the reasons for each denial. Sebelius said that information is being collected, and that the agency would get back to him.

Approximately 97 percent of those entities that have applied for a waiver have been granted one. Grassley joins Hatch and Rep. Fred Upton (R-MI) in requesting information on an increase in waivers granted to unions and companies from mandates in the health reform law. - *Brian Everstine*

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