The Long and Winding Road: Recent Directions in Medicaid & SCHIP

February 7, 2008

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Overview

- Broad national policy updates
  - Extension of SCHIP law
  - CMS SCHIP eligibility criteria for >250% FPL
  - Evolution of citizenship documentation requirements
- Trends in state activities under Medicaid and SCHIP
- Specific reforms approved by CMS under the DRA, and Section 1115 waivers

Broad National Policy Updates

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Broad national policy highlights

- After ideological stalemate, Congress and the President agreed to extend SCHIP, with the underlying policies essentially as-is, until March 31, 2009 with “adequate funding.”
- CMS’ eligibility criteria policy effectively may cap eligibility at 250% FPL
- CMS citizenship and identity documentation requirements evolved to provide marginal relief for beneficiaries and states

Medicare, Medicaid and SCHIP Extension Act of 2007

- Extends funding for SCHIP through March 31, 2009
- Does not address CMS SCHIP eligibility policy changes or create other policy/program changes
- Does not extend funding for new coverage for the eligible-but-not-enrolled population
- Maintains current funding level as baseline: $5 billion in FFY 08 & FFY09
- For FFY 08, provides additional $1.6 billion
- For first two quarters of FFY 09, outlines redistribution process and provides additional $275 million

Implications for states in FFY 08

- At the $5 billion funding level, 21 states were projected to experience a shortfall*
- The first states were projected to exhaust funding in March 2008
- $1.6 billion in additional federal funds is expected to maintain current SCHIP programs in FFY 08, without a shortfall (but no growth)
- States may use unspent FY06 – FY07 allotments
- States may receive funds from redistribution

*Peterson, Chris. (Updated 2007, October 25). *Report for Congress: FY2008 SCHIP Allotments*. (RS22739). Washington, DC: Congressional Research Service (CRS).

CMS "clarifies" SCHIP policy to "prevent interference" with enrolling lower FPL children and to prevent crowd-out

- August 17, 2007, CMS letter to state officials "clarifies" requirements to extend SCHIP eligibility >250% FPL
- CMS' policy dictates that because the potential for crowd-out is greater at higher incomes, CMS expects states to include certain required elements in their SCHIP programs
- States already covering >250% FPL must amend state plan or Section 1115 waiver to come into compliance within 1 year
- According to August letter and related testimony, CMS does "not expect any effect on current enrollees"; not intended to impact enrollment, procedures, or other terms for currently enrolled

The August 17, 2007 letter had several requirements for states with SCHIP programs with coverage >250% FPL

- SCHIP cost sharing requirement must not be more favorable than it would be in private plans by >1%*
- Individuals must have been uninsured for at least 1 year
- State must prove that it has enrolled at least 95% of children <200% FPL eligible for Medicaid or SCHIP
- State must assure that erosion in private insurance has not occurred by demonstrating that the number of children in the target population insured by private employers has not decreased by more than 2% points over the prior 5 year period

* Unless SCHIP plan cost sharing is set at 5% family cap

With impossible requirements, SCHIP eligibility essentially capped at 250% FPL

- "We are horrified at the new federal policy"*
- Pending legal challenges to CMS' policy
- Extremely difficult to meet the 95% coverage threshold
- 23 states currently cover children at >250% FPL or have enacted legislation to do so**
- States responses vary: scaling back proposed expansions, not moving forward with planned expansions, or using state funds >250% FPL

*Ann Clemency Kohler quoted in Pear, Robert. (2007 August 21). Rules May Limit Health Program Aiding Children *The New York Times. Retrieved on February 1, 2008 from http://www.nytimes.com/2007/08/21/washington/21health.html?scp=1&sq=program+aiding+children&st=nyt*

**Mann, Cindy and Michael Ode. (December 2007). *Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive to Impose New Limits on States' Ability to Cover Uninsured Children.* Center for Children and Families, Georgetown University Health Policy Institute.

CMS' application of its new policy is unclear

- CMS denied Ohio's request to increase Medicaid eligibility to 300% FPL
- In early January, CMS indicated it will apply the same criteria in the August 17, 2007 SCHIP letter to proposals for expanding Medicaid
  - "To be consistent and logical, you have to apply the criteria to Medicaid and CHIP" - Dennis Smith*
- In late January, a CMS spokesperson stated that CMS has not made a decision about whether to apply the new policy to Medicaid; however, she confirmed CMS does apply policy to Medicaid programs that combine SCHIP and Medicaid funding**
- Not clear how CMS will implement the new requirements; no additional written guidance has been provided to states

*Pear, Robert. (2008, January 4). U.S. Curtailing Bids to Expand Medicaid Rolls. *The New York Times.*

**Trapp, Doug. (2008, January 28). CMS Denials of State Medicaid Expansions Fuel Confusion: Medical Society Officials are Disappointed in the Agency's Decisions in Oklahoma and Ohio. *AMNews*. Retrieved January 30, 2008 from http://www.ama-assn.org/amednews/2008/01/28/gvsc0128.htm

"Establishing Citizenship for Medicaid Eligibility will be Easier for States . . ."*

- Burdensome requirements in the DRA negatively impacted Medicaid enrollment, especially for children
- Tax Relief and Health Care Act (TRHCA) exempts additional populations from the documentation requirements
- March 2007 - CMS Issued "Deemed Newborns" Clarification
  - First redetermination (up to one year) for deemed newborns of non-citizen mothers eligible to continue receiving Medicaid benefits
- July 2, 2007 - CMS Issued Final Rule incorporating policy changes that may ease some burden on states
- CMS beginning onsite reviews of state implementation

*Centers for Medicare & Medicaid Services. (2007, July 2) *CMS Issues Final Citizenship Guidelines for Medicaid Eligibility: Documents Expanded, Groups Exempted*. Press Release. Retrieved on January 29, 2008 from http://www.cms.hhs.gov/apps/media/press_releases.asp

"Documents Expanded, Groups Exempted"*

- More groups exempted from the documentation requirements in July 2007 Final Rule
  - Incorporation of groups exempted under TRHCA
  - Deemed newborns clarification
- For groups required to provide documents, the acceptable documents were expanded in July 2007 Final Rule
  - Citizenship
    - Systematic Alien Verification for Entitlements (SAVE) database
    - US religious records recorded within 3 months of birth; Early school records
    - Roll of Alaska Natives
    - Affidavit process for naturalized citizens
  - Identity
    - Use of 3 or more corroborating documents (employer ID, marriage license, etc.)
    - Identify affidavits for children up to age 18 in certain circumstances and disabled individuals in residential care facilities
    - Clinic, doctor, and hospital records to verify a child's identity

* Centers for Medicare & Medicaid Services. (2007, July 2). *CMS Issues Final Citizenship Guidelines for Medicaid Eligibility: Documents Expanded, Groups Exempted*. Press Release. Retrieved on January 29, 2008 from http://www.cms.hhs.gov/apps/media/press_releases.asp

Trends in state activities under Medicaid and SCHIP

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The past year in Medicaid coverage trends: expansion and Innovation

- Expansion of Eligibility
  - New groups
  - Higher income levels
- Innovations in Coverage
  - DRA – Benefit Flexibility/Benchmark and Health Opportunity Account Demonstration
  - Section 1115 waiver programs
  - Often part of larger coverage initiative

State trends in increasing eligibility

- Increasing Medicaid/SCHIP eligibility levels for children- several States increase level up to 300% FPL prior to release of CMS policy clarification
- Allowing individuals discharged from foster care at age 18 to retain Medicaid coverage through age 21
- Increasing eligibility levels for adults
- Attempting to expand eligibility, but proposals denied by CMS
- Simplifying enrollment and renewal procedures for children's coverage

Specific reforms approved by CMS under the DRA, and Section 1115 waivers

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Five more states implement coverage initiatives through DRA benefit flexibility authorities

- In 2006, WA, KY, ID, and KS implemented DRA benefit flexibility in Medicaid
- Five more states have utilized DRA benefit flexibility
  - Virginia
  - Washington
  - Missouri
  - Wisconsin
  - South Carolina

In general, the new programs use the authority to expand, not contract, programs

- South Carolina became the first (and still only) state to implement a Health Opportunity Account (HOA) demonstration program

Virginia's Healthy Returns

- In March 2007, CMS approved Virginia's Healthy Returns
- Individuals determined to have asthma, congestive heart failure, coronary artery disease, and/or diabetes may elect to participate (voluntary program)
- In addition to traditional Medicaid services, individuals receive additional benefits tailored to specific health needs:
  - Condition-specific education
  - Access to 24-hour nurse call line (with access to other licensed health professionals)
  - Regularly scheduled telephonic health care management and support
  - Care coordination, including feedback to primary care physician

Washington's Care Coordination

- CMS approved Washington's Benchmark SPA in June 2007
- Two components: a statewide care management program, and a local care management program in King County
- Improve access, outcomes, and cost-effectiveness for high-risk, high-cost individuals with multiple chronic care needs through care management
- Once identified, adults diagnosed with certain chronic conditions may elect to participate (voluntary)
- In addition to traditional Medicaid services, individuals receive additional benefits tailored to specific needs

Missouri's Insure MO

- Missouri expands statewide eligibility under Medicaid for parents and caretaker relatives up to 100% FPL
- In January 2008, CMS approved Missouri's Insure MO Benefit Flexibility SPA
- The benchmark benefit is the federal employees health benefit program BCBS "Standard Option PPO"
- Enrollment into the benchmark benefit is mandatory for the expansion population
- State pursuing additional phases of Insure MO to cover working families up to 185% FPL and to create an insurance pool for small business employers

Wisconsin's Uses Benefit Flexibility a part of BadgerCare Plus Initiative

- Wisconsin takes advantage of DRA benefit flexibility to implement one piece of its overall comprehensive reform initiative, BadgerCare Plus
- Wisconsin increased eligibility for pregnant women to 250% FPL
- In November 2007, CMS approved Wisconsin's statewide Medicaid benefit flexibility plan for pregnant women 200–250% FPL
- The benefit is delivered through the state's largest HMO, UnitedHealthcare's Choice Plus, with additional wrap-around services

South Carolina's HOA High Deductible Health Plan . . .

- Voluntary enrollment is effective for 12 months for up to 1,000 children and parents in the Columbia, SC area
- Beneficiaries receive preventive care coverage without regard to an annual deductible
- State deposits $2,500 per adult and $1,000 per child in HOA
- Beneficiaries are subject to 10% cost sharing, once the HOA is exhausted, prior to returning to traditional Medicaid
- After loss of eligibility, account balance (less 25%) is available to individual for up to 3 years for health insurance or tuition/job training

South Carolina's High Deductible Benchmark Plan

- CMS approved this in conjunction with HOA in June 2007
- Voluntary enrollment for a different group of up to 1,000 children, in the Columbia, SC area (who may opt out at any time)
- The benchmark: recipients will receive the same benefits as South Carolina state employees
- Annual deductible amounts are $3,000 for an individual and $6,000 for family coverage
- There is no cost sharing until the deductible has been met; then nominal state plan cost sharing
- State will provide EPSDT to children under age 19

Indiana's Healthy Indiana Plan (HIP): a Section 1115 approach

- Under a Section 1115 demonstration, Indiana implements Healthy Indiana Plan (HIP) for uninsured adults (<200% FPL) not currently eligible for Medicaid
- The program is a high-deductible plan and an HSA-like account, or Personal Wellness and Responsibility (POWER) account
- HIP recipients get $500 in "first dollar" preventive benefits
- POWER Account valued at $1,100 per adult to pay for initial medical costs
- Members make monthly contributions to POWER accounts based on income level
- Commercial benefits package is provided once the costs exceed $1,100

Other Recent Activities

- Continuing themes
  - Person-centered and consumer-driven
  - Personal responsibility with incentives for preventive care
  - Engaging participation in mainstream health insurance
- Transformations of state Medicaid programs
- Transitions of state SCHIP programs
- Implementation of initiatives to provide Premium Assistance for Employer-Sponsored Insurance
- Idaho's Wellness Preventative Health Assistance (PHA) in SCHIP, rewarding prevention behaviors by offsetting premiums

Questions

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