The Hilltop Institute

analysis to advance the health of vulnerable populations

Medicaid Basics in an Era of Health Reform

Health Policy Institute of Ohio Legislative Briefing

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UMBC

AN HONORS UNIVERSITY IN MARYLAND

Overview

- The Medicaid Basics
- Economic Trends and Medicaid
- The Affordable Care Act (ACA)
- Budget Tools and the Changing State/Federal Relationship

The Medicaid Basics

Medicaid: Background

- Enacted in 1965, largely as a program for the poor who did not have insurance through work or a work history
- State-administered and jointly funded (with the federal government)
- Based on a "Medicaid state plan"–a contract in which the states agree to fulfill the mandatory requirements under federal law, and the federal government agrees to pay the federal matching funds

Medicaid

- Eligibility
- Benefits
- Provider rates
- Beneficiary cost sharing

Mandatory pathways to Medicaid emerged from discreet policy goals . . .

- Provide health benefits to **accompany cash assistance**, akin to providing health benefits attached to a "paycheck"
  - Aid to Families with Dependent Children (AFDC), retained in 1996 welfare reform law
  - Supplemental Security Income (SSI) (federal benefits to aged, blind, and disabled)

. . . including jump-starting care for children and pregnant women . . .

- Children younger than age 6, to 133% of the federal poverty level (FPL)
- Children aged 6 to 18, to 100% of the FPL
- Pregnant women to 133% of the FPL

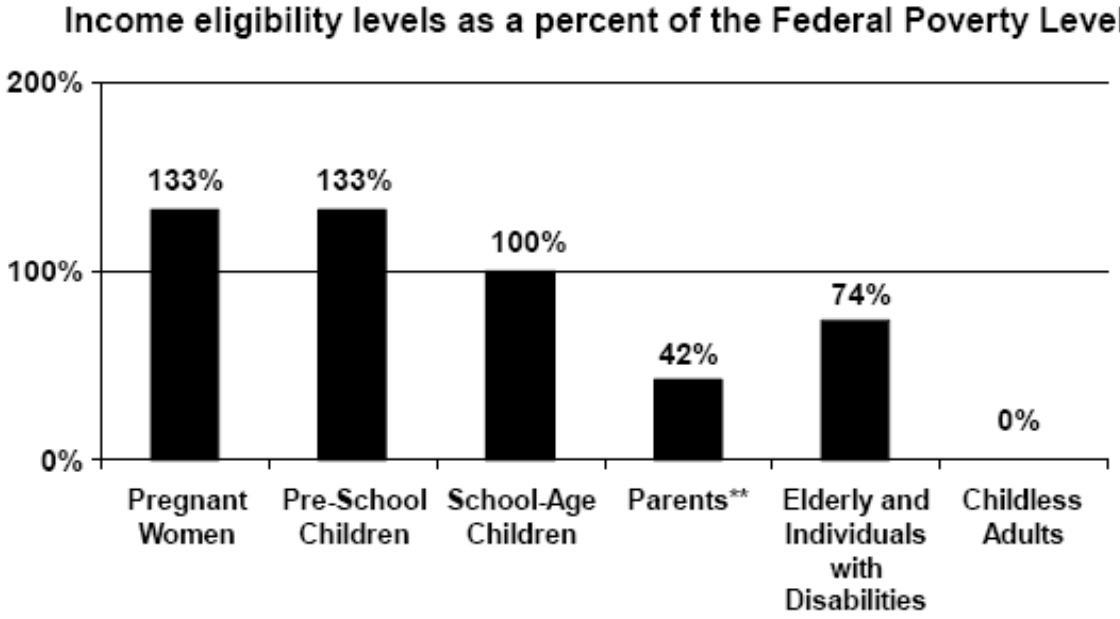
. . . and with other mandates to meet other goals . . .

- Assist Medicare beneficiaries with their Medicare cost sharing
  - Qualified Medicare beneficiaries (QMBs) from 74% to 100% of the FPL
    - No Medicaid benefits, but all Medicare cost sharing
  - Specified low-income Medicare beneficiaries (SLMBs) and qualified individuals (QIs), from 100-135% of the FPL
    - Limited to Medicare Part B premium payments only
- Reduce disincentive for welfare recipients to work
  - Transitional Medical Assistance, on a time-limited basis

. . . and the result is that Medicaid does not cover "the poor," but instead covers targeted groups.

Figure 1

Minimum Medicaid Eligibility Levels, 2004



Notes: *The federal poverty level was $9,310 for a single person and $15,670 for a family of three in 2004.
**The income eligibility level given for parents (42% FPL) is the national median income threshold for non-working parents based on a family of three as of July 2004.
SOURCE: Cohen Ross and Cox, 2004 and The Kaiser Commission on Medicaid and the Uninsured, Medicaid Resource Book, 2002.

States also may cover "optional" groups, without a waiver, such as . . .

- Many of the previous mandatory groups, but to higher income levels:
  - Children up to 185% of the FPL
  - SCHIP covers children up to 200% of the FPL, or 50% above the state's level before SCHIP, whichever is higher
  - Pregnant women up to 185% of the FPL
  - Low-income parents above AFDC mandate
  - Aged, blind, and disabled ("SSI") up to 100% of the FPL

As with eligibility, the federal Medicaid Act distinguishes between "mandatory" and "optional" . . .

Figure 8

Medicaid Acute Care Benefits

"Mandatory" Items and Services	"Optional" Items and Services*
• Physicians services	• Prescription drugs
• Laboratory and x-ray services	• Medical care or remedial care furnished by other licensed practitioners
• Inpatient hospital services	• Rehabilitation and other therapies
• Outpatient hospital services	• Clinic services
• Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21	• Dental services, dentures
• Family planning and supplies	• Prosthetic devices, eyeglasses, durable medical equipment
• Federally-qualified health center (FQHC) services	• Primary care case management
• Rural health clinic services	• TB-related services
• Nurse midwife services	• Other specialist medical or remedial care
• Certified pediatric and family nurse practitioner services	

KAISER COMMISSION ON
Medicaid and the Uninsured

. . . and Medicaid is often called a "Cadillac" benefit plan.

- One reason for "Cadillac" benefits is that current federal Medicaid law mandates that states offer certain services beyond what's available through private insurance.
  - E.g., EPSDT; long-term custodial nursing facility care
- Another reason is that the poverty and disability status of many Medicaid beneficiaries requires services that are not needed by a generally healthier and wealthier population in a private insurance plan.
  - E.g., behavioral health; non-emergency medical transportation; long-term custodial nursing facility care; ICF/MR

Benefit Utilization

- States have the flexibility to alter the “amount, duration, and scope” of benefits, provided the benefits are sufficient to reasonably achieve their purpose
- States have the flexibility to incorporate utilization management practices
- In most instances, restricting a beneficiary’s choice of the provider from whom the beneficiary may receive a benefit requires a waiver, so most managed care programs require a waiver

Unlike eligibility and benefits, federal Medicaid law does not set precise requirements regarding provider rates.

"[A]ssure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

42 USC Section 1396a(30)(A)

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

Table 1. Fees for High-Volume Evaluation and Management Procedures

Procedure Code	Procedure Description	MC	MD	DE	VA	WV	PA	DC
99203	Office/outpatient visit, new	$103	$77	$97	$76	$69	$54	$103
99204	Office/outpatient visit, new	$160	$113	$150	$118	$108	$90	$158
99212	Office/outpatient visit, establish	$41	$31	$39	$30	$27	$26	$42
99213	Office/outpatient visit, establish	$69	$48	$65	$51	$46	$35	$69
99214	Office/outpatient visit, establish	$103	$73	$97	$77	$69	$54	$103
99223	Initial hospital care	$199	$134	$187	$146	$136	$42	$196
99285	Emergency Department visit	$179	$166	$168	$118	$126	$50	$182
99291	Critical care, first hour	$272	$200	$256	$202	$184	$152	$280
99394	Preventive visit, age 12-17	$96	$79	$93	$83	$65	$20	$103
99472	Pediatric critical care, subsequent	$405	$325	$382	$305	$283	$240	$416
	Average % of Medicare Fees		**76%**	**92%**	**75%**	**66%**	**45%**	**102%**

Notes: All fees correspond to 2010 non-facility (e.g., office) fees. MC = Medicare.

States have limited flexibility in beneficiary cost sharing.

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

The Deficit Reduction Act of 2005 allowed states to increase cost sharing in narrow ways.

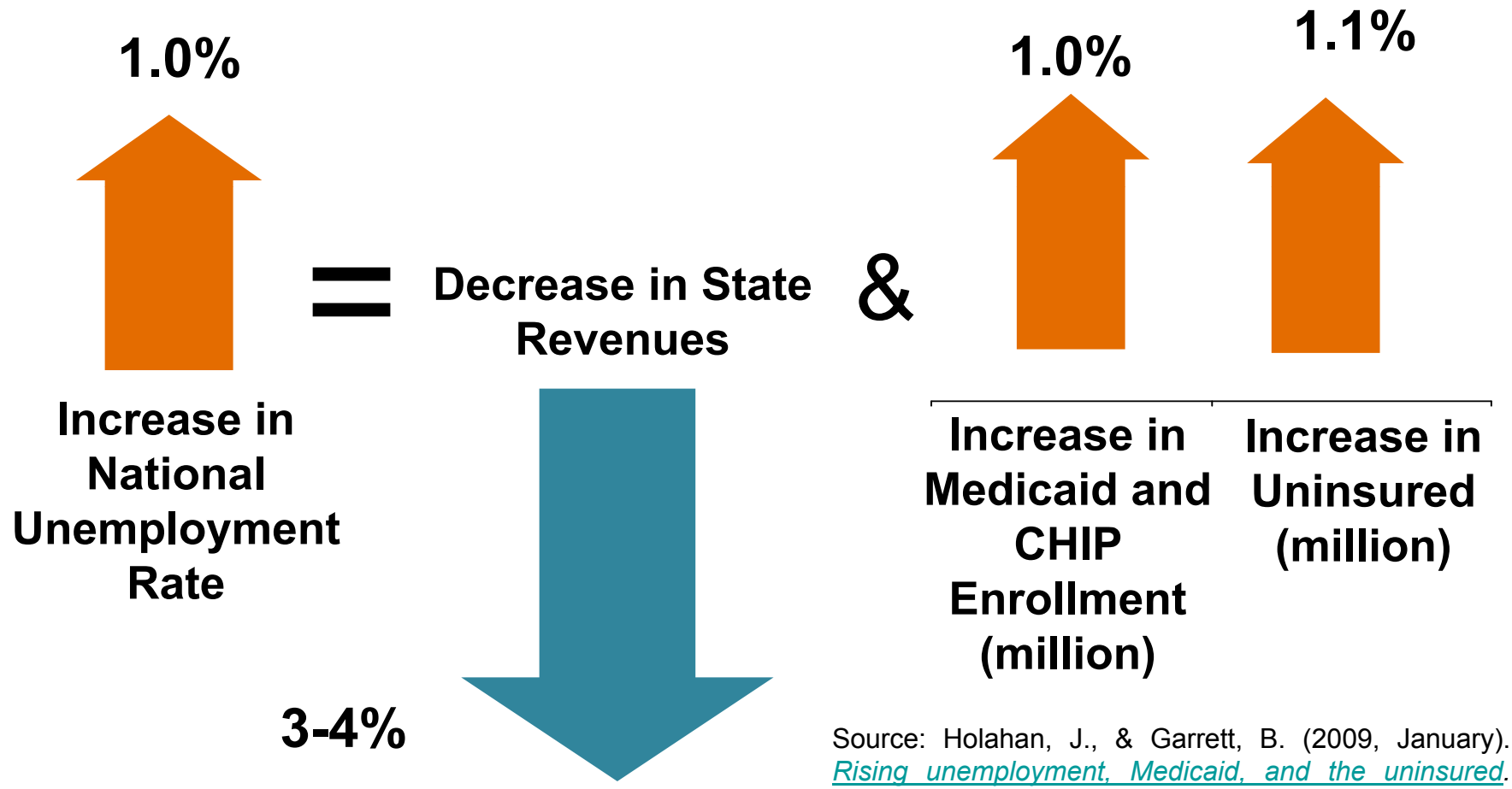
- No changes for populations below 100% of the FPL
- Certain exemptions from both premiums, and coinsurance

Summary

- Before recent developments, states reduced Medicaid costs by:
  - Cutting provider rates
  - Reducing or eliminating optional benefits to adults
  - Reducing or eliminating optional eligibility groups
  - Changing utilization patterns, often through managed care

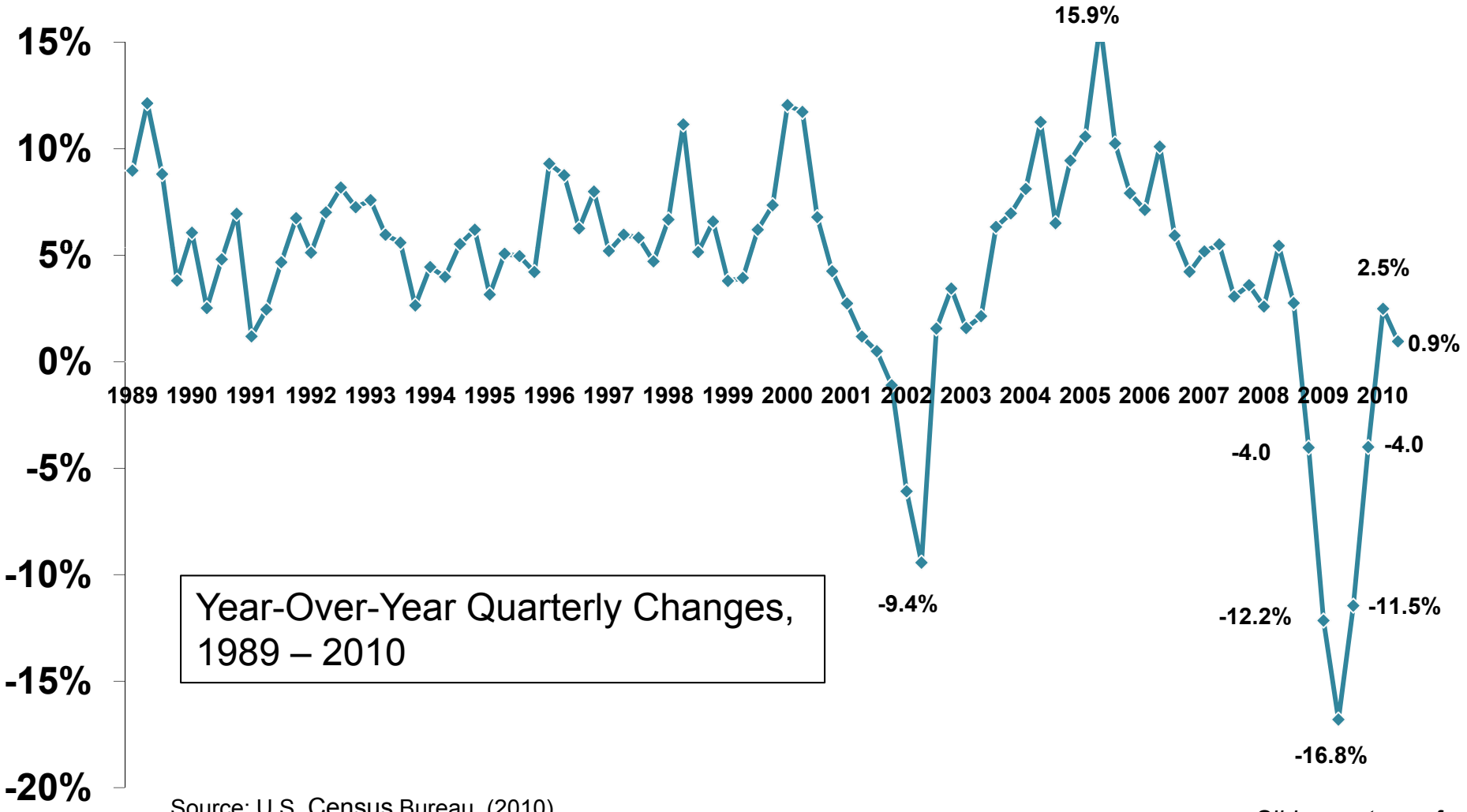
Economic Trends and Medicaid

A recession stresses state budgets with reduced revenue and an expanded Medicaid enrollment.



Source: Holahan, J., & Garrett, B. (2009, January). *Rising unemployment, Medicaid, and the uninsured*. Prepared for the Kaiser Commission on Medicaid and the Uninsured.

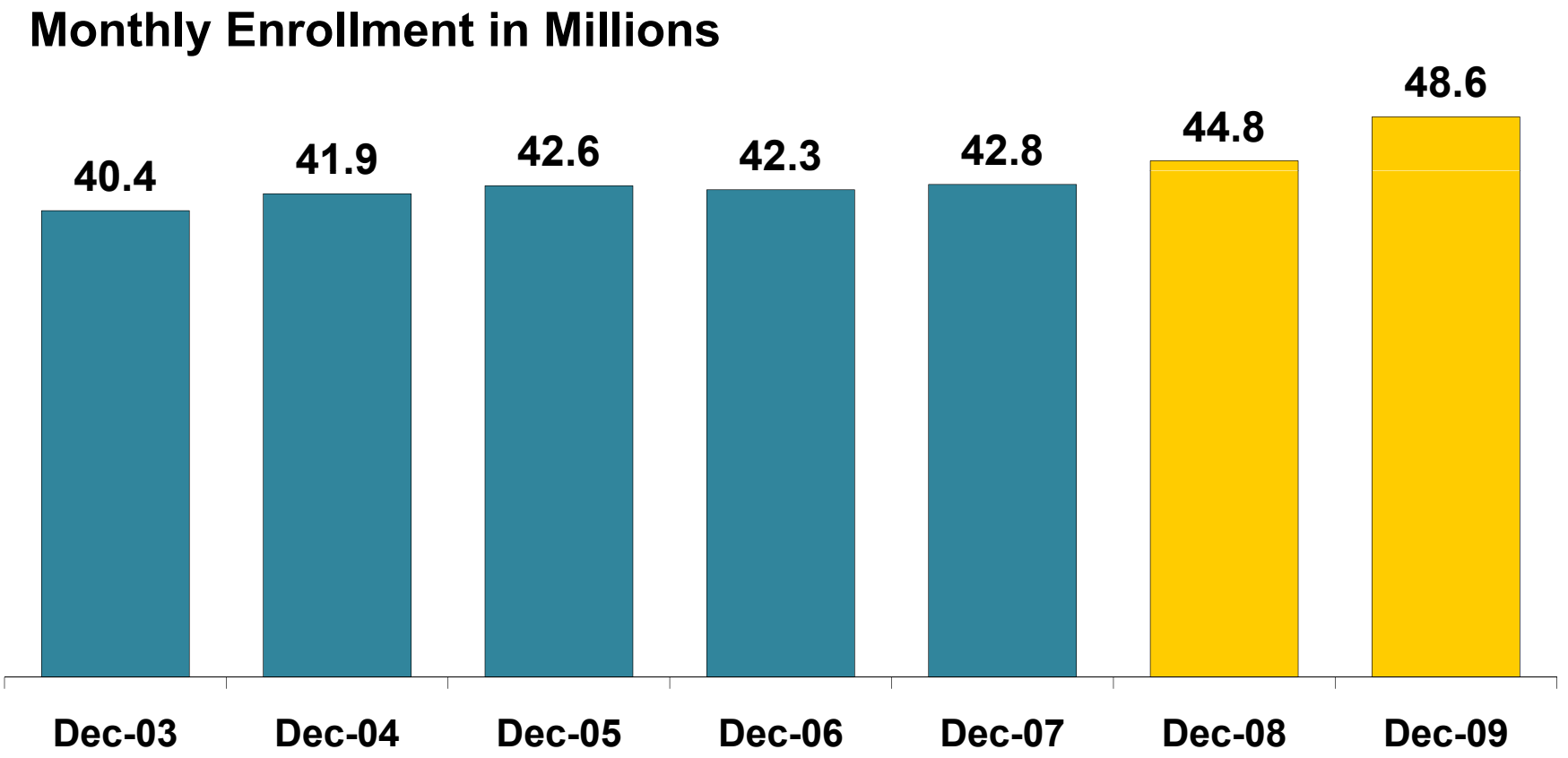
The past two years have reduced state revenues in historic ways.



Source: U.S. Census Bureau. (2010).

Slide courtesy of Vern Smith, Health Management Associates

Enrollment in Medicaid grew by nearly 6 million from December 2007 to December 2009.



Source: Analysis for KCMU by Health Management Associates from compiled state Medicaid enrollment reports.

Slide courtesy of
Vern Smith, Health Management Associates

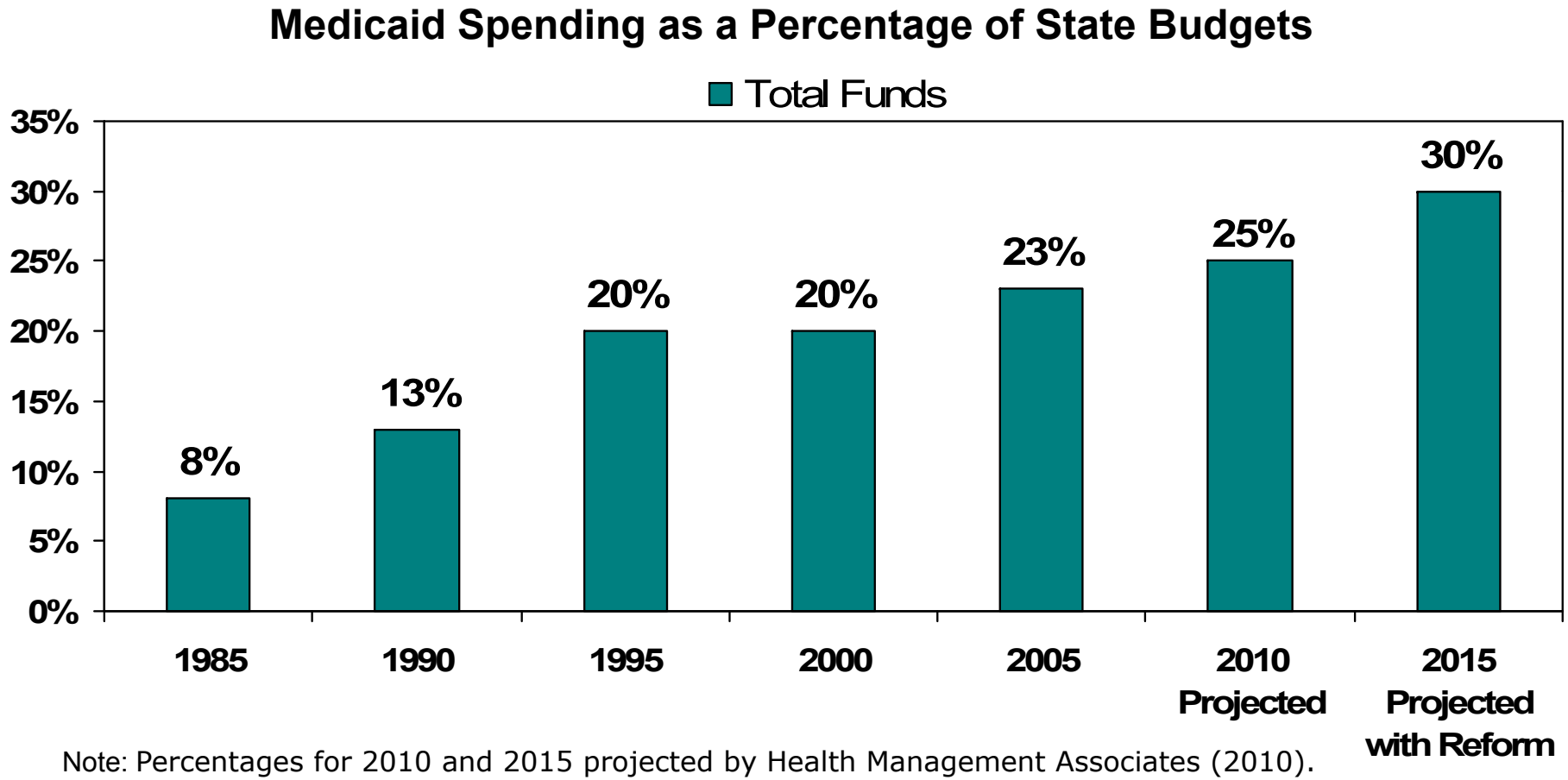
Medicaid has steadily substituted for a greater portion of employer-sponsored insurance.

Source of Coverage for Non-Elderly (0-64), Per 1000 Population, By Year

Source	1997	2003	2009
Employer	651	634	568
Other Private	69	55	48
Medicaid and CHIP	76	119	162
Other Public	49	42	32
Uninsured	154	150	190

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates;
HSC Community Tracking Study Household Survey, Tracking Report No. 94.

Medicaid is an increasingly large component of state budgets.



Note: Percentages for 2010 and 2015 projected by Health Management Associates (2010).
Source: National Association of State Budget Officers. (2009 and earlier). *State expenditure reports.*

ARRA and then the Affordable Care Act have prohibited states from reducing eligibility, so states have responded by cutting Medicaid benefits for adults . . .

Number of States Reducing Covered Medicaid Benefits, by Year

FY 2008	FY 2009	FY 2010
3	10	15

Source: Survey of states conducted by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured.

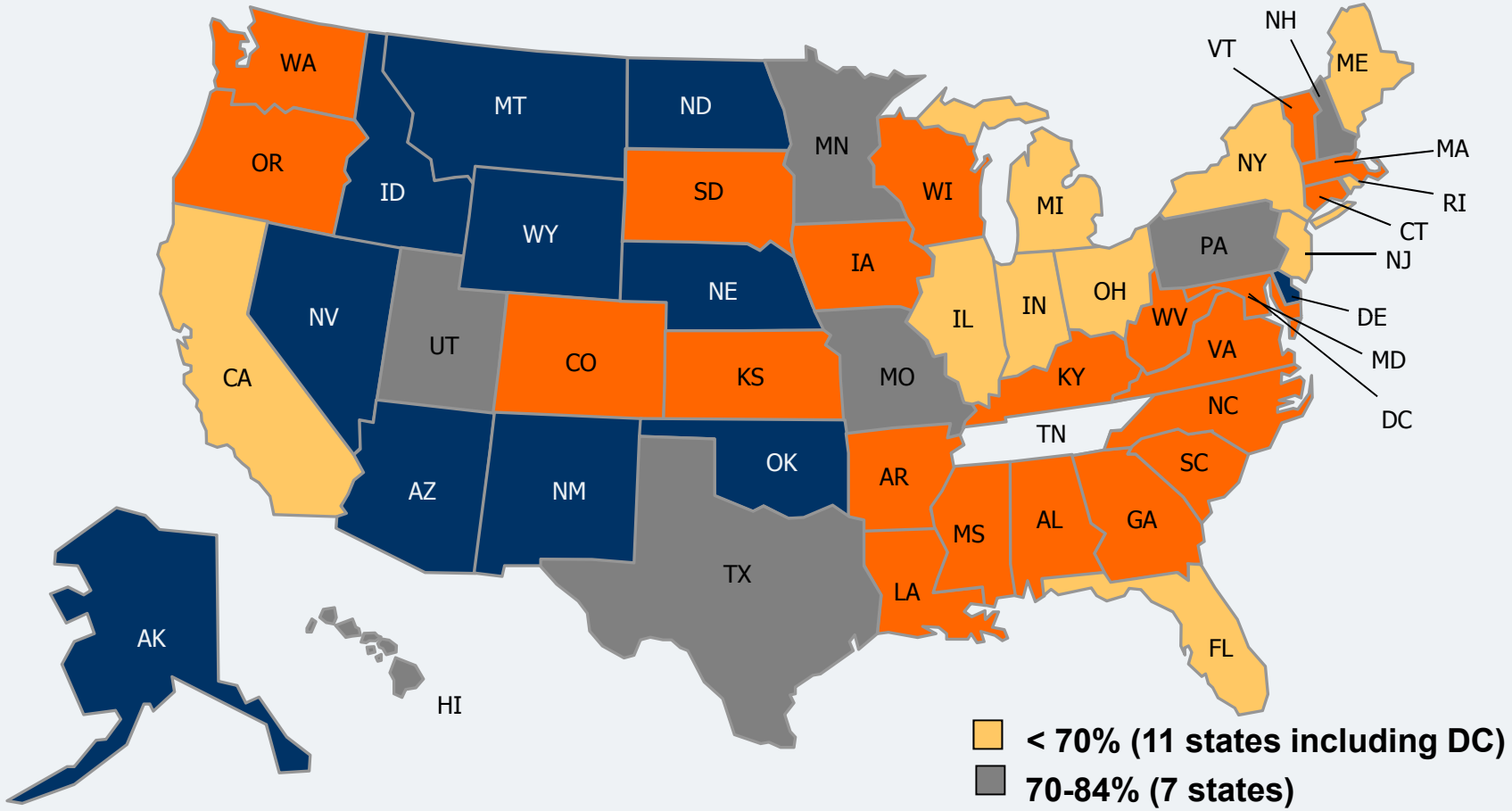
. . . and with reductions in Medicaid provider rates.

Number of States Reducing Medicaid Provider Rates, by Year

Provider Type	FY 2007	FY 2008	FY 2009	FY 2010
Inpatient Hospital	17	16	27	33
Physician	0	1	8	13
MCO	0	1	5	5
Nursing Home	6	5	14	26
Any of these	26	21	33	39

Source: Survey of states conducted by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured.

Medicaid provider rates averaged 72% of Medicare by the end of 2008, across all services.



U.S. Average = 72% of Medicare fees

Note: Tennessee does not have a fee-for-service component in its Medicaid program.
Source: Zuckerman, S., Williams, A. F., & Stockley, K. E. (2009, April 28). Trends in Medicaid physician fees, 2003-2008. *Health Affairs*.

Providers prefer to accept new patients with a source of payment other than Medicaid . . .

Physician Acceptance of New Patients, by Payer, 2008

	Percentage of physicians accepting all or most new patients	Percentage of physicians accepting no new patients
Private Insurance	87	4
Medicare	74	14
Medicaid	53	28

Note: Percentage of physicians accepting "some" new patients is excluded from table.
Source: Boukus et al. (2009, September). A snapshot of U.S. physicians: Key findings from the 2008 Health Tracking Household Survey. Center for Studying Health System Change.

. . . which has led, over time, to a greater concentration of Medicaid patients in Medicaid-focused physician practices . . .

Percent of Revenue from Medicaid	1996-1997	2000-2001	2004-2005
0-9%	10.6	9.0	7.8
10-19%	27.2	24.3	20.6
20-29%	19.1	20.7	20.6
30% or higher	43.1	46.1	51.0

Note: Physicians who derived no revenue from Medicaid are excluded.
Source: Cunningham, P., & May, J. (2006, August). Medicaid patients increasingly concentrated among physicians. *Center for Studying Health System Change Tracking Report No. 16*.

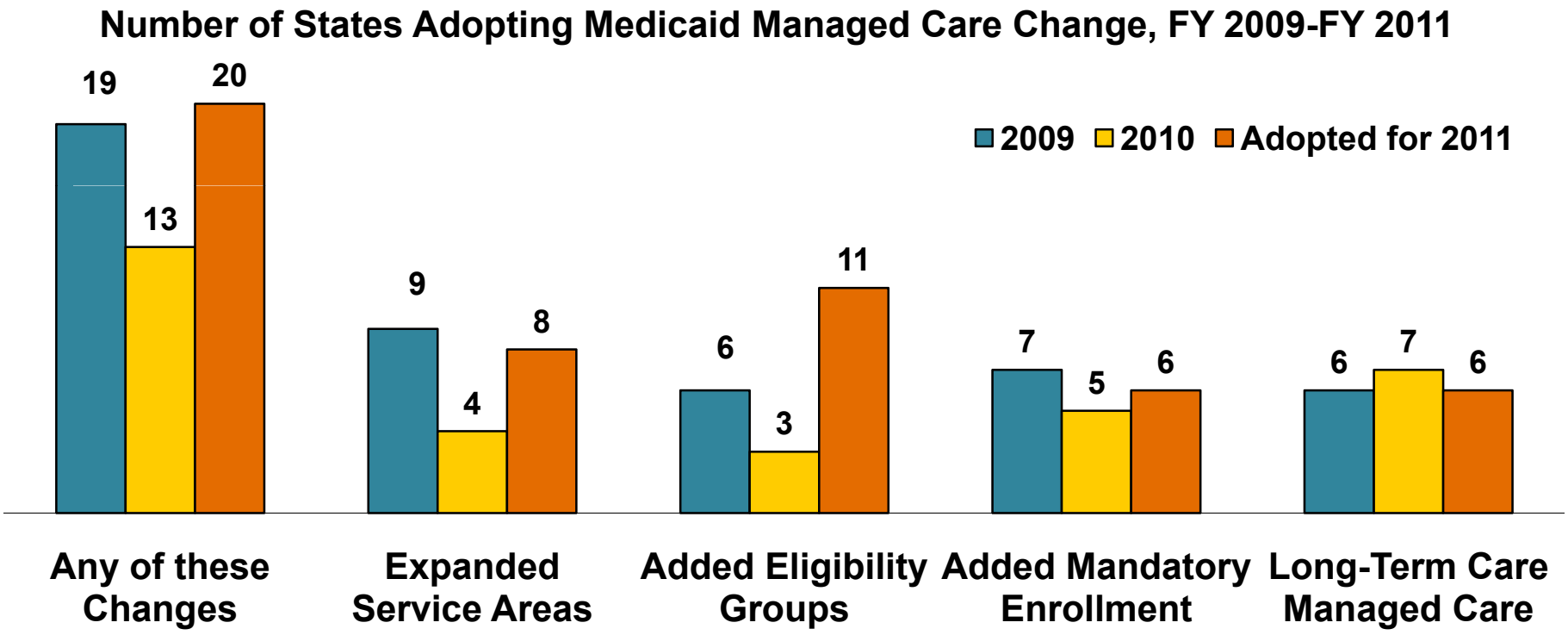
. . . and potential access issues, the severity of which vary by physician specialty.

Percentage of Physicians Accepting New Medicaid Beneficiaries, by Specialty, 2008

Specialty	Percentage Accepting New Medicaid Beneficiaries
Internal Medicine	40
Family Practice	44
Pediatrics	65
Medical Specialties	65
Psychiatry	42
Surgical Specialties	55
ObGyn	50

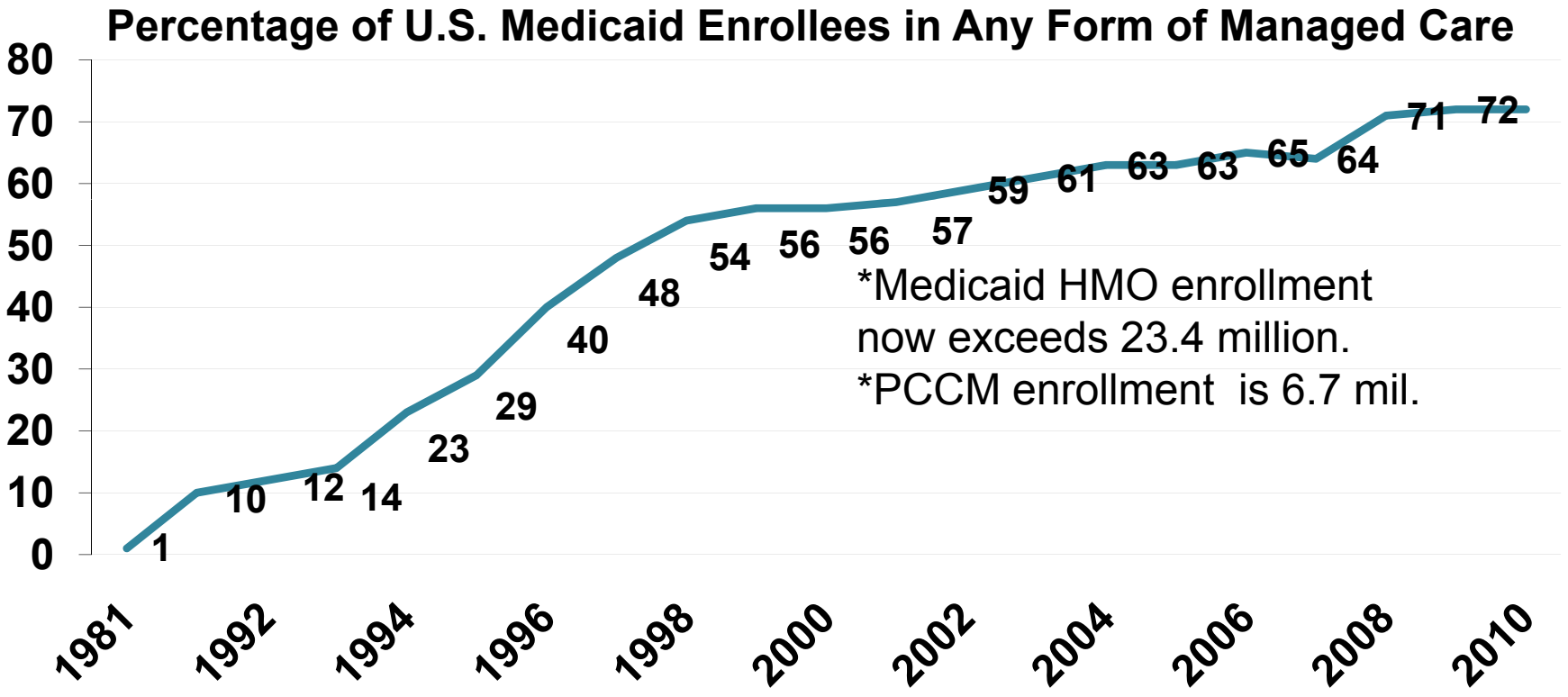
Source: Boukus et al. (2009, September). A snapshot of U.S. physicians: Key findings from the 2008 Health Tracking Household Survey. Center for Studying Health System Change.

States also have tried to manage through the budget challenge by adopting delivery system reforms . . .



Source: Smith, V., Gifford, K., Ellis, E., Rudowitz, R., & Snyder, L. (2010, September). Hoping for economic recovery, preparing for health reform: Medicaid spending, coverage and policy trends. The Kaiser Commission on Medicaid and the Uninsured. Retrieved from http://www.kff.org/medicaid/8105.cfm.

. . . and more Medicaid beneficiaries are enrolled in some form of managed care.



Note: "Managed Care" includes HMOs, PIHPs, HIOs, and state-administered Primary Care Case Management Plans (PCCMs).
Source: CMS. (1994-2009). *Medicaid managed care reports*.

Slide courtesy of
Vern Smith, Health Management Associates

States also have responded with leaner administrations . . .

- Only 4 percent of all Medicaid expenditures are devoted to administrative costs
- Pay freezes
- Furloughs
- Hiring freezes

. . . and by, among other things, adopting more efficient electronic health platforms.

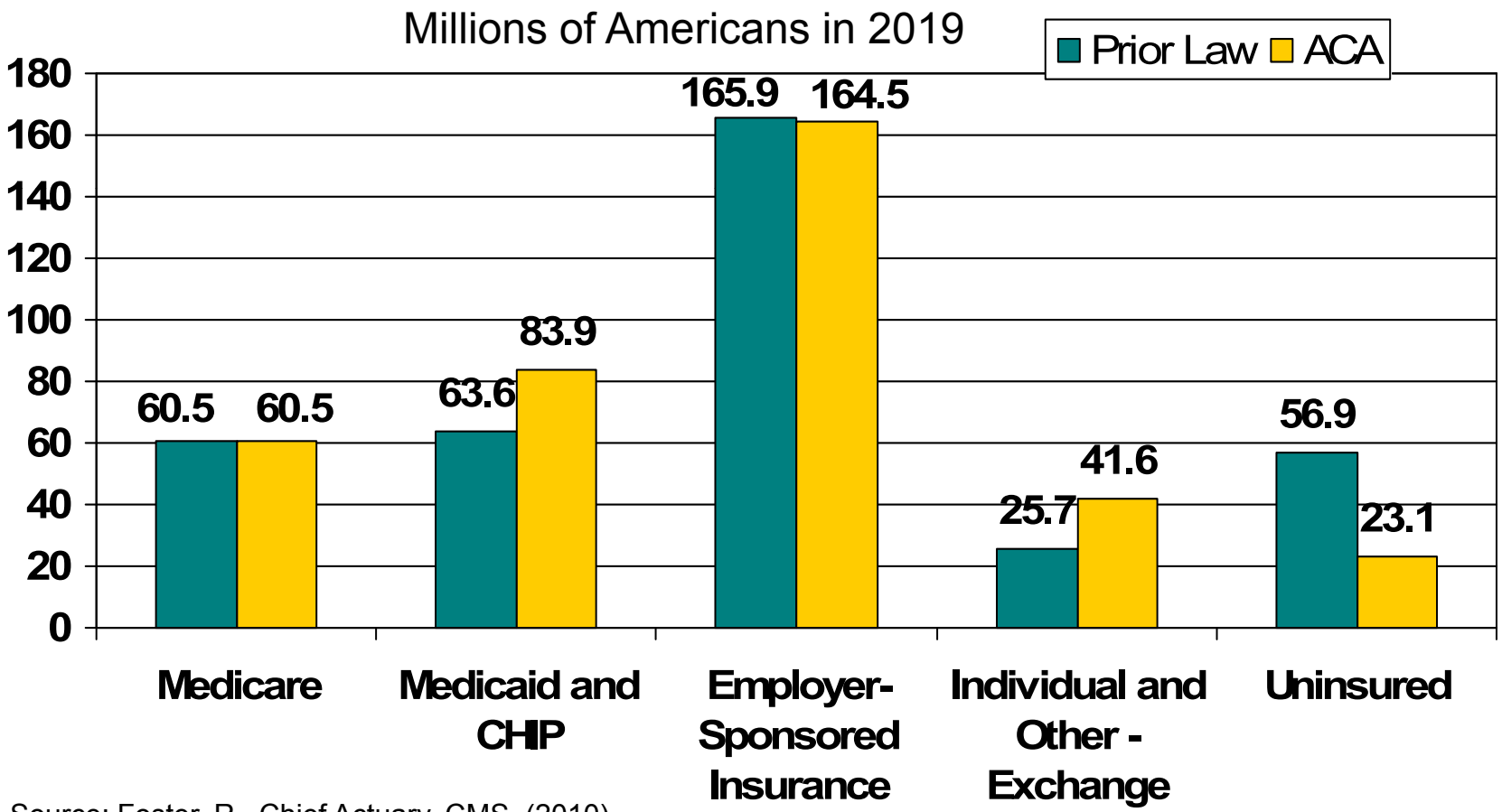
Number of States Participating in Initiative in Medicaid, Cumulative

Type of E-Initiative	FY 2009	FY 2010
E-prescribing	23	32
Electronic health or medical records	22	40

Source: Survey of states conducted by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured.

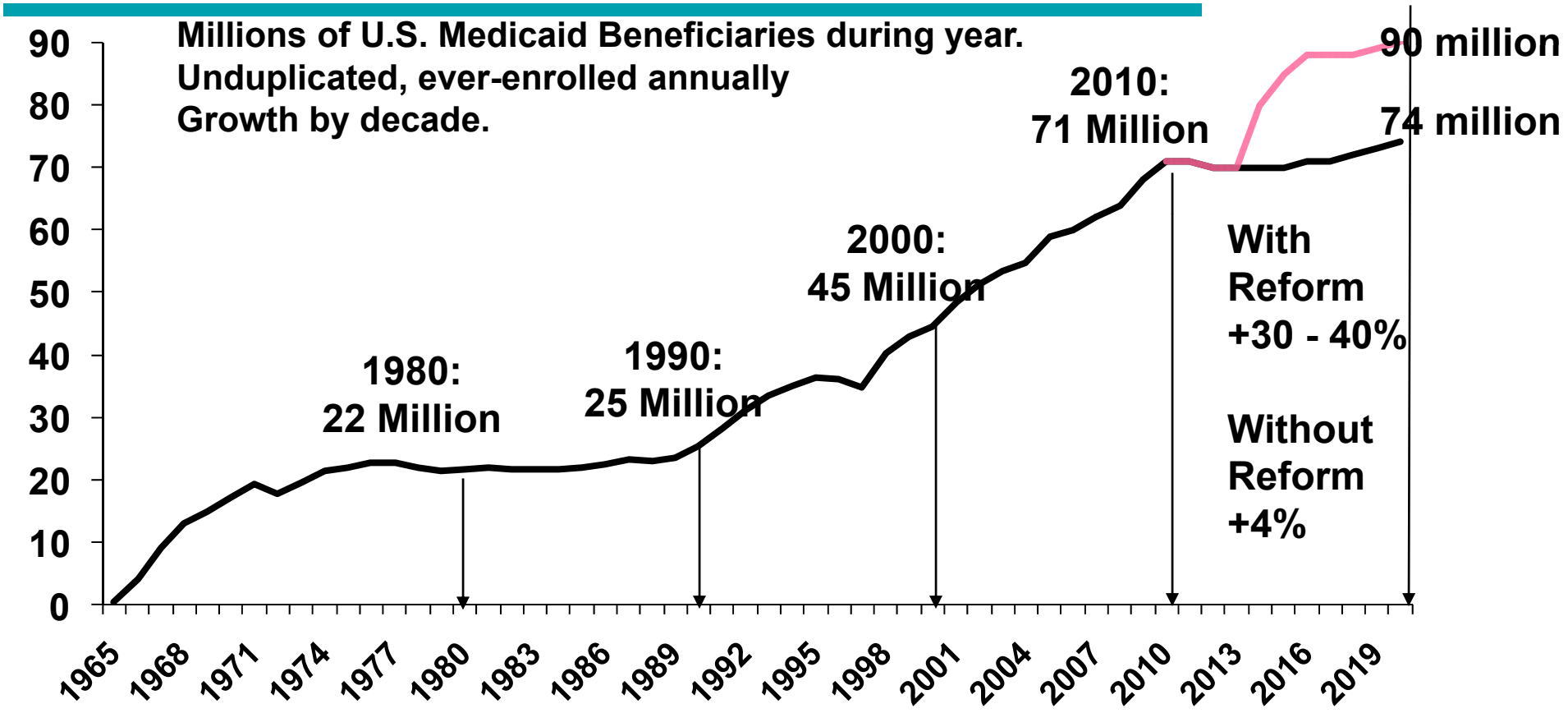
The Affordable Care Act (ACA)

The ACA is expected to increase the Medicaid enrollment by 16 million . . .



Source: Foster, R., Chief Actuary, CMS. (2010).

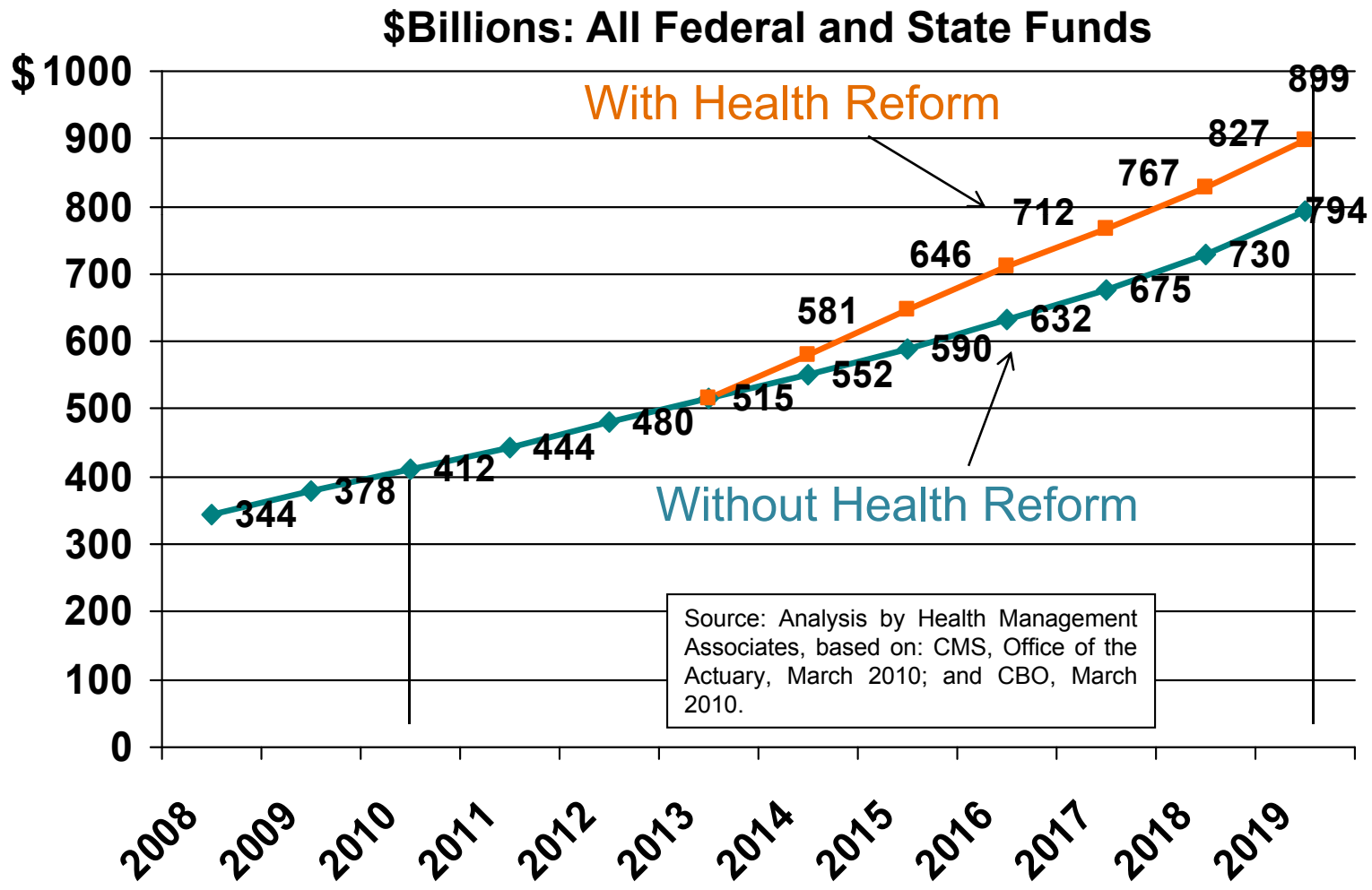
. . . rather than level off after the recession is expected to end.



Source: 1966 – 2009: Health Management Associates analysis of CMS and CBO historical data. 2010-2019: Health Management Associates calculations based on CBO Medicaid projections, 2010.

Slide courtesy of
Vern Smith, Health Management Associates

Medicaid spending is expected to double over the next decade, with over 95% of the expansion group $$ coming from the feds.



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Key Issues in Health Reform for Medicaid

- Managing state budgets through 2014 with the Medicaid and CHIP eligibility maintenance of effort, and the loss of enhanced match
- Ensuring provider participation and engagement in the face of rate cuts and with the adoption of managed care
- Building the infrastructure for the seminal changes
  - *Increase* provider networks
  - Eligibility system development to reflect paradigm shift
  - Interface with Exchange
- New strategic vision for purchasing strategy
- Long-term care reform, too

Budget Tools and the Changing State/Federal Relationship

Major State Budget Tools Involving Medicaid

Expenditures

1. Eligibility
2. Benefits
3. Provider Rates
4. Change Utilization

Revenues

5. Provider Taxes
6. New Revenue
7. “Maximization”

1. Eligibility

- Old Rules (pre ARRA)
  - Restrict or eliminate eligibility for optional categories of eligibility
  - Alter eligibility methods and periods
- ARRA Rules
  - In exchange for enhanced federal matching rate, states were barred from changing eligibility in more restrictive way
- ACA Rules
  - Maintenance of effort (MOE) for adults through January 2014
  - MOE for children through September 2019

2. Benefits

- Children (through age 21)
  - Pre and post ACA, benefits cannot be restricted due to the early and periodic screening, diagnosis, and treatment (EPSDT) requirement

- Adults
  - Optional benefits may be reduced or eliminated and have been by many states (e.g., vision, dental, personal care, and Rx)
  - For mandatory benefits, “amount, duration, and scope” restrictions are permitted, yet subject to CMS’ new unpublished “90%” rule: benefits must be sufficient to fully meet the needs of 90% of all adults

3. Provider Rates

- Old paradigm:
  - States had wide latitude to set rates. The statutory requirement is that a state must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers . . . to the extent that such care and services are available to the general population."
- New paradigm:
  - Decisions by the 9th Circuit have required CMS to exercise more oversight of state rates and require proof of network adequacy after the proposed rate reduction
  - The Medicaid and CHIP Payment Advisory Committee, created in 2009, reports to Congress on Medicaid rates and access

3. Provider Rates continued

- More broadly, it is difficult for states to cut rates when the enrollment growth requires sufficient capacity in the delivery system for millions of additional beneficiaries
- AND, with the upcoming surge in Medicaid enrollment as a result of the ACA, retaining providers in Medicaid—and their trust in the state—is essential

4. Change Utilization

- States are adopting many approaches to change utilization patterns (both the volume and mix of services), such as:
  - Managed care expansions
  - Disease management
  - Dual eligible demos
  - Stricter utilization review in fee-for-service
  - Beneficiary wellness and prevention incentives
  - Use of tiered copays
  - Payment reform (nonpayment for errors and avoidable events, such as readmissions)

5. Provider Taxes

- States are using provider taxes and assessments—especially on hospitals, nursing homes, and managed care organizations—to increase federal financing without a net increase in state financing

- These approaches have certain rules, including:
  - Maximum permissible tax rate
  - Prohibition on “hold harmless” (some providers must lose $$)
  - Tax must be broad-based

- Congress and CMS are wary, and always exercise strict oversight

6. New Revenue

- States traditionally have sought new revenue sources, such as:
  - Supplemental Rx rebates
  - Better coordination of benefits to obtain recoupments (especially with Medicare)
  - Estate recovery

- In the ACA, to help pay for the expansion, the federal government took the full share of certain supplemental Medicaid Rx rebates states had negotiated

7. “Maximization”

- States sometimes *intentionally* grow Medicaid, to move programs otherwise entirely funded by state or local programs into Medicaid, to obtain partial federal financing. Examples:
  - School-based special education services
  - Juvenile justice
  - Foster care
  - Child and adult protective services
  - Adult mental health
- Congress and CMS are wary, and often tighten rules
- These programs then become subject to Medicaid rules

The Upshot

- State discretion is steadily diminishing (the eligibility MOE even without the ARRA enhanced match; the “90%” rule; litigation and oversight of provider rates; etc.)
- Federal financing, as a portion of all dollars, has increased (grants; demos; enhanced match for services, eligibility, and IT systems; primary care rate increases in 2013/2014; etc.)
- The federalism pendulum has swung in the direction of federal control, especially as states depend on federal $$
- To survive and thrive, states must *transform* Medicaid, using new models under the ACA and likely involving other payers

About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels.

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