

**STATE OF MAINE
122nd LEGISLATURE
SECOND REGULAR SESSION**

**Final Report
of the**

**BLUE RIBBON COMMISSION ON THE
FUTURE OF MAINECARE**

January 2006

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Executive Summary

Resolves 2005, Chapter 117 established the Blue Ribbon Commission on the Future of MaineCare. The Commission was directed to submit a report with findings and recommendations to the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Appropriations and Financial Affairs by December 7, 2005. A copy of the resolve is included as Appendix A. The charge to the Commission includes:

1. Make recommendations on how to improve the quality, adequacy, effectiveness and delivery of services under the program in the most cost-effective manner possible in an effort to ensure the sustainability of the program over time, including various options for providing coverage for persons in need of health care services.
2. Review and make recommendations about the extent to which MaineCare is meeting its current and future responsibilities and include a review of the effectiveness of various models in financing and providing health care coverage to low-income and vulnerable populations, including, but not limited to, low-income families and children, the physically disabled, the elderly, the chronically ill and the uninsured;
3. Study and report eligibility levels, service benefits, expenditures and other factors affecting future costs under the MaineCare program;
4. Estimate future program costs, taking into account relevant factors, including, but not limited to, demographics; health care cost drivers; cost-savings and cost-control initiatives in place at the time of the study; other economic variables, including changes in individual and family income rates, changes in uninsured rates and changes in employer-based coverage rates; cost drivers and cost shifting related to coverage provided under the program; and other related economic factors;
5. Review and summarize the economic effect of MaineCare and its role in maintaining Maine's health care provider network, including primary, specialty and acute care;
6. Provide an analysis of changes in federal funding and health care policy, including changes in the federal match rate formula, and how such changes will affect MaineCare; and
7. Review and make recommendations related to actions taken by the federal Medicaid Commission.

The MaineCare Commission was formed during the fall of 2005, with the appointment of all 10 members. A copy of the membership of the MaineCare Commission is included as Appendix B. The MaineCare Commission held 4 public meetings in Augusta on October 11, November 1, November 15 and December 6, 2005 and a final public meeting on December 14, 2005.

The MaineCare Commission makes the following findings and recommendations and notes ongoing issues confronting the MaineCare program for future consideration. In addition the MaineCare Commission voted to request legislative approval for reauthorization of the MaineCare Commission to work after the 2006 legislative session. MaineCare Commission members are interested in working together to review Medicaid developments on the federal level and their implications for Maine and to discuss implementation of the MaineCare portions of the supplemental budget and the list of policy issues for further consideration regarding the MaineCare program.

Findings

1. MaineCare plays a critical role in the overall health care delivery system in Maine by providing coverage to many persons with disabilities or other serious health conditions, the majority of long-term care services, and other medically necessary services to low-income families and individuals who would otherwise be uninsured. Any program changes must be made carefully with consideration of the impact that those changes would have on the overall health care system.
2. The Commission finds that state and federal law provide only limited policy direction for the Medicaid program. Further, the Commission finds that due to the lack of policy direction and in the absence of program goals and management focused on those goals, MaineCare has fallen into a pattern of policy-making that is driven by fluctuations in the state budget.
3. The Commission finds that MaineCare health care spending, like all health care spending, has been increasing faster than inflation, that it comprises 20% of the state budget, and that the State needs to better manage MaineCare in order to contain costs and produce accountability and predictability and to ensure the sustainability of the program.
4. The Commission recognizes and commends the Department of Health and Human Services for designing and implementing new initiatives that will provide better services to MaineCare members and slow the rate of growth of expenditures and for beginning the planning for other initiatives, such as managed behavioral health care. The Commission notes the challenges that change brings to such a large program that serves a critical role in Maine's health care system. The Commission finds that attention to Medicaid issues is needed on state and national levels. In particular, the Commission notes that federal Medicaid program changes are under consideration as this report is being prepared and that the second phase recommendations of the federal Medicaid Commission are expected late in 2006.

Recommendations

1. The Commission recommends that the federal Medicaid Commission review and make recommendations to alter the methodology for calculating the federal medical assistance percentages (FMAP) so that the methodology does not contain a time lag, represents a better measure of state fiscal capacity and captures each state's demographic structure.
2. In the further implementation of managed care in MaineCare the Commission recommends that the Department of Health and Human Services apply primary care case management to a broader population, particularly to the elderly and persons with chronic conditions and disabilities as well as focusing on individuals with high cost care. The Commission recommends that the initiative be anchored in a commitment to high quality services to members, substituting lower cost community-based care for higher cost institutional based care.
3. In planning and implementing managed behavioral health care benefits as authorized by Public Law 2005, Chapter 457, the Commission recognizes that the initiative will capitate behavioral health financing only and urges the department to adopt best practice for integrating capitated behavioral health services with physical health services on an integrated basis and that it apply to adults and children.
4. The Commission recommends utilizing the Maine Health Data Organization all claims database in the management of the MaineCare program, including use for managed care, quality assurance and administrative purposes.
5. With regard to all MaineCare initiatives and waivers, the Commission recommends that the program be guided by clear policy, that goals be established to achieve that policy, that realistic budgets be developed to meet those goals, and that fiscal management be applied so that the program delivers high quality services in partnership with service providers and remains within budget. In managed care initiatives, the Commission recommends that the goals be integration of health care and management of the funding of those services. This recommendation requires the allocation of personnel and resources to ensure adequate administrative capacity and success. In addition, it envisions a new level of accountability within the program.
6. The Commission endorses the current private health insurance premium program and believes that increased enrollment may be possible, bringing increased partnership with private health coverage and savings for the MaineCare program.
7. The Commission recommends that the Legislature review incentives for the purchase of long-term care insurance, which must be viewed within the context of any federal restrictions and requirements.
8. The Commission supports the incorporation of new technologies that create efficiencies or decrease costs, particularly electronic medical records.

9. The Commission recommends that action be taken to provide immediate professional leadership for the Department of Health and Human Services and major offices within the department. The new leaders must have vision, skills and experience to provide the MaineCare program with staffing, an internal evaluation component and long-term planning so that stability, predictability and accountability may be achieved.

Policy issues for further consideration regarding the MaineCare program

1. Simplification of federal program eligibility rules, focusing on income level and replacing the categories of eligibility now used.
2. Consideration of the role of private market forces, including private health insurance and health savings accounts.
3. Review of options for financing long-term care, including incentives for the purchase of long-term care insurance.
4. Resolution of the implementation problems with the MECMS provider payment system.
5. Resolution of the issue of timely payments to hospitals for MaineCare services.
6. Consideration of the role of member co-payments, including the effect of mandatory and voluntary co-payments on the member, the provider and the program.
7. Management of the noncategorical adult waiver to ensure access to and maximization of coverage.
8. Consideration of the Medicare Part D drug program and its impact on MaineCare and related recipients, and the state budget.
9. Review of the results of implementation of the State Health Plan.
10. Review of federal application of prescription drug pricing based on Average Manufacturer Price, with state flexibility on dispensing fees, and the effect on access to prescription drugs.
11. Review implementation of the development by the Department of Health and Human Services of models to better analyze and forecast program trends and growth rates.
12. Clarification of the roles of the Department of Health and Human Services, Office of MaineCare Services and the Governor's Office of Health Policy and Finance in the development and implementation of MaineCare policy.

13. Monitoring of the number of uninsured persons in the State, considering the costs of health care and health insurance and the role of MaineCare.

I. INTRODUCTION

Resolves 2005, Chapter 117 established the Blue Ribbon Commission on the Future of MaineCare. The Commission was directed to submit a report with findings and recommendations to the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Appropriations and Financial Affairs by December 7, 2005. A copy of the resolve is included as Appendix A. The charge to the Commission includes:

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Presentations were made to the MaineCare Commission by the following persons:

- ◆ Trish Riley, Director, Governor's Office of Health Policy and Finance
- ◆ Jack R. Nicholas, Commissioner, Department of Health and Human Services
- ◆ J. Michael Hall, Deputy Commissioner, Department of Health and Human Services
- ◆ Brenda Harvey, Deputy Commissioner, Department of Health and Human Services
- ◆ Neva Kaye, National Academy for State Health Policy
- ◆ Bill Gardner, Financial Forecast Manager, Department of Health and Human Services
- ◆ Maura Howard, Office of MaineCare Services, Department of Health and Human Services
- ◆ Brenda McCormick, Office of MaineCare Services, Department of Health and Human Services
- ◆ The Honorable Angus S. King, Jr., Former Governor of the State of Maine and Vice-Chair of the federal Medicaid Commission

II. BACKGROUND INFORMATION

A. FEDERAL MEDICAID LAW AND POLICY

1. Federal Medicaid law

Congress enacted Title XIX of the Social Security Act in 1965, establishing a voluntary state-federal health care program known as Medicaid. The program provides medically necessary health care to certain low-income persons, the elderly and persons with disabilities. Under the Medicaid program, federal funding is available to states on a matching basis to assist in covering the costs of health care services provided to recipients and the states' administrative costs.

As a condition of participation in the Medicaid program states must administer their programs in accordance with federal law and regulation, following state plans approved by the Centers for Medicare and Medicaid Services (CMS) within the federal Department of Health and Human Services. The state plan details the categories of persons who will be eligible, including populations that are required to be covered, such as pregnant women and children and the elderly, and "optional populations" that the state may elect to serve. Eligibility requirements refer to the federal poverty guidelines adopted annually by the federal Department of Health and Human Services.¹

The state plan details the categories of medically necessary services that will be covered, including required services such as inpatient and outpatient hospital care, laboratory services, prenatal care, and periodic screening and check-ups for children. The plan designates certain optional services that the state elects to cover, such as prescription drugs, diagnostic and hospice services and eyeglasses. Originally designed to provide services primarily in hospitals, physicians' offices and nursing facilities, Medicaid has grown to cover more non-facility-based services, home and community-based care and the largest single category of expenditures, prescription drugs. See Table 1 for Medicaid acute care benefits and Table 2 for Medicaid long-term care benefits. Each state is required to convene a Medicaid advisory committee to participate in policy development and provide administrative oversight. Other federal law and regulations impose additional requirements regarding eligibility, benefits, reimbursement, and program administration and operation.

¹ The federal poverty guidelines are referred to informally as the "federal poverty level" or FPL.

2005-2006 Federal Poverty Guidelines

Persons in Family Unit	100% fpl	135%	150%	185%	200%	250%	300%	350%
1	\$9,570	\$12,920	\$14,355	\$17,705	\$19,140	\$23,925	\$28,710	\$33,495
2	\$12,830	\$17,321	\$19,245	\$23,736	\$25,660	\$32,075	\$38,490	\$44,905
3	\$16,090	\$21,722	\$24,135	\$29,767	\$32,180	\$40,225	\$48,270	\$56,315
4	\$19,350	\$26,123	\$29,025	\$35,798	\$38,700	\$48,375	\$58,050	\$67,725
5	\$22,610	\$30,524	\$33,915	\$41,829	\$45,220	\$56,525	\$67,830	\$79,135
Each additional person	\$3,260	\$4,401	\$4,890	\$6,031	\$6,520	\$8,150	\$9,780	\$11,410

Table 1

Medicaid Acute Care Benefits	
<u>“Mandatory” Items and Services</u>	<u>“Optional” Items and Services*</u>
<ul style="list-style-type: none"> • Physicians services • Laboratory and x-ray services • Inpatient hospital services • Outpatient hospital services • Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21 • Family planning and supplies • Federally-qualified health center (FQHC) services • Rural health clinic services • Nurse midwife services • Certified pediatric and family nurse practitioner services 	<ul style="list-style-type: none"> • Prescription drugs • Medical care or remedial care furnished by other licensed practitioners • Rehabilitation and other therapies • Clinic services • Dental services, dentures • Prosthetic devices, eyeglasses, durable medical equipment • Primary care case management • TB-related services • Other specialist medical or remedial care
<p>* These benefits are treated as mandatory for children under 21 through EPSOT in this analysis.</p>	

Table 2

Medicaid Long-Term Care Benefits	
<u>“Mandatory” Items and Services</u>	<u>“Optional” Items and Services*</u>
Institutional Services	
<ul style="list-style-type: none"> • Nursing facility (NF) services for individuals 21 or over 	<ul style="list-style-type: none"> • Intermediate care facility services for the mentally retarded (ICF/MR) • Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD) • Inpatient psychiatric hospital services for individuals under age 21
Home & Community-Based Services	
<ul style="list-style-type: none"> • Home health care services (for individuals entitled to nursing facility care) 	<ul style="list-style-type: none"> • Home and community-based waiver services • Other home health care • Targeted case management • Respiratory care services for ventilator-dependent individuals • Personal care services • Hospice services • Services furnished under a PACE program
<p>*These benefits are treated as mandatory for children under 21 through EPSDT in this analysis, with the exception of Home and Community based waiver services.</p>	

Medicaid waiver programs may be approved by CMS to waive certain federal requirements in order to allow the states to try new ways to deliver services, such as through managed care organizations, or to provide assistance to particular populations, such as

women with cervical cancer, persons with disabilities receiving care at home and persons with HIV/AIDS.

2. Federal policy goals and program responsibilities

Starting from the federal goal of providing necessary health care for certain low-income persons, the elderly and persons with disabilities, the states have flexibility to design their Medicaid programs in response to each state's own health care needs, priorities and available funding. States may set policy goals that cover more people or health care services. Reimbursement rates for health care service providers may be adjusted up or down by the state. These rates, the timeliness of payment and the administrative requirements of the program affect the number of participating providers and access to care for members and thus also reflect the state's policy goals for the program.

B. THE MAINECARE PROGRAM

The Medicaid program in Maine, known as the MaineCare program, operates under the general policy statement of the Department of Health and Human Services, which is stated at Title 22-A, section 202: "The mission of the department is to provide health and human services to the people of Maine so that all persons may achieve and maintain their optimal level of health and their full potential for economic independence and personal development." MaineCare relies on personnel within the Department of Health and Human Services Office of MaineCare Services (formerly the Bureau of Medical Services) to administer the program. Office personnel respond to requests for information, develop rules and procedures, process claims, monitor compliance, train providers and address complaints.² Eligibility determinations are handled within the Office of Integrated Access and Support within the department.

Since 1998, Maine has adopted a number of policies that have expanded the number of persons eligible for MaineCare in order to reduce the number of people without health insurance. Between 2000 and 2004 MaineCare rolls increased 2.7%, to over 260,000.³ During that time period the percentage of uninsured nonelderly adults in Maine decreased 1.1%⁴ placing Maine 5th in the nation in reducing the percentage of uninsured residents.⁵ In contrast, from 2000 to 2004 the number of uninsured nonelderly adults actually rose in all other New England states - in Connecticut by 2.1%, in New Hampshire by 3.6%, in Vermont by 3%, in Massachusetts by 3.2% and in Rhode Island by 4.2%.⁶ See Table 3. Table 4 provides information on mandatory and optional MaineCare beneficiary groups.

² Statewide, overall coordination of health policy and health reform and assistance with prescription drug issues are provided by the Governor's Office of Health Policy and Finance.

³ "MaineCare, Annual Report to the State Legislature 2004," pg 2, Department of Health and Human Services.

⁴ Kaiser Commission on Medicaid and the Uninsured, State Medicaid Fact Sheet, Maine and the United States, December, 2005. The number of uninsured nonelderly adults decreased by 7988 from 2000 to 2004.

⁵ Kaiser Commission on Medicaid and the Uninsured, State Health Facts, 50 State Comparisons, "Percentage Point Change in Uninsured Among Nonelderly, 2000-2004."

⁶ "Health Coverage in America, 2004 Data Update," page 13, Kaiser Commission on Medicaid and the Uninsured.

Table 3
Percentage Change in the Uninsured Population

	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
2000-2004	+2.1%	-1.1%	+3.2%	+3.6%	+4.2%	+3%

Table 4

MaineCare Beneficiary Groups	
Mandatory Populations	Optional Populations
Children under age 6, below 133% FPL	Low-income children above 100% FPL, not mandatory by age
Children age 6 and older, below 100% FPL	
Parents below 200% FPL	Low-income parents with income at or below 1996 AFDC level
Pregnant women at or below 133% FPL	Pregnant women above 133% FPL
Elderly and disabled SSI beneficiaries at or below 77% FPL	Elderly and disabled above SSI level but below 100% FPL
Certain working disabled adults	Certain working disabled
Medicare Buy-in groups (QMB, SLMB, QI)	Medically needy
	Nursing home residents above SSI levels but below 300% SSI
	Persons at risk of needing nursing home or ICF-MR care

MaineCare coverage was expanded in 2003 through a waiver from CMS for adults with incomes below 100% FPL, \$9570/year, who do not have minor children. The population in this waiver is informally referred to as “noncategoricals.” Implementation of this waiver brought with it unexpectedly heavy enrollment, utilization and expense, which exceeded projections of costs. Rising to nearly 25,000 by March, 2005, noncategorical waiver coverage threatened to outspend the federally imposed spending cap and endanger the waiver’s federal matching funds. After informing the Legislature, the Department of Health and Human Services responded in March, 2005 by freezing enrollment, so that enrollment in December, 2005 had dropped to 14,939. Beginning in December, 2005, covered services for noncategorical adults were decreased from 54 services to just 18 services.

The income and asset limits for financial eligibility for MaineCare are detailed in Table 5. Table 6 contains a listing of MaineCare services divided by preventive care, acute care, long term care, behavioral health and other services.

Table 5

MaineCare Eligibility, 2005

Population	Income Limit	Asset Limit*	Note
Pregnant women	200% FPL	None	60-day post-partum eligibility
Infants (< 1 year)	200% FPL	None	12-month continuous eligibility
Children (1-19 years)	150% FPL	None	12-month continuous eligibility
Cub Care (SCHIP) children	200% FPL	None	12-month continuous eligibility
Parents	200% FPL	\$2,000 per unit	
Non-Categorical Adults	100% FPL	None	Enrollment suspended in 2005
Elderly & disabled	100% FPL	\$2,000/\$3,000 per individual/couple	
Working disabled	250% FPL	\$8,000/\$12,000 per individual/couple	
Disabled in need of institutional care	300% SSI standard	\$2,000/\$3,000 per individual/couple	
Specified Low-income Medicare Beneficiary/Qualifying Individual	100-135% FPL	\$4,000/\$6,000 per individual/couple	Only covered for Medicare Part B premiums

* Some assets, such as a home, primary vehicle, and certain types of savings (including IRAs) are not counted.

Table 6

MaineCare Services, 2005

Preventive Care	Acute Care	Long Term Care	Behavioral Health	Other
<ul style="list-style-type: none"> •Early intervention (birth through age 5) •Smoking cessation •Asthma and diabetes education •Family planning services and supplies •School-based rehabilitation 	<ul style="list-style-type: none"> •Inpatient & outpatient hospital services •Laboratory and x-ray services •Physician, nurse practitioner services, and other advanced practice nursing services (also those provided in rural health clinics and federally-qualified health centers) •Dental services •Chiropractic services •Ambulance services •Podiatry services •Occupational & physical therapy •Speech, hearing, and language disorder services 	<ul style="list-style-type: none"> •Institutional care (nursing facility and assisted living) •Community-based care (private duty nursing, personal care, hospice, adult day health) 	<ul style="list-style-type: none"> •Institutional care (inpatient psychiatric services, intermediate care facilities for people with mental retardation) •Community-based care (licensed social worker protective services, psychological services, day habilitation, day treatment, home and community based waiver services for people with mental retardation, community support, substance abuse treatment services) 	<ul style="list-style-type: none"> •Pharmacy •Transportation •Medical supplies and durable medical equipment, eyeglasses, and orthotic and prosthetic devices •Medicare Part B premium payments

1. MaineCare's role in the provision of health care

The MaineCare program provides health care services to certain low-income persons, the elderly and persons with disabilities. The MaineCare program is at the hub of the state's health care system, playing a central role in the provision of services to persons who are unable to afford care.

- ◆ Providing health care coverage for 20% of Maine's population, MaineCare keeps private health insurance premiums lower than they would be without MaineCare by covering many persons with disabilities and serious illnesses.
- ◆ MaineCare provides coverage for health care services, including inpatient hospital care, that would otherwise be uncompensated care and bad debt.
- ◆ MaineCare is the largest payor for long-term care services in the state, covering services in nursing facilities and home and community-based services. These services are among the highest cost Medicaid services.
- ◆ MaineCare pays consumers' cost-sharing under Medicare and pays for prescription drugs. Prescription drugs are a major cost-driver among MaineCare services, with outpatient prescription drug spending rising 13.2% in state fiscal year 2002, 17.7% in 2003 and 10.9% in 2004.
- ◆ Beginning in 2006 MaineCare will work with Medicare Part D to cover prescription drugs for persons who are elderly or disabled, shifting significant responsibilities to the Medicare Part D program. MaineCare Commission members noted the need for attention as the Medicare Part D program begins operation. They expressed concern about the possibility of gaps in coverage or increased costs for persons previously receiving drug benefits, the shift of costs out of MaineCare and the state "clawback" payment, a payment that is payable to the federal government to provide funding for the Part D benefit, which the Governor's Office of Health Policy and Finance estimates will cost the MaineCare program an additional \$11,000,000 in state funds between January and December, 2006.

2. MaineCare law and policy

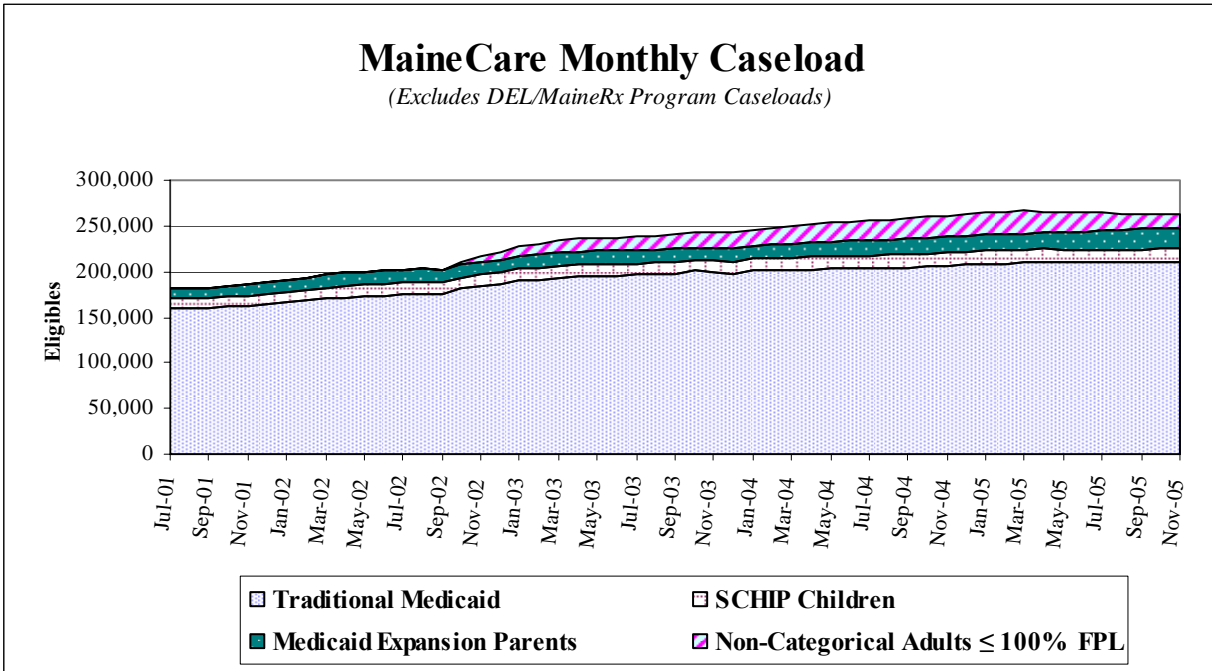
The benefits to the states of using federal funds to pay for necessary health care services have led many states to a policy of maximizing the use of Medicaid. As have other states, Maine has enacted laws and policies purposefully expanding MaineCare and the services it covers in order to decrease the number of uninsured persons. In 2006 federal funds will pay close to \$63 of every \$100 of health care services under the MaineCare program. MaineCare is then able spend \$37 of state funds and buy nearly \$100 of health care services. Particularly when a state is already paying for services with 100% state funds, federal funding participation is an attractive aspect of the Medicaid program.

Maine has expanded MaineCare to cover previously state-paid services in the areas of targeted case management, school-based health care and residential care for children and adults with disabilities in private non-medical institutions. Expansion of programs in order to take advantage of the federal Medicaid match, a policy known as Medicaid maximization, has enabled Maine to expand access to services while providing partial federal funding. Maine has also instituted health care provider taxes on hospitals, nursing facilities, private non-medical institutions and residential treatment facilities. These taxes are permissible

under federal law and result in increased MaineCare funding for the health care providers and revenue for the State. In addition to contributing funding for the states, provider taxes and the methodology for the match rate regularly controversy and political debate. For a discussion of the federal funds rate methodology and issues, see section C, 2 and 3.

Maine has elected to cover more persons and services under MaineCare than required by CMS, doing so under the state plan and any amendments to it and CMS approved waivers. MaineCare enrollees, known as “members,” include mandatory and optional populations covered through expansions that extend coverage to children under the State Children’s Health Insurance Program (SCHIP), formerly known in Maine as Cub Care, parents and legal guardians of minor children, and waiver programs for the noncategoricals, persons with mental retardation receiving home and community-based care, persons with HIV/AIDS, women with breast and cervical cancer and persons with disabilities receiving care at home under the consumer-directed home care program. Table 7 shows the MaineCare caseload by population category for July 2001 to November 2005.

Table 7



3. Services

The array of MaineCare covered services, which must be medically necessary, remained stable through 2003. In recent years some limits have been imposed on certain services for adults through the adoption of MaineCare Basic, under which the following services for adults are subject to limits: speech, occupational and physical therapy, rehabilitation services, psychological services, durable medical equipment, chiropractic services and services under the private duty nursing and personal care program and waiver programs. In addition, noncategorical members are subject to the decrease in covered services from 54 to 18 discussed above, are subject to limitations on inpatient and outpatient hospital visits and

brand name prescription drugs and are entitled to benefits from the date of acceptance into the program prospectively only.

4. Provider reimbursement

In recent years, MaineCare reimbursement rates for providers have increased slightly for some providers, including dentists and physicians, while remaining unchanged for most providers. The implementation of the MECMS claims management system for the payment of providers has presented very difficult challenges for MaineCare providers and the Department of Health and Human Services in 2005.

5. Co-payments and premiums

Co-payments for MaineCare services are limited by federal law to nominal amounts and cannot be charged for services to pregnant women and children. In MaineCare monthly premiums are allowed for SCHIP children's coverage and for coverage under the waivers for Katie Beckett disabled children and working adults with disabilities.

6. Expenditures

Total MaineCare expenditures, in state and federal funds, have increased from \$1.1 billion in 1998 to just over \$2.0 billion in 2004, an average annual growth rate of 10.3%. Putting MaineCare's expenditure growth into some context, during this same period Medicaid spending nationally grew at an average annual rate of 9.0%, while total personal health care spending in Maine - both public and privately funded - increased at rate of 7.5% per year.⁷ MaineCare spending has been driven by many of the same growth factors affecting other public and privately-funded health care spending (i.e., increases in health care costs, caseloads, and utilization of services). However, in addition, Maine's efforts to maximize the use of Medicaid for programs that previously were 100% state-funded have shifted certain expenditures from the General Fund to the MaineCare program. While this has added to MaineCare's budget growth it has also reduced the cost to the state for delivering the covered service from 100% General Fund dollars to 37% General Fund dollars. MaineCare provider tax initiatives have also maximized the use of federal Medicaid funds. Again, these initiatives have played a significant role in increasing total MaineCare expenditures, but they have enabled MaineCare to increase reimbursement to providers and to decrease reliance on General Fund dollars.

Prescription drug costs have also been a major cost driver during this period, with state and federal spending increasing from \$109.9 million in 1998 to \$284.1 million by 2004, an average annual growth rate of 17.2%.⁸ In an effort to control these drug cost increases, a preferred drug list has been implemented, with access to non-preferred drugs through a prior

⁷ MaineCare expenditure data from "Understanding MaineCare: A Chartbook About Maine's Medicaid Program," By Rachel Garfield, January 2005, p. 24; National Medicaid data from the Centers for Medicare and Medicaid Services (CMS) data; and Maine total personal health care expenditures data from "Maine's State Health Plan: A Road Map to Better Health," (November 2005 Draft) p. 15 (derived from CMS data).

⁸ "Understanding MaineCare: A Chartbook About Maine's Medicaid Program," p. 28.

authorization process and exceptions for certain classes of drugs, certain populations and special medical conditions (assumed savings of \$65.5 million per year by second year of implementation). The department also has begun voluntary mail-order for MaineCare members whose prescriptions do not change frequently (assumed savings of \$14.4 million in first year of implementation).

State-funded MaineCare spending also represents a significant and growing portion of the State General Fund budget, with its share of General Fund spending increasing during this period from 13.7% in 1998 to 20.1% by 2004. See Table 8.

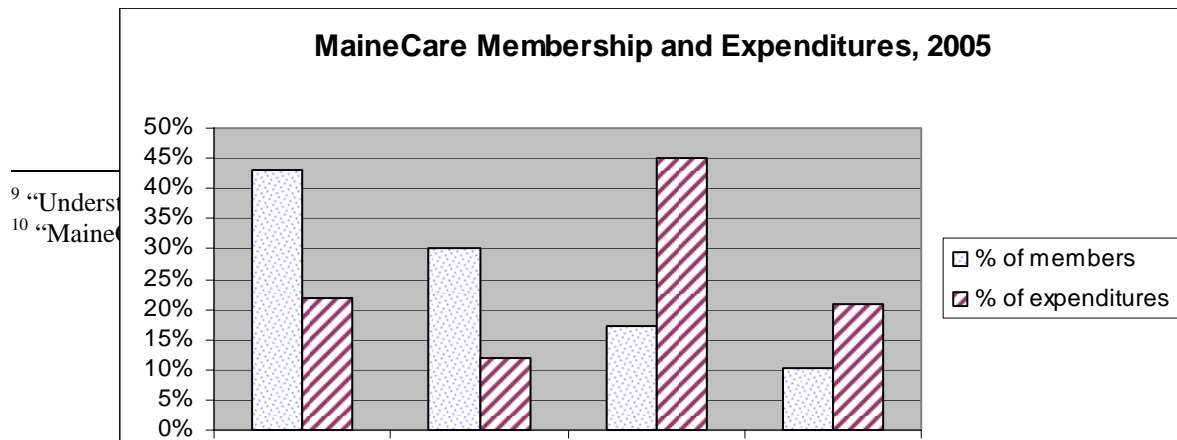
Table 8

MaineCare GF Spending's Share of State Total							
<i>(\$'s in millions, state fiscal years)</i>							
	1998	1999	2000	2001	2002	2003	2004
MaineCare and Related GF Spending	\$259.8	\$382.6	\$424.7	\$449.9	\$476.5	\$500.7	\$518.7
MaineCare GF Spending's Share of Total State GF Spending	13.7%	17.8%	18.3%	17.5%	18.4%	19.8%	20.1%

Source: 1999-2004 Data: OFPR MaineCare/Medicaid Funding History 12/8/2005

MaineCare spending, by category of member served, follows national trends. In 2004, children comprised 42.3% of the MaineCare population but accounted for just 22.2% of the spending, adults comprised 30% of the population and accounted for 11.7% of spending, and the elderly and persons with disabilities comprised 27.6% of the population and accounted for 66% of all expenditures.⁹ While seemingly disproportional, the high cost of serving the elderly and persons with disabilities reflects the expenses of long-term care and other residential services, prescription drugs, case management and disability support services. Table 9 shows a breakdown of MaineCare members by category of eligibility and the expenditures for each category.¹⁰

Table 9



C. MEDICAID – FINANCIAL CHALLENGES

1. Federal level financial projections

The growth in Medicaid spending experienced in recent years is expected to continue. The Congressional Budget Office estimates an average 10 year growth rate of approximately 7.8% for 2005-2015 and a likely range of growth rates for total Medicaid payments between 7.1% and 9.6%.¹¹ MaineCare Commission members agreed that with MaineCare growing faster than inflation the State needs to better manage MaineCare in order to produce accountability and predictability and to ensure the sustainability of the program.

2. Medicaid match rate

Federal Medical Assistance Percentages (FMAPs), commonly referred to as the federal match rate, are used to determine the amount of Federal matching funds for State expenditures for medical assistance payments under Medicaid and for certain other social services. The Social Security Act requires the U.S. Secretary of Health and Human Services to calculate and publish the FMAPs each year.

Section 1905(b) of the Social Security Act specifies the formula for calculating Federal Medical Assistance Percentages. "Enhanced Federal Medical Assistance Percentages" are used for the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. Section 2105(b) of the Social Security Act specifies the formula for calculating Enhanced Federal Medical Assistance Percentages. There is no specific requirement to publish the Enhanced Federal Medical Assistance Percentages, but they are included in the FMAP notice for the convenience of the states.

¹¹ "Parameters for Long Term Growth in MaineCare Expenditures," page 2, Maine Department of Health and Human Services, November 14, 2005. The Congressional Budget Office provides 10 year estimates for federal expenditure programs, assuming Medicaid spending per enrollee over the next 10 years will grow .7% faster than per capita gross domestic product. This rate is combined with a .9% growth in aggregate enrollment and the Congressional Budget Office baseline economic assumptions to estimate the likely 10 year growth rate.

The FMAPs are calculated using a formula based on each state's relative per capita income, specifically, each state's per capita income in relation to national per capita income. The intent of the formula is to narrow differences among states in their ability to fund Medicaid services by providing states with lower relative per capita incomes higher federal match rates and states with higher relative incomes lower federal match rates, subject to the limit that no state's FMAP can be less than 50%. Relative per capita income is measured based on the latest three years of per capita income data as measured by the U.S. Department of Commerce, Bureau of Economic Analysis (BEA). For example, the FMAPs for federal fiscal year 2006, which began on October 1, 2005, were published in the fall of 2004 based on per capita income data for calendar years 2001, 2002, and 2003. As indicated in Table 10 below, in recent years, Maine has been experiencing a significant decline in its FMAPs.¹²

Table 10¹³

Maine's Medicaid Match Rates						
Medicaid		2002	2003	2004	2005	2006
	Federal	66.58%	66.22%	66.01%	64.89%	62.90%
	State	33.42%	33.78%	33.99%	35.11%	37.10%
State Child Health Insurance Program (SCHIP)						
	Federal	76.61%	76.35%	76.21%	75.42%	74.03%

3. FMAP issues

The MaineCare Commission reviewed a report entitled *Project Report: The Impact of the Federal Medical Assistance Matching Formula in Maine* (Chuck Lawton, Planning Decisions, Inc., 2005) that in addition to providing background information on the FMAP, identified three problems with the FMAP as a measure of each state's relative ability to fund its Medicaid program: (1) the time lag inherent in the FMAP formula (e.g., 2001, 2002, 2003 data used for federal fiscal year 2006); (2) the inadequacy of relative per capita personal income as a measure of state fiscal capacity; and (3) the failure of relative per capita income to capture each state's demographic structure, particularly the relative number of elderly and disabled persons, which is a significant cost driver for state Medicaid programs.

During the MaineCare Commission's discussion of this issue, it was noted that Senator Snowe has introduced a bill regarding the FMAP formula but that reform at the federal level this year is uncertain because the debate in Congress would pit states against each other unless additional money were made available so that no state would be negatively affected

¹² As a rule of thumb, assuming a \$2 billion MaineCare program, a 1% change in the FMAP results in an approximate shift of \$20 million in spending between Maine and the federal government.

¹³ For the five quarter period from April 2003 through June 2004, the federal Jobs and Growth Tax Relief and Reconciliation Act of 2003 provided a one-time increase in FMAPs. For Maine, the increase was approximately 3 percentage points above the FMAP amounts shown above for the period.

by an FMAP formula change.¹⁴ In his presentation to the MaineCare Commission, Governor King expressed a similar concern about the difficulty in making FMAP formula changes, noting the federal Medicaid Commission specifically decided not to consider recommendations regarding changes to the FMAP.

4. Financial challenges for the MaineCare program

As discussed in part B of this report, growth in Medicaid expenditures has exerted significant fiscal pressures on the State General Fund budget, particularly when that growth has outpaced revenue for the State, and as a result MaineCare’s share of total General Fund spending continues to increase. This trend is expected to continue. Table 11 includes preliminary estimates of state General Fund MaineCare spending through the 2008-2009 biennium.

Table 11

MaineCare General Fund Spending's Share of Total General Fund -- Estimated						
<i>(\$'s in millions, state fiscal years)</i>						
	2004	2005	Budgeted		OFPR Preliminary Estimate	
			2006 ¹	2007 ¹	2008	2009
MaineCare and Related GF Spending	\$518.7	\$595.2	\$619.7	\$624.6	\$723.1	\$771.5
MaineCare GF Spending's Share of Total State GF	20.1%	21.7%	22.0%	21.8%	22.9%	23.3%

¹ *MaineCare 2006 and 2007 appropriations adjusted to "smooth out" the impact of making all hospital lawsuit settlements in 2006*

Source: 2004-2007 Data: OFPR MaineCare/Medicaid Funding History 12/8/2005
2008-2009 Structural Gap Preliminary Estimates: OFPR Budget Overview 7/1/2005

While MaineCare-specific longer term cost projections do not currently exist, recent trends suggest growth at or above the Congressional Budget Office’s national average annual 10 year growth rate of approximately 7.8%, is likely. The Department of Health and Human Services has begun to work in earnest on 5 and 10-year projections of MaineCare expenditures. Commission members expressed interest in economic forecasting for the MaineCare program and await further word on the results of this initiative.

D. FEDERAL MEDICAID COMMISSION

1. Overview

¹⁴ As referenced in the Federal Medicaid Commission section of this report, the Senate-passed version of the 2005 federal budget reconciliation bill included an amendment giving fiscal relief to states experiencing reductions in their 2006 FMAPs. The House-passed bill did not include this language and its fate is uncertain in conference.

On May 19, 2005, the Secretary of the U.S. Department of Health and Human Services established the federal Medicaid Commission to advise the Secretary on ways to modernize the Medicaid program so that it can provide high-quality health care to its beneficiaries in a financially sustainable way. The federal Medicaid Commission was a product of the debate over the FY 2006 Congressional Budget Resolution's provisions requiring Medicaid program savings.

The Secretary selected the former governor of Tennessee, the Honorable Don Sundquist as the Chair of the Commission and the former governor of Maine, the Honorable Angus S. King, Jr., as the Vice-Chair. The federal Medicaid Commission was to include up to 15 voting members (with 13 having been appointed to date) and 15 non-voting members.

The federal Medicaid Commission was tasked with two specific charges:

1. Report to the Secretary by September 1, 2005 on options to achieve \$10 billion in "scorable" Medicaid savings over 5 years while at the same time making progress toward meaningful longer-term changes to better serve beneficiaries.
2. Report to the Secretary by December 31, 2006 with longer-term recommendations on the future of the Medicaid program.

2. Short-Term Report

After meeting during the summer of 2005, including two public meetings, and receiving testimony from a broad array of governmental and non-governmental concerned parties, the federal Medicaid Commission released its short-term report making recommendations to achieve \$11 billion in "scorable" savings to the Medicaid program over 5 years.¹⁵ Governor Angus King noted in his testimony before the MaineCare Commission that \$11 billion in savings would reflect slowing the growth rate from 7.4% to 7.2%.¹⁶ Table 12 below summarizes the Federal Medicaid Commission short-term recommendations.¹⁷ The full report of the federal Medicaid Commission is included as Appendix C.

¹⁵ In his presentation to the Maine Blue Ribbon Commission on the Future of MaineCare, Governor King noted the federal Medicaid Commission specifically decided not to consider recommendations regarding the Medicaid match rate (i.e., the Federal Medical Assistance Percentage or FMAP)

¹⁶ Governor Angus S. King, Jr., testimony before the Blue Ribbon Commission on the Future of MaineCare, November 15, 2005.

¹⁷ With regard to the savings estimates noted in the table, the proposals may interact with each other, causing a reduction in savings of up to \$200 million.

Table 12**Summary of Federal Medicaid Commission Short-term Recommendations**

Subject	Recommendation	Estimated savings / 5 years
Prescription Drug Reimbursement Formula	Allow states to establish prescription drug prices based on Average Manufacturer Price (AMP) rather than Average Wholesale Price (AWP) and implement reforms to ensure that manufacturers appropriately report data.	\$4.3 billion
Prescription Drug Rebates in Medicaid Managed Care	Allow Medicaid managed care health plans access to the drug manufacturer rebate program, giving states the option of collecting the rebates or the managed care plan collecting the rebates and being paid a lower capitation rate. (Maine does not have Medicaid managed care.)	\$2.0 billion
Estate Transfer Penalty Period	With respect to eligibility for nursing facility care, move the start date for the penalty period for non-allowed transfers from the date of transfer to the date of application for Medicaid or the date of nursing facility admission, whichever is later.	\$1.4 billion
Estate Transfer "Look-back" Period	With respect to eligibility for nursing facility care, increase from 36 to 60 months the "look-back" period, during which transfers of assets may disqualify an applicant for care.	\$100 million
Co-payments for Prescription Drugs	Allow states to develop tiered co-payment structures to encourage cost-effective drug utilization. Allow states to increase co-payments on non-preferred drugs above the nominal amount when a preferred drug is available. Retain nominal co-payments for persons below the poverty level. Require co-payments for preferred drugs to be enforceable. Allow states to waive co-payments for true hardship or when failure to take a non-preferred drug might create serious adverse health effects.	\$2.0 billion
Medicaid Managed Care Organizations provider taxes	Reform health care provider tax law for Medicaid managed care organizations so that they are treated like all other health care providers - uniformity among providers and no guarantee of return to the provider of taxes paid. (Maine does not have Medicaid managed care.)	\$1.2 billion

3. Status of Short-Term Recommendations

Given the federal Medicaid Commission had its origins in the Congressional budget process, specifically the FY 2006 Congressional Budget Resolution, the initial fate of these recommendations will be determined in the currently pending legislation to implement the Budget Resolution – a so-called reconciliation bill – titled the Deficit Reduction (Omnibus Reconciliation) Act of 2005.¹⁸

The Senate passed its version of the reconciliation bill (S. 1932) on November 3, 2005. The Senate-passed bill includes \$34.6 billion in net "savings" to entitlement/mandatory

¹⁸ As part of the congressional budget process established in 1974, the annual Congressional Budget Resolution establishes the framework for determining the annual federal budget. The details of the federal budget are then enacted in annual appropriations bills and when required, a so-called reconciliation bill, making statutory changes in mandatory/entitlement programs.

programs over five years, including \$4.3 billion in Medicaid program net “savings” over five years.¹⁹

The House passed its version of the reconciliation bill (H.R. 4241) on November 18, 2005. The House-passed bill includes just under \$50 billion in net “savings” to entitlement/mandatory programs over five years, including \$8.9 billion in Medicaid program net “savings” over five years.²⁰

A conference committee will attempt to resolve differences between the two bills in December. At this point it is difficult to predict what the outcome of the conference committee will be. However, some of the federal Medicaid Commission’s short term recommendations, along with some of a similar set of proposals made by the National Governor’s Association,²¹ are reflected in some form in either the House or Senate bills. The National Governor’s Association report is included as Appendix D. An outline of the report is included as Appendix E.

4. Longer-Term Report

The second charge of the federal Medicaid Commission is to submit a report to the Secretary of the U.S. Department of Health and Human Services by December 31, 2006, making longer-term recommendations on the future of the Medicaid program that ensure the long-term sustainability of the program. The federal Medicaid Commission was further directed to develop proposals that address the following issues:

1. Eligibility, benefits design, and delivery;
2. Expanding the number of people covered with quality care while recognizing budget constraints;
3. Long term care;
4. Quality of care, choice and beneficiary satisfaction;
5. Program administration; and
6. Other topics that the Secretary may submit to the Commission.

The federal Medicaid Commission met on October 27 and 28, 2005, to begin consideration of phase 2 of its charge. The federal Medicaid Commission received presentations on the defined issues that comprise the second charge and is expected to continue its deliberations over the next year to meet the December 31, 2006 reporting deadline.

E. STATE MEDICAID POLICY INNOVATIONS

The MaineCare Commission reviewed key types of policy innovations in state Medicaid programs across the nation. The foundation for this review was provided by Neva Kaye, Senior Program Director, The National Academy for State Health Policy, in a presentation to the MaineCare Commission on November 1, 2005.

¹⁹ The Senate-passed bill’s \$4.3 billion net Medicaid savings assumption over five years reflects \$2.1 million in FY 2006 net spending increases offset by \$6.4 million in net savings over the FY 2007-2010 period.

²⁰ The House-passed bill’s \$8.9 billion net Medicaid savings assumption over five years reflects \$2.1 million in FY 2006 net spending increases offset by \$11 million in net savings over the FY 2007-2010 period.

²¹ “Short-Run Medicaid Reform,” National Governors Association, August 29, 2005.

1. Medicaid policy innovations in managed care

The MaineCare Commission reviewed information regarding innovation in managed care provided by Ms. Kaye and information specific to Maine provided by representatives of the Department of Health and Human Services.

A. National policy innovations in managed care

- 1) **Traditional Managed Care.** Nearly all state Medicaid programs have implemented managed care programs as a strategy to manage costs and improve care. There are three key models of managed care used by state Medicaid programs: (1) comprehensive Medicaid managed care organizations (MCOs) that assume financial risk for the delivery of services to beneficiaries in exchange for a fixed monthly payment per enrollee; (2) prepaid plans, including prepaid inpatient health plans and prepaid ambulatory health plans, that assume financial risk for a portion of services (for example, behavioral health), in exchange for a fixed fee; and (3) primary care case management (PCCM) programs that pay participating providers a monthly case management fee to coordinate and monitor health care services for enrollees. As of June 2004, all but 3 states (AK, NH, WY) had managed care programs in place for their Medicaid enrollees, and 60% of Medicaid beneficiaries nationwide were enrolled in some form of managed care.²²
- 2) **Managed Behavioral Health Care.** Managed behavioral health care under Medicaid may be (1) integrated with an MCO (described above) or (2) implemented as a “carve out” in which behavioral health services are contracted for separately from medical benefits. One option under the “carve out” approach is to contract with a public or private managed behavioral health organization (BHO) that specializes in mental health and substance abuse. In 2004, 41 states delivered mental health services to Medicaid beneficiaries through managed behavioral health care.
- 3) **Disease Management.** Disease management (DM) programs are designed to lower health care costs and improve health outcomes for individuals with chronic health conditions through enhanced coordination of care, treatment monitoring, patient education, and adherence to best practices. DM programs typically target individuals with specific diagnoses, such as asthma, diabetes, cardiovascular disease, hypertension and depression. CMS has endorsed disease management under Medicaid.²³ CMS identifies 3 key DM models for use under Medicaid: (1) DM through contracting with a disease management organization; (2) DM through an enhanced PCCM program in which providers deliver DM services, typically for an enhanced PCCM fee; and (3) DM through individual fee-for-service (FFS) providers in the community.
- 4) **Pay-for-Performance.** Pay-for-performance refers to a health care purchasing strategy that rewards providers for meeting specific measurable performance standards, with the goal of advancing the quality of health care services.²⁴ Data collection and measurement

²² “State Health Facts, 50 State Comparisons,” Kaiser Commission on Medicaid and the Uninsured, June 30, 2005.

²³ Centers for Medicare and Medicaid Services, State Medicaid Director Letter 04-0002.

²⁴ “CMS Pays for Performance Programs,” Terris A. King, July 15, 2005.

of provider performance is critical to this strategy. Performance incentives may include: financial rewards, financial penalties and non-financial incentives, such as public presentation of performance data.²⁵ In recent years, a handful of state Medicaid programs have begun to implement pay-for-performance, most often as part of Medicaid managed care contracts. In California, the Local Initiative Rewarding Results program applies pay-for-performance to the Medi-Cal (Medicaid) and Healthy Families (SCHIP) programs.

B. MaineCare managed care initiatives. MaineCare has undertaken a number of initiatives in managed care that the MaineCare Commission recommends continuing, with renewed commitment, dedication of personnel and focus.

- 1) Primary Care Case Management.** Maine has implemented primary care case management, with the following goals: increasing access to primary care, promoting preventive care, reducing episodic care, controlling chronic conditions and reducing health care costs. In 2004, approximately 163,000 MaineCare members were enrolled in PCCM (62% of all members). Currently, PCCM is required for MaineCare members who receive TANF benefits, are in families with minor children, are SCHIP members, or are covered under the noncategorical adult waiver.

Elderly and disabled MaineCare members are not eligible for MaineCare PCCM. This is in contrast to most states in which some or all elderly and disabled Medicaid beneficiaries are enrolled in a managed care program.

Under the PCCM program, the MaineCare enrollee has a primary care physician (PCP) who provides a “medical care home” and manages and coordinates care for the member. MaineCare pays participating PCPs a nominal fee per member per month for their case management responsibilities. The PCCM program also includes a pay-for-performance component, the Primary Care Physician Incentive Program (PCPIP). Under PCPIP, participating PCPs are tracked for quality indicators and receive regular performance reports, and MaineCare pays an incentive payment to those PCPs ranked above the 20th percentile on specified performance measures within their primary care specialty. Examples of performance criteria include emergency room utilization rates, admission rates for avoidable hospitalizations, lead screening rates and mammogram rates.

The experience of primary care case management is promising. In 2004 98% of MaineCare children ages 12-24 visited their primary care providers, 79% of women ages 21—64 had their annual PAP tests and 71% of MaineCare members with diabetes had their HbA1c tests.²⁶

²⁵ “Are Incentives Effective in Improving The Performance of Health Care Plans,” pg 6, by Mary Beth Dyer, March 2002.

²⁶ “MaineCare Landscape,” Department of Health and Human Services presentation to the Blue Ribbon Commission on the Future of MaineCare, November 1, 2005.

- 2) **Managed Behavioral Health Care.** Maine is currently in the process of planning a managed behavioral health care program pursuant to Public Law 2005, chapter 457, Part PP. The program will provide comprehensive mental health and substance abuse services and will be implemented as a “carve out” for all MaineCare beneficiaries. The law requires that the program be implemented through a contract with an organization with demonstrated success in managed care for behavioral health services. Responsibilities of the managed care organization will include: contracting with providers, credentialing and quality assurance, utilization review, coordination of care, data collection and reporting. The law deappropriates \$10.4 million from the state General Fund in state fiscal year 2006-2007 for savings to be achieved by implementing the managed behavioral health care program and, in the event that savings are not realized, requires DHHS to inform the Legislature of alternative proposals to achieve the savings.

Next steps in development and implementation of the managed behavioral health care program include: development of a statewide behavioral health plan; an actuarial study of mental health and substance abuse expenditures; preparation of a state plan amendment or waiver application to CMS; and contracting with a managed care organization.

- 3) **High Cost Member Pilot Program.** Maine is planning a pilot program for high cost members that will incorporate aspects of primary care case management and pay for performance and serve the approximately 300 members with annual expenditures from \$30,000 to \$100,000. Participants will be assigned a “nurse care manager” whose responsibilities will include patient education, assisting the member and the member’s health care providers in the development of an individual care plan, promoting compliance with the care plan, linking the member to community resources and coordinating the member’s care. In addition, each participant will be linked with a PCP who will provide a “medical care home” as described above. The state plans to provide an enhanced PCCM fee to PCPs for high cost member pilot participants to reflect the expectation of enhanced case management responsibilities, including working with the nurse care manager, reviewing all prescriptions and durable medical equipment purchases and coordination of relatively complex care needs. In addition, participating PCPs will receive additional financial incentives based on performance outcomes (pay-for-performance). The state has issued an RFP for nurse care management services and received five bids and plans to begin program implementation in early 2006.

C. MaineCare Commission support for managed care innovations. MaineCare Commission members support the following innovations with regard to managed care in MaineCare and offer these recommendations:

- 1) Expand PCCM and PCPIP to cover more persons, specifically to include persons with chronic health conditions who could be served through disease management and the elderly, persons with disabilities and other persons with high cost care.
- 2) Integrate physical health services and behavioral health services, including substance abuse services, for adults and children, while managing the funding of those services.

- 3) Anchor MaineCare’s managed care initiatives in a commitment to provide high quality service to members, substituting lower-cost community-based care for higher cost institutional based care.
- 4) Administer and implement all managed care initiatives to achieve their policy goals, budgeting to achieve the budget developed for the initiatives and dedicating personnel and resources to ensure adequate administrative capacity and success.
- 5) Utilize the Maine Health Data Organization all claims database in the management of MaineCare programs, including use for managed care, quality assurance and administrative purposes.
- 6) Proceed slowly to consider pay-for-performance, recognizing the need for reliable data and quality measures and integrating any initiative with changes in provider reimbursement, PCCP and PCPIP.

2. Medicaid policy innovations in program management

The MaineCare Commission reviewed information regarding innovations in program management provided by Ms. Kaye and information specific to Maine provided by representatives of the Department of Health and Human Services.

A. National innovations in program management

- 1) **Selective contracting.** Selective contracting refers to a strategy in which a state Medicaid program contracts with a restricted set of providers chosen through a competitive bidding process to provide certain Medicaid services.²⁷ Selective contracting requires several federal waivers, including a waiver to limit a beneficiary’s choice of health care providers, and a waiver to award contracts based on methodologies other than Medicaid’s cost-based principles. State Medicaid programs have used selective contracting for a range of services including inpatient care, nursing home care, medical transportation services and eyeglasses, but this approach is not widespread.
- 2) **Consumer empowerment initiatives.** In recent months, two states-Iowa and Florida-have received CMS approval for Section 1115 waivers to implement Medicaid reform programs that incorporate the principles of consumer empowerment and personal responsibility for health. By incorporating these principles into Medicaid, the states aim to improve the health of Medicaid enrollees and, as a result, reduce costs. Under Iowa’s expansion program, enrollees will be required to pay a monthly premium. To provide incentives for healthy behavior, the state can reduce the premium if the enrollee engages wellness activities, such as smoking cessation or compliance with a personal health improvement plan. Under Florida’s Medicaid reform program, enrollees who engage in specified wellness activities will accumulate “healthy behavior credits”, with cash value, in an “enhanced benefit account” that the enrollee can use for out-of-pocket medical expenses.²⁸

B. Maine innovations in program management

²⁷ “Strategy 10, Selective Contracting,” page 1, National Conference of State Legislatures, 2005.

²⁸ Florida Medicaid Reform, 1115 Waiver Application, pg 3; “State Medicaid Actions,” Health Policy Tracking Service, September 20, 2005.

The MaineCare program does not include any program management innovations in selective contracting or consumer empowerment.

C. MaineCare Commission comments regarding program management innovations.

MaineCare Commission members did not endorse these program management options but offer the following comments:

- 1) Selective contracting could perhaps provide options for a new model of managed care to benefit the program and members. Selective contracting should be carefully scrutinized to ensure that it does not limit access, create a 2-tiered system, or interfere with choice, quality of service, existence of a provider network and provider capacity.
- 2) Consumer empowerment innovations, which impose responsibilities on Medicaid enrollees for their health related behaviors have not been operating long enough to produce data on their effects. Data is needed on the effect of these initiatives on consumer behavior, access to services and health. Commission members expressed concern that MaineCare members could take more responsibility for their health and their care, that consumers with so little income and assets should not take on risk and that safety net providers could ultimately bear the burden of providing free care as an unforeseen consequence.

3. Medicaid policy innovations regarding private health coverage

The MaineCare Commission reviewed information regarding innovations regarding private health coverage provided by Ms. Kaye and information specific to Maine provided by representatives of the Department of Health and Human Services.

A. National innovations

- 1) **Leveraging Employer Health Insurance / Premium Assistance Programs.** Premium assistance programs subsidize the purchase of private, employer-sponsored health insurance by low-income individuals and families using federal and state Medicaid or SCHIP funds. The 2001 Health Insurance Flexibility and Accountability (HIFA) section 1115 waiver initiative has promoted the adoption of premium assistance programs by states.²⁹ The design of premium assistance programs varies state-to-state with respect to employer contribution requirements, enrollee contribution requirements, wraparound coverage for Medicaid benefits and excess cost sharing and measurement of cost-effectiveness.³⁰ Depending on how the program is structured it may be done with a state plan amendment or may require a waiver from CMS.

B. MaineCare initiative regarding private health coverage.

- 1) **Private Health Insurance Premium Program.** Maine enacted a premium assistance program known as the Private Health Insurance Premium Program (PHIPP) in 1998.³¹

²⁹ “Premium Assistance Programs: How Are They Financed and Do They Save States Money,” pg 1, Kaiser Commission on Medicaid and the Uninsured, October, 2005

³⁰ “Premium Assistance Programs: How Are They Financed and Do They Save States Money,” pg 14, Kaiser Commission on Medicaid and the Uninsured, October, 2005.

³¹ 22 MRSA section 18.

Under PHIPP, MaineCare will subsidize enrollment in a private group health plan for an individual who is otherwise eligible for MaineCare if the state determines it is cost-effective. The law defines “cost effective” as the expected reduction in MaineCare expenditures as a result of enrollment in the group health plan being greater than the expected additional expenditures required by the state to provide wrap-around coverage, meaning any premiums, deductibles, coinsurance and cost-sharing requirements of the group health plan for services otherwise covered under MaineCare.

Current enrollment in PHIPP has been very low, 120 cases, involving a total of 200 individuals. DHHS has started to explore the reasons for low participation and potential strategies to increase participation. Resolves 2005, chapter 9, passed earlier this year requires DHHS to report by January 15, 2006, to the Health and Human Services Committee and the Insurance and Financial Services Committee on the status of the PHIPP, including information about payments made under the program, premiums and the carriers to which they are paid and savings achieved by the department. The resolve authorizes the 2 committees to report out legislation related to the report.

C. MaineCare Commission comments on innovations regarding current private health coverage. MaineCare Commission members endorse the current private health insurance premium program and believe that increased enrollment may be possible, bringing increased partnership with private health coverage and savings for the MaineCare program. They await the report in January, 2006, from the Department of Health and Human Services to the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Insurance and Financial Services.

MaineCare Commission members expressed interest in the Long-term Care Partnership Program, which enables persons who purchase and make use of long-term care insurance to shelter certain assets and qualify for the Medicaid program. The National Governors Association report “Short-Run Medicaid Reform” suggests that federal laws be changed to allow more states to participate in the Long-term Care Partnership Program, that states have flexibility in qualifying policies for approval and that nationwide standards on asset protection be adopted.³²

III. FINDINGS AND RECOMMENDATIONS

The MaineCare Commission makes the following findings and recommendations and notes ongoing issues confronting the MaineCare program for future consideration. In addition the MaineCare Commission voted to request legislative approval for reauthorization of the MaineCare Commission to work after the 2006 legislative session. MaineCare Commission members are interested in working together to review Medicaid developments on the federal level and their implications for Maine and to discuss implementation of the MaineCare portions

³² “Short-Run Medicaid Reform,” pg 5.

of the supplemental budget and the list of policy issues for further consideration regarding the MaineCare program.

A. Findings

1. MaineCare plays a critical role in the overall health care delivery system in Maine by providing coverage to many persons with disabilities or other serious health conditions, the majority of long-term care services, and other medically necessary services to low-income families and individuals who would otherwise be uninsured. Any program changes must be made carefully with consideration of the impact that those changes would have on the overall health care system.
2. The Commission finds that state and federal law provide only limited policy direction for the Medicaid program. Further, the Commission finds that due to the lack of policy direction and in the absence of program goals and management focused on those goals, MaineCare has fallen into a pattern of policy-making that is driven by fluctuations in the state budget.
3. The Commission finds that MaineCare health care spending, like all health care spending, has been increasing faster than inflation, that it comprises 20% of the state budget, and that the State needs to better manage MaineCare in order to contain costs and produce accountability and predictability and to ensure the sustainability of the program.
4. The Commission recognizes and commends the Department of Health and Human Services for designing and implementing new initiatives that will provide better services to MaineCare members and slow the rate of growth of expenditures and for beginning the planning for other initiatives, such as managed behavioral health care. The Commission notes the challenges that change brings to such a large program that serves a critical role in Maine's health care system. The Commission finds that attention to Medicaid issues is needed on state and national levels. In particular, the Commission notes that federal Medicaid program changes are under consideration as this report is being prepared and that the second phase recommendations of the federal Medicaid Commission are expected late in 2006.

B. Recommendations

1. The Commission recommends that the federal Medicaid Commission review and make recommendations to alter the methodology for calculating the federal medical assistance percentages (FMAP) so that the methodology does not contain a time lag, represents a better measure of state fiscal capacity and captures each state's demographic structure.
2. In the further implementation of managed care in MaineCare the Commission recommends that the Department of Health and Human Services apply primary care case management to a broader population, particularly to the elderly and persons with chronic

conditions and disabilities as well as focusing on individuals with high cost care. The Commission recommends that the initiative be anchored in a commitment to high quality services to members, substituting lower cost community-based care for higher cost institutional based care.

3. In planning and implementing managed behavioral health care benefits as authorized by Public Law 2005, Chapter 457, the Commission recognizes that the initiative will capitate behavioral health financing only, and urges the department to adopt best practice for integrating capitated behavioral health services with physical health services, and that it apply to adults and children.
4. The Commission recommends utilizing the Maine Health Data Organization all claims database in the management of the MaineCare program, including use for managed care, quality assurance and administrative purposes.
5. With regard to all MaineCare initiatives and waivers, the Commission recommends that the program be guided by clear policy, that goals be established to achieve that policy, that realistic budgets be developed to meet those goals, and that fiscal management be applied so that the program delivers high quality services in partnership with service providers and remains within budget. In managed care initiatives, the Commission recommends that the goals be integration of health care and management of the funding of those services. This recommendation requires the allocation of personnel and resources to ensure adequate administrative capacity and success. In addition, it envisions a new level of accountability within the program.
6. The Commission endorses the current private health insurance premium program and believes that increased enrollment may be possible, bringing increased partnership with private health coverage and savings for the MaineCare program.
7. The Commission recommends that the Legislature review incentives for the purchase of long-term care insurance, which must be viewed within the context of any federal restrictions and requirements.
8. The Commission supports the incorporation of new technologies that create efficiencies or decrease costs, particularly electronic medical records.
9. The Commission recommends that action be taken to provide immediate professional leadership for the Department of Health and Human Services and major offices within the department. The new leaders must have vision, skills and experience to provide the MaineCare program with staffing, an internal evaluation component and long-term planning so that stability, predictability and accountability may be achieved.

C. Policy issues for further consideration regarding the MaineCare program

1. Simplification of federal program eligibility rules, focusing on income level and replacing the categories of eligibility now used.

2. Consideration of the role of private market forces, including private health insurance and health savings accounts.
3. Review of options for financing long-term care, including incentives for the purchase of long-term care insurance.
4. Resolution of the implementation problems with MECMS provider payment system.
5. Resolution of the issue of timely payments to hospitals for MaineCare services.
6. Consideration of the role of member co-payments, including the effect of mandatory and voluntary co-payments on the member, the provider and the program.
7. Management of the noncategorical adult waiver to ensure access to and maximization of coverage.
8. Consideration of the Medicare Part D drug program and its impact on MaineCare and related recipients, and the state budget.
9. Review of the results of implementation of the State Health Plan.
10. Review of federal application of prescription drug pricing based on Average Manufacturer Price, with state flexibility on dispensing fees, and the effect on access to prescription drugs.
11. Review implementation of the development by the Department of Health and Human Services of models to better analyze and forecast program trends and growth rates.
12. Clarification of the roles of the Department of Health and Human Services, Office of MaineCare Services and the Governor's Office of Health Policy and Finance in the development and implementation of MaineCare policy.
13. Monitoring of the number of uninsured persons in the State, considering the costs of health care and health insurance and the role of MaineCare.

APPENDIX A

Authorizing Resolve – Resolve 2005, Chapter 117

APPENDIX B

Membership list, Blue Ribbon Commission on the Future of MaineCare

Blue Ribbon Commission on the Future of MaineCare

Resolve 2005, Ch. 117
Wednesday, November 30, 2005

Appointment(s) by the Governor

Nancy B. Kelleher Representing MaineCare Advisory Committee

Ronald S. Welch Representing MaineCare Advisory Committee

Appointment(s) by the President

Sen. Michael F. Brennan Senate Member

Sen. Richard A. Nass Senate Member

Jean Cotner Representing Privately Funded Health Care

Christine Hastedt Representing Public Health Care Policy or Health Financing

Appointment(s) by the Speaker

Rep. William R. Walcott House Member

Rep. Darlene J. Curley House Member

Lynn Davey Representing Health Data Collection and Interpretation

Paul Saucier Representing State Fiscal Policy or Economic Policy

Staff:

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APPENDIX C

The Medicaid Commission

Report to the Honorable Secretary Michael O. Leavitt,
Department of Health and Human Service
and
The United States Congress
September 1, 2005

Bipartisan Commission on Medicaid Reform
Roster of Commissioners

Voting Members

The Honorable Don Sundquist
Former Governor of Tennessee
Founding Partner, Sundquist Anthony LLC
Townsend, TN

The Honorable Angus S. King, Jr.
Former Governor of Maine
Partner, Bernstein, Shur, Sawyer & Nelson
Brunswick, ME

Nancy V. Atkins, MSN, RNC, NP
Commissioner
Bureau for Medical Services
West Virginia Department of Health and
Human Resources
Charleston, WV

Melanie Bella, MBA
Vice President for Policy
Center for Health Care Strategies, Inc.
Princeton, NJ

Gail C. Christopher, DN
Vice President
Office of Health, Women and Families
Joint Center for Political and Economic
Studies
Washington, DC

Gwen Gillenwater
Senior Director for Policy and Outreach
American Association of People with
Disabilities
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Robert B. Helms, PhD
Resident Scholar in Health Policy Studies
American Enterprise Institute
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Kay Coles James
Former Director, U.S. Office of Personnel
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Troy Justesen, PhD
Deputy Assistant Secretary
Office of Special Education and
Rehabilitative Services
Department of Education
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S. Anthony McCann
Secretary
Maryland Department of Health and Mental
Hygiene
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Michael J. O'Grady, PhD
Assistant Secretary for Planning and
Evaluation
Department of Health and Human Services
Washington, DC

William N. Shiebler
Vice Chairman of Deutsche Asset
Management
Deutsche Bank
Park City, Utah

Grace-Marie Turner
President, Galen Institute
Alexandria, VA

Non-voting Members

James M. Anderson
Chairman and CEO
Cincinnati Children's Hospital and Medical
Center
Cincinnati, OH

Julianne O'Connell Beckett
National Policy Coordinator
Family Voices
Cedar Rapids, IA

Carol Berkowitz, MD, FAAP
President
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Director, Pediatric Clinic and Group
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Maggie Brooks
County Executive
County of Monroe
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Mark de Bruin
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Rite Aid Corporation
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Valerie J. Davidson
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Yukon-Kuskokwim Health Corporation
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John D. Kemp
Principal
Powers, Pyles, Sutter & Verville, PC
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Joseph W. "Chip" Marshall, III
Chairman and CEO
Temple University Health System
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John P. Monahan
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John C. Nelson, MD
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Joy Johnson Wilson
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Acknowledgements

We would like to thank all of those who provided guidance and assistance in the formulation of the proposals we considered for this report. In particular, we would like to thank those individuals and organizations that performed presentations during our July 27th and August 17th-18th meetings: Martha Roherty, Director, National Association of State Medicaid Directors and American Public Human Services Association; Vivian Riefberg, Director & Senior Partner, McKinsey&Company; Charles J. Milligan, Executive Director, Center for Health Program Development and Management at the University of Maryland, Baltimore County; Dennis Smith, Director, Centers for Medicaid and State Operations, CMS; Douglas Holtz-Eakin, Director, Congressional Budget Office; Ray Scheppach, Executive Director, National Governors Association and Matt Salo, Director of the Health and Human Services Committee, National Governors Association; and Margaret Murray, Executive Director, Association of Community Affiliated Plans.

Letter of Transmittal

September 1, 2005

To The Honorable Secretary Michael O. Leavitt:

On behalf of the Medicaid Commission, we are pleased to transmit to you the Commission's September 1, 2005 report reflecting our recommendations for achieving \$11 billion in savings over the next 5 years. This report fulfills the Commission Charter's mandate to report to you for submission to Congress our recommendations for \$10 billion in savings no later than September 1, 2005.

We look forward to beginning the next phase of our mandate, during which we will work collaboratively for the purpose of making longer-term recommendations on the future of the Medicaid program that ensure long-term sustainability.

We would like to take this opportunity to thank our fellow Commissioners for their dedication to participating in the effort to improve the Medicaid program.

Sincerely,

The Honorable Don Sundquist
Former Governor of Tennessee
Founding Partner, Sundquist Anthony LLC

The Honorable Angus S. King, Jr.
Former Governor of Maine
Partner, Bernstein, Shur, Sawyer & Nelson

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Introduction

Purpose of the Commission

The Medicaid Commission was established by charter by the Honorable Michael O. Leavitt, Secretary of the United States Department of Health and Human Services, in May 2005. The commission charge is defined as follows:

- a) The Commission shall report to the Secretary, for his consideration and submission to Congress, by September 1, 2005, their recommendations on options to achieve \$10 billion in scorable Medicaid savings over 5 years while at the same time make progress toward meaningful longer-term program changes to better serve beneficiaries.
- b) By December 31, 2006, the Commission shall submit to the Secretary a report making longer-term recommendations on the future of the Medicaid program that ensure the long-term sustainability of the program. They shall develop proposals that address the following issues:
 - 1) Eligibility, benefits design, and delivery;
 - 2) Expanding the number of people covered with quality care while recognizing budget constraints;
 - 3) Long term care;
 - 4) Quality of care, choice and beneficiary satisfaction;
 - 5) Program administration; and
 - 6) Other topics that the Secretary may submit to the Commission.

The Medicaid Program Today

Medicaid is a program that pays for medical assistance for certain individuals and families with low incomes and resources. The program became law in 1965 and is jointly funded by the Federal and state governments (including the District of Columbia and the Territories) to assist states in providing medical acute and long-term care assistance to people who meet certain eligibility criteria. Medicaid is the largest source of funding for medical and health-related services for people with limited income.

The portion of the Medicaid program that is paid by the Federal government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each state by a formula that compares the state's average per capita income level with the national average. By law, the FMAP cannot be lower than 50 percent or greater than 83 percent. The wealthier states, as measured by per capita income, have a smaller share of their costs reimbursed. The Federal government also shares in the state's expenditures for administration of the Medicaid program at generally 50 percent. Due to the entitlement nature of Medicaid, the amount of total federal outlays for Medicaid has no statutory limit.

Program Enrollment

The Medicaid program, as the safety net for much of the nation's low-income uninsured population, has taken on an increasing responsibility for providing health coverage for this segment of the nation's population. For the five-year period from 1998 to 2003, total enrollment in the program increased by 30 percent.

Enrollment growth in the Medicaid program will play a large part in determining future spending. According to figures presented by the Centers for Medicare and Medicaid Services Office of the Actuary (CMS OACT) in the President's FY 2006 Budget, Medicaid enrollment is expected to increase from 54 million enrollees in 2003 to 65 million in 2015, a 21 percent increase. The growth in enrollment will vary by eligibility category, affecting the share of total enrollees in each of the four general categories of children, adults with dependent children, aged and disabled.

Program Expenditures

Consistent with the rapid rise in enrollment, Medicaid expenditures increased at a faster rate than other insurance coverage types between 1998 and 2003. Overall Medicaid expenditures increased by 62 percent from \$153 billion to \$248 billion, with spending on adults increasing by 77 percent, the greatest increase among all enrollment categories. These increases compare to increases of 51 percent for private insurance expenditures and 36 percent for Medicare over the same time period.

Beginning in 2004 it is projected that the rate of increase in Medicaid spending will exceed the rate of increase in overall health care spending. Projections by OACT indicate that total health care spending will continue to increase at over seven percent per year for the next ten years while Medicaid spending is expected to increase at a rate of nearly eight percent per year.

Additional estimates from OACT indicate that total Medicaid spending will increase from \$275 billion in 2003 to \$685 billion in 2015, an overall increase of almost 145 percent over the 12-year period (7.9 percent per year). Federal spending will have increased from \$161 billion to \$390 billion and state spending from \$114 billion to \$295 billion, increases of approximately 7.6 percent per year and 8.2 percent per year respectively.

Recommendations for Savings

The Medicaid Commission received over 100 submissions for consideration for the September 1, 2005 report. The Medicaid Commission charter directs the Commission to “report to the Secretary, for his consideration and submission to Congress, by September 1, 2005, their recommendations on options to achieve \$10 billion in scorable Medicaid savings over 5 years while at the same time make progress toward meaningful longer-term program changes to better serve beneficiaries.” Based on this requirement for scorable savings, only options that have been previously scored by either the Congressional Budget Office (CBO) or OACT, or that contained sufficient detail upon submission to allow OACT to provide a score prior to the subsequent Commission meeting, *and* that demonstrate savings in the 5-year period could be included as options to be presented to the Commission for consideration.

At a public meeting convened August 17-18, 2005, the Commission deliberated and voted on proposed options for savings that were submitted according to the guidelines established by the Commission at its July 27, 2005 meeting. Following presentations of all scored options, Chairman Governor Sundquist and Vice-chair Governor King prepared a “Chairman’s Mark”. This Mark was their suggestion of a package of options which would achieve \$11 billion in Medicaid savings over 5 years, and served as a starting point for the Committee deliberations. The Mark consisted of six of the options presented during the first day of the meeting, and reflected the Chairs’ recommendations to the Commission.

All Commission members were provided an opportunity to discuss the individual options on the Mark, ask clarifying questions of the subject matter experts present, and move to amend the recommended package by suggesting omissions and substitutions of other options. Three motions were made for amendments. None of the amendments had a sufficient number of votes to pass, and the Chairman’s Mark was not modified. The Commission then voted unanimously to adopt the Chairman’s Mark without amendment.

The Commission recommends the following reforms:

Prescription Drug Reimbursement Formula Reform

Current Law

Currently many states establish pharmaceutical prices based on the Average Wholesale Price (AWP). The AWP is the published suggested wholesaler price to retailers of a drug compiled by third party compendia and is typically significantly higher than the price actually paid by purchasers of the drug (e.g., pharmacies, etc). It is commonly used by state Medicaid agencies as a basis for determining Estimated Acquisition Cost (EAC) for pharmacy reimbursement purposes.

The EAC is the Medicaid agency’s best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer in the package size most frequently purchased by providers. It is used to determine the Medicaid’s agency’s pharmacy provider payment and is typically set at a product’s AWP minus a percentage, but varies from state to state.

Proposal

The Commission recommends allowing states to establish pharmaceutical prices based on the Average Manufacturer Price (AMP) rather than the published Average Wholesale Price (AWP). Additionally, reforms should be implemented to ensure that manufacturers are appropriately reporting data. Such improvements should include reforms to ensure: 1) clear guidance from CMS on manufacturer price determination methods and the definition of AMP; 2) manufacturer-reported prices are easily auditable so that systematic oversight of the price determination can be done by HHS; 3) manufacturer-reported prices and rebates are provided to states monthly rather than the current quarterly reporting; and 4) new penalties are implemented to discourage manufacturers from reporting inaccurate pricing information.

Estimated Savings

\$4.3 Billion over 5 years (CMS Office of the Actuary)¹

Extension of the Medicaid Drug Rebate Program to Medicaid Managed Care

Current Law

Section 1927 of the Social Security Act, effective January 1, 1991 sets forth the requirements of the Medicaid Drug Rebate Program. In order for Federal Medicaid matching funds to be available to States for covered outpatient drugs of a manufacturer, the manufacturer must enter into and have in effect a rebate agreement with the Federal government. Without an agreement in place, States cannot generally receive Federal funding for outpatient drugs dispensed to Medicaid recipients. Rebate amounts received by states are considered a reduction in the amount expended by States for medical assistance for purposes of Federal matching funds under the Medicaid program.

The basic rebate for brand name drugs is the greater of 15.1 percent of the Average Manufacturer Price (AMP) or AMP minus Best Price (BP). Best Price is the lowest price at which the manufacturer sells the covered outpatient drug to any purchaser, with certain statutory exceptions, in the United States in any pricing structure, in the same quarter for which the AMP is computed.

The rebate for generic drugs is 11 percent of AMP.

Under current law Medicaid states cannot collect rebates from managed care organizations in the Medicaid Drug Rebate Program.

¹ These estimates for the recommended proposals from the Office of the Actuary were based on available details and specifications. When specific legislation is developed, these estimates may change. There is the possibility that some or all of these proposals will interact with one another and that this could change the estimated savings of the total package. A preliminary estimate of the effect of such interactions is \$200 million in reduced savings over 5 years.

Proposal

The Commission recommends providing Medicaid managed care health plans access to the existing pharmaceutical manufacturer rebate program currently available to other Medicaid health plans. States should have the option of collecting these rebates directly or allowing plans to access them in exchange for lower capitation payments.

Estimated Savings

\$2 Billion over 5 years (CMS Office of the Actuary)²

Change the Start Date of Penalty Period for Persons Transferring Assets for Medicaid Eligibility.

Current Law

States determine financial eligibility for Medicaid coverage of nursing home care using a combination of state and federal statute and regulation. Personal income and assets must be below specified levels before eligibility can be established. Personal resources are sorted into two categories: those considered countable (those that must be spent down before eligibility criteria is met) and those considered non-countable (those that applicants can keep and still meet the eligibility criteria such as real estate that is the beneficiary's primary residence). Some assets held in trust, annuities and promissory notes are also not counted. If it is determined that the applicant has excess countable assets, these must be spent before they can become eligible. Personal income is applied to the cost of care after a personal needs allowance and a community spouse allowance is deducted.

Federal law requires states to review the assets of Medicaid applicants for a period of thirty-six months prior to application or sixty months if a trust is involved. This period is known as the "look back period." Financial eligibility screeners look for transfers from personal assets made during the look back period that appear to have been made for the purpose of obtaining Medicaid eligibility. Transfers made before the look back period are not reviewed.

Applicants are prohibited from transferring resources during the look back period for less than fair market value. Some transfers of resources are allowed, such as transfers between spouses. If a state eligibility screener finds a non-allowed transfer, current law (OBRA 1993) requires the state to impose a "penalty period" during which Medicaid will not pay for long-term care. The length of the penalty period is calculated by dividing the amount transferred by the monthly private pay rate of nursing homes in the state. The penalty period starts from the date of the transfer. Using the date of the transfer as the start date provides an opportunity for applicants to preserve assets because some or all of the penalty period may occur while the applicant was not paying privately for long term care.

² Commissioner John Monahan submitted a letter to Chairman Sundquist and Vice-Chairman King on August 25, 2005, requesting that with regard to this recommendation, the Medicaid managed care organization rates should not be adversely impacted and that rate development continue to be subject to the federal regulations requiring actuarially sound rates. The letter is to be included as supplementary information to the report and can be found at <http://www.cms.hhs.gov/faca/mc/details.asp>.

Proposal

The Commission recommends moving the start date of penalty period from the date of the transfer to the date of application for Medicaid or the nursing home admission date, whichever is later.

Estimated Savings

\$1.4 Billion over 5 years (Congressional Budget Office)³

Increase the "Look-Back" Period from Three to Five Years

Current Law

Financial eligibility screeners look for transfers from personal assets of Medicaid applicants made during a period of time prior to application (this is referred to as the "look-back" period) that appear to have been made for the purpose of obtaining Medicaid eligibility. Applicants are prohibited from transferring resources during the look back period for less than fair market value. Currently, the "look back" period is 36 months (3 years).

Proposal

The Commission recommends increasing the "look-back" period from 36 months to 5 years.

Estimated Savings

Less than \$100 million over 5 years (CMS Office of the Actuary)

Tiered Co-Payments for Prescription Drugs

Current Law

Federal statute limits the amount of co-payments that can be charged. In most cases, co-payments of up to \$3 can be imposed for prescription drugs, physician visits, and outpatient hospital visits. However, certain categories of beneficiaries, such as children under 18, pregnant women, and the institutionalized cannot be charged co-payments. Co-pays are also prohibited for some services, including hospice care, emergency care, and family planning and services.

Proposal

The Commission recommends allowing States the flexibility to be able to increase co-payments on non-preferred drugs beyond nominal amounts when a preferred drug is available, to encourage beneficiaries to fill the least costly effective prescription for treatment. For beneficiaries at or below the federal poverty line, co-payments for preferred drugs should remain nominal. States should be given the ability to develop effective tiered co-pay structures to encourage cost-effective drug utilization where appropriate for all beneficiaries, regardless of income. All co-payments for the preferred drug list should become enforceable. States should be

³ Commissioner Douglas Struyk submitted a letter to Secretary Leavitt on August 29, 2005, outlining his concern that certain regulatory and/or legislative changes are needed to prevent long-term care providers from bearing the financial implications of this recommendation. The letter is to be included as supplementary information to the report and can be found at <http://www.cms.hhs.gov/faca/mc/details.asp>.

given broad authority to waive co-payments in cases of true hardship or where failure to take a non-preferred drug might create serious adverse health effects.

Estimated Savings

\$2 Billion over 5 years (CMS Office of the Actuary)

Reform of the Medicaid Managed Care Organization (MCO) Provider Tax Requirement

Current Law

Until 1991, when Federal law restricted the use of health care provider related taxes, states were able to tax health care providers as a way to raise their share of the Medicaid matching payment. These funds, used to draw down Federal Medicaid dollars were then returned to the provider, in effect, holding them harmless for the tax they originally paid. This loophole in Federal law permitted states to shift the cost of their Medicaid programs directly to the Federal government.

After 1991, state taxes on health care providers were required to:

- Be imposed on a permissible class of health care services;
- Be broad based or apply to all providers within a class;
- Be uniform, such that all providers within a class must be taxed at the same rate; and
- Avoid hold harmless arrangements in which collected taxes are returned to the taxpayers directly or indirectly.
- The Secretary shall approve broad based (and uniformity) waiver applications if the net impact of the tax is generally redistributive and that the amount of the tax is not directly correlated to Medicaid payments. The hold harmless requirements cannot be waived.

The loophole in current law, which defines as a separate class of health care services the services of a Medicaid managed care organization, permits states to impose taxes solely on Medicaid. Managed care organizations are increasingly taking advantage of this loophole by reorganizing in order to protect the commercial lines of business from tax liability that is then targeted only on the Medicaid subsidiary of the managed care organization.

If the reorganization of the managed care organizations with Medicaid contracts continues, all states could impose a tax only on the Medicaid revenues of the managed care organizations, effectively shifting the entire burden of the tax to the Medicaid program.

Proposal

The Commission recommends changing the law so that managed care organizations (MCOs) are treated the same as other classes of health care providers with respect to provider tax uniformity requirements. Specifically, States would be required to tax all managed care organizations, not just those with Medicaid contracts, in order to meet the uniformity requirements. States should be prevented from guaranteeing that tax revenues paid to states by MCOs be returned.

Estimated Savings

\$1.2 Billion over 5 years (Congressional Budget Office)

Future Work

As directed by the charter, the second mandate for the Medicaid Commission is as follows:

By December 31, 2006, the Commission is tasked with making longer-term recommendations on the future of the Medicaid program that ensure the long-term sustainability of the program.

The Commission shall develop proposals that address the following long-term issues:

- Eligibility, benefits design and delivery;
- Expanding the number of people covered with quality care while recognizing budget constraints;
- Long term care;
- Quality of care, choice, and beneficiary satisfaction;
- Program administration; and
- Other topics that the Secretary may submit to the Commission.

The Commission shall consider how to address these issues under a budget scenario that assumes federal and state spending under the current baseline; a scenario that assumes Congress will choose to lower the rate of growth in the program; and a scenario that may increase spending for coverage. The Commission shall assume that the basic matching relationship between the Federal government and the states will be continued.

Appendix

Summaries of the Options for the September 1, 2005 Report

Following are summaries of the proposals being recommended by the Commission. These narratives are excerpted from the full summary document that contained narratives of all the scored options, and were provided to the Commissioners for their deliberations during the August 17-18, 2005 meeting. The information presented below for each option is taken directly from the information provided by the author of the proposal. Each summary includes language used by the proposal author for the purpose of describing the summary, key points/findings, and final thoughts for each narrative. Any views presented in these summaries do not necessarily reflect the views of the Commission and should not be construed as doing so based on their inclusion in the Appendix section of this report.

Option 5/6: Change the start date of the penalty period for persons transferring assets for Medicaid eligibility.

Author: President's Budget FY 2006 & National Governors Association

Savings Generated: \$1.4 Billion over 5 years (2006-2010)

Scored By: Congressional Budget Office

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.

URL: <http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf>

This option was also submitted by the National Governors Association (NGA). NGA is the bipartisan organization of the nation's Governors.

BACKGROUND (Due to the complexity of this topic, an overview of current law regarding asset transfers is provided.)

Medicaid is the largest payer for long term care services in the country. Medicaid pays for long-term care services for persons who are poor and need long-term care, as well as for those who are made poor through paying privately the high cost of long-term care services. Determining eligibility for this later group presents a different challenge than for other Medicaid eligibility groups.

States determine financial eligibility for Medicaid coverage of nursing home care using a combination of state and federal statute and regulation. Personal income and assets must be below specified levels before eligibility can be established. Personal resources are sorted into two categories: those considered countable (those that must be spent down before eligibility criteria is met) and those considered non-countable (those that applicants can keep and still meet the eligibility criteria such as real estate). Some assets held in trust, annuities and promissory notes are also not counted. If it is determined that the applicant has excess countable assets, these must be spent before they can become eligible. Personal income is applied to the cost of care after a personal needs allowance and a community spouse allowance is deducted.

Federal law requires states to review the income and assets of Medicaid applicants for a period of thirty-six months prior to application or sixty months if a trust is involved. This period is known as the "look back period." Financial eligibility screeners look for transfers from personal assets made during the look back period that appear to have been made for the purpose of obtaining Medicaid eligibility. Transfers made before the look back period are not reviewed. Some states and others maintain that thirty-six months is not a long enough time to discourage transfers.

Applicants are prohibited from transferring resources during the look back period for less than fair market value. Some transfers of resources are allowed, such as transfers between spouses. If a state eligibility screener finds a non-allowed transfer, current law (OBRA'93) requires the state to impose a "penalty period" during which Medicaid will not pay for long-term care. The length of the penalty period is calculated by dividing the amount transferred by the monthly private pay rate of nursing homes in the state. The penalty period starts from the date of the transfer. Using the date of the transfer as the start date provides an opportunity for applicants to preserve assets because some or all of the penalty period may occur while the applicant was not paying privately for long term care. Some elder law attorneys advise their clients on how to use the penalty period to retain assets.

The following two proposals suggest ways to change the way Medicaid determines an applicant's financial eligibility for nursing home care. Both proposals alter aspects of the penalty period and one of them goes further to also change the length of the look back period.

SUMMARY

The Administration proposes to move the start date of penalty period from the date of the transfer to the date of application for Medicaid or the nursing home admission date whichever is later. Changing this date extends the time during which Medicaid applicants who made transfers are financially responsible for the cost of their care. Such a change decreases Medicaid expenditures and increases private payment.

KEY POINTS/FINDINGS

- There is concern among states and others that many persons who anticipate needing nursing home care are transferring their assets for less than fair market value in order to reduce private payment for care.
- Current law provides an incentive for such transfers because even if such a transfer is found, the application of the penalty period allows applicants to retain a significant share of their assets that might have been otherwise available to pay for long-term care.
- A cottage industry of elder law attorneys, as well as "half-a-loaf calculator websites", inform consumers about how to time such transfers to maximize retained assets while still qualifying for Medicaid. Not only does this practice cost Medicaid in the near term, it also runs counter to the Department's efforts to encourage consumers to take control of their long-term care and plan ahead for the care they may need. It is difficult to make the case for advance financial planning while such other arrangements are available.

FINAL CONSIDERATIONS

Many consumer advocates fear that changes to the transfer of assets policy will impose hardship on persons needing long-term care. In cases in which a transfer is found and a penalty period is imposed they suggest that applicants, unable to pay for services privately, will be forced to go without care. States are required to have hardship provisions in place to assist those unable to make other arrangements; however, little research exists on well such provisions operate.

Commissioners Angus King, Julianne Beckett on behalf of Family Voices, Joseph W. "Chip" Marshall, III, and Douglas Struyk on behalf of the American Association of Homes and Services for the Aging and the American Health Care Association, submitted proposals that endorsed reforms of the asset transfer penalty and the look-back period, but did not provide sufficient detail to score as separate proposals. They did not endorse this specific proposal but are generally in support of reforming this area of Medicaid.

Commissioner Valerie Davidson has requested that the following recommendation be considered during the discussion of this reform option:

At a minimum, all assets of AI/AN individuals described in CMS's State Medicaid Manual, Section 3810.A.7 should be exempt from Medicaid eligibility calculations and estate recovery provisions.

OACT has estimated that amending the proposal to include this recommendation would result in approximately a 1 percent loss in the estimated savings overall.

State Medicaid Manual Section 3810.A.7:

American Indians and Alaska Natives.—The Federal government has a unique trust responsibility for American Indian (AI) Tribes and Alaska Native (AN) Villages and their members. Section 1917(b)(3) of the Social Security Act gives the Secretary authority to establish standards for hardship. This includes exemptions from estate recovery for certain assets and resources.

a. American Indians and Alaska Natives: Income, Resources and Property Exempt from Medicaid Estate Recovery.—The following AI/AN income, resources, and property are exempt from Medicaid estate recovery:

1. Certain AI/AN income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
2. Ownership interest in trust or non-trust property, including real property and improvements:
 - a. Located on a reservation (any federally-recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
 - b. For any federally recognized Tribe not described in (a), located within the most recent boundaries of a prior Federal reservation.
 - c. Protection of non-trust property described in (a) and (b) is limited to circumstances when it passes from an Indian (as defined in section 4 of the Indian Health Care Improvement Act) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a Tribe and non-Indians, such as spouses and step-children, that their culture would nevertheless protect as family members; to a Tribe or Tribal organization; and/or to one or more Indians;
3. Income left as a remainder in an estate derived from property protected in 2 above, that was either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.
4. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights, and income either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and
5. Ownership interests in or usage rights to items not covered by 1-4 above that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom.

b. American Indians and Alaska Natives Income, Resources and Property Not Exempt from Medicaid Estate Recovery.—You may recover the following income, resources and property from the estates of American Indians and Alaska Natives:

1. Ownership interests in assets and property, both real and personal, which are not described in 7.a, items 1-5 above.
2. Any income and assets left as a remainder in an estate that do not derive from protected property or sources in 7.a, items 1-5.

Option 7: Extend the asset transfer look back period from three to 5 years.

Author: National Governors Association

Savings Generated: Less than \$100 Million over 5 years (2006-2010)

Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

States should have increased ability to prevent inappropriate transfer of assets by seniors to qualify for Medicaid. To that end, the look-back period should be increased from three to five years.

Accordingly, if at any time during the applicable five year look-back period an applicant, the applicant's spouse, or a fiduciary or person acting for the applicant, the applicant's spouse, or both, transfers or sequesters resources or the right to receive resources, income, or both, from any source, and as a result of the transfer or sequestration the funds available to pay for medical assistance are diminished, the applicant shall be ineligible for medical assistance for the period of time that would cause the transferred or sequestered resources, income, or both, to be fully expended at the weighted average nursing facility rate in effect when the transfer or sequestration occurred (either the monthly rate or the daily per diem multiplied by 30.42 and rounded to the nearest dollar).

If the transfer is between spouses this rule does not apply to the extent that the transfer does not cause the transferees' resources and rights to receive income, resources, or both, to exceed the maximum community spouse resource allowance in effect at the time of the transfer. This same exemption also applies to dependent disabled children. Furthermore, if a dependent disabled child is living in their parent(s) home at a time such parent is applying for Medicaid, that child has the right to stay in the home. In the event of death of the child, the state then has the right to recover the asset of the home.

KEY POINTS/FINDINGS

- The CRS Report for Congress Medicaid and SCHIP: The President's FY2006 Budget Proposals, published February 15, 2005 states that Medicaid law includes provisions establishing penalties for individuals who transfer assets for less than fair market value for the purpose of becoming Medicaid-eligible.
- Specifically, Medicaid law requires states to delay Medicaid eligibility for persons needing institutional coverage (including nursing home care) and certain home and community-based services who transfer assets on or before a "look-back date."
- For most assets, this date is 36 months (three years) prior to Medicaid application.

FINAL CONSIDERATIONS

Commissioner Joseph W. "Chip" Marshall, III, endorsed asset transfer reforms consistent with this NGA proposal.

Option 10: Providing states flexibility in defining co-payment requirements for prescription drugs requirements.

Author: National Governors Association

Savings Generated: \$2 Billion over 5 years (2006-2010)

Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

States should be given the ability to develop effective tiered co-pay structures to encourage cost-effective drug utilization where appropriate for all beneficiaries, regardless of income. Although states may currently operate tiered co-pays, Medicaid's current cost sharing rules, with an unenforceable maximum co-pay of \$3 per drug is not conducive to encouraging cost-effective utilization. States should be able to increase co-pays on non-preferred drugs beyond nominal amounts when a preferred drug is available, to encourage beneficiaries to fill the least costly effective prescription for treatment. Such co-pays must be enforceable to be meaningful.

For beneficiaries at or below the federal poverty level, co-payments for preferred drugs would remain nominal, although they would be enforceable. For this population, states would be able to increase these enforceable co-payments beyond nominal amounts for a non-preferred drug. States should be given broad authority to waive these co-pays in cases of true hardship or where failure to take a preferred drug might create serious adverse health effects.

KEY POINTS/FINDINGS

- There are approximately 6.3 million Medicaid beneficiaries who are currently eligible for or receiving benefits through both Medicare and Medicaid. Medicaid will no longer be responsible for providing prescription drug coverage to these beneficiaries beginning January 1, 2006.⁴
- On average 24 percent of all eligibles in Medicaid pharmacy benefit management managed care utilize prescription benefits.⁵

⁴ Medicare Modernization Act, Pharmacy MMA Information, Medicare Help at the Counter: Medicare Rx Update June 10, 2005. Available online at: <http://www.cms.hhs.gov/medicarereform/pharmacy/update061005.asp>.

⁵ Pharmaceutical Care Network, April 2004. *Pharmacy Benchmark Study for Managed Medicaid Health Plans*. Available online at: http://www.pharmcarenet.com/pdf/benchmarks_medicaid_2004.pdf.

FINAL CONSIDERATIONS

Commissioner Angus King submitted a broad proposal that endorsed applying enforceable co-payments for prescription drugs, but did not provide sufficient detail to score as a separate proposal. He did not necessarily endorse this specific proposal but is generally in support of reforming this area of Medicaid.

Option 16: Medicaid prescription drug reimbursement formula reform.

Author: National Governors Association

Savings Generated: \$4.3 Billion over 5 years (2006-2010)

Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

States negotiate prices on prescription drugs according to the published average wholesale price (AWP). There is widespread acceptance that AWP is inflated and does not reflect a valid benchmark for pricing. A different reference price should be established and made available to the states that more accurately reflects the actual price for drugs. The Average Manufacturer Price (AMP) should be used for this purpose.

KEY POINTS/FINDINGS

If AMP replaces AWP in pricing, reforms need to be made to ensure that manufacturers are appropriately reporting pricing data. Such improvements should include reforms to ensure: 1) clear guidance from CMS on manufacturer price determination methods and the definition of AMP; 2) manufacturer-reported prices are easily auditable so that systematic oversight of the price determination can be done by HHS; 3) manufacturer-reported prices and rebates should be provided to states monthly rather than the current quarterly reporting; and 4) new penalties are implemented to discourage manufacturers from reporting inaccurate pricing information.

FINAL CONSIDERATIONS

Recent reports by the General Accounting Office (GAO) and the Office of Inspector General (OIG) concluded that improvements in manufacturer price determination methods and reporting, and increased oversight by CMS are essential to ensure that AMP is a reliable and accurate reference price for states if AMP is to be used for the pharmacy reimbursement formula.

Option 20/21: Extension of the Medicaid drug rebate program to Medicaid managed care.
Author: National Governors Association & the Association of Community Affiliated Plans
Savings Generated: \$2 Billion over 5 years (2006-2010)
Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

The Association for Community Affiliated Plans (ACAP) is a national trade association representing "safety net health plans" that are Medicaid-focused and are non-profit or owned by non-profit entities like public hospitals or community health centers. As of July 2005, ACAP represents 19 plans serving 2.1 million Medicaid beneficiaries in 12 states. ACAP plans serve one of every six Medicaid managed care enrollees.

SUMMARY

As more and more states utilize managed care to help administer their program, managed care companies should be able to directly access rebates for prescription drugs purchased for their Medicaid population. States should have the option of collecting these rebates directly or allowing plans to access them in exchange for lower capitation payments.

KEY POINTS/FINDINGS

- A Center for Health Care Strategies (CHCS) report concluded that MCOs are able to reduce their average per member per month (PMPM) drug costs for families in Medicaid managed care to \$17.36 compared to \$20.46 in the state FFS programs.
- A Lewin report concluded that Arizona's managed care program was able to achieve the lowest pharmacy costs in the nation at the time of the study, 38 percent below the national Medicaid average.
- Support for this reform proposal from includes the following organizations: National Association of State Medicaid Directors, Medicaid Health Plans of America.

FINAL CONSIDERATIONS

Because managed care penetration varies widely by state, the fiscal impact of a reform of this nature would vary considerably across states. Therefore, while it may achieve overall savings for the Federal government, not all states would experience measurable savings.

Option 30: Reform of Medicaid Managed Care Organization provider tax requirements.

Author: President's Budget FY 2006

Savings Generated: \$1.2 Billion over 5 years (2006-2010)

Scored By: Congressional Budget Office

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.

URL: <http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf>

SUMMARY

The 2006 Budget proposes to require that managed care organizations (MCOs) be treated the same as other classes of health care providers with respect to uniformity requirements. Under this proposal, states would be prevented from guaranteeing that tax revenues paid to states by MCOs would be returned.

KEY POINTS/FINDINGS

- Provider taxes are a financing mechanism states have used to generate state funds needed to obtain federal Medicaid matching payments.
- During the mid 1980s, states began using provider taxes as a mechanism to leverage additional federal funds and cost shift Medicaid expenses to the Federal government. After the taxes were matched with federal funds and paid to the providers, the providers did not keep the payments. Instead, the providers returned most of the federal monies to the states, where the funds could be used for other purposes.
- In 1991, the Congress passed legislation to limit states' use of provider taxes.
- CRS reports that under current law, Medicaid MCOs are treated differently than other providers regarding provider taxes.
- As a result, states currently may tax Medicaid MCOs and provide a guarantee that the tax revenues will be returned to the MCOs. States may receive the full federal match for the tax funds that are returned.

FINAL CONSIDERATIONS

These proposals are intended to strengthen requirements and ensure the fiscal integrity of the Medicaid program.

CRS states that this proposal will pertain to both Medicaid and non-Medicaid MCOs.

Commissioners Grace-Marie Turner and Robert Helms endorsed payment reforms consistent with this Administration proposal.



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John P. Monahan
President
State Sponsored Business

August 25, 2005

Hon. Donald Sundquist, Chairman
Hon. Angus S. King, Jr., Vice Chairman
Medicaid Commission
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Chairman Sundquist and Vice Chairman King:

I am writing to request inclusion in the Commission's report an important clarification regarding the recommendation to expand access to the Medicaid Prescription Drug Rebate Program to Medicaid Managed Care Organizations (MCOs) [adoption of Option #21, "Extension of the Medicaid Drug Rebate program to Medicaid Managed Care"]. In adopting this proposal, I appreciate the Commission's recognition of MCO success with drug benefit management tools that provide clinically sound and cost effective drug benefits to members. As I mentioned at the Commission meeting last week, however, it is critical to include an emphasis on actuarially sound Medicaid managed care rates for prescription drug and medical benefits.

The successful role of MCOs in managing Medicaid drug benefits requires that MCO rate-setting be consistent, reliable and actuarially sound. Federal law and CMS guidelines require states to actuarially certify Medicaid MCO rates, but some states apply an arbitrary factor outside the actuarial rate-setting process to meet annual budget requirements. Uncertainty and low payment rates lead to market disruption and fewer choices for enrollees. Establishing rates that are not actuarially derived undermine the demonstrated ability of managed care to improve access to quality care for enrollees, and lower program costs for states.

For these reasons, states should not view expanding the Medicaid Drug Rebate Program as another potential "factor" to be used to arbitrarily reduce MCO fees. To assist states in setting MCO rates, the American Academy of Actuaries (AAA) recently developed guidelines for states specific to Medicaid MCOs. I recommend that the Commission reflect these guidelines in its report by stating that, with respect to savings identified in option #21, "Extension of the Medicaid Drug Rebate Program to Medicaid Managed Care", the Medicaid Commission supports this option with the understanding that Medicaid MCO rates should not be adversely impacted and that rate development continue to be subject to the federal regulations requiring actuarially sound rates.

I am honored to participate in the Medicaid Commission. I look forward to the work ahead of us and appreciate the leadership you are providing.

Sincerely,

John P. Monahan



August 29, 2005

The Hon. Michael O. Leavitt
Secretary, U.S. Department of Health and Human Services
200 Independent Avenue, S.W.
Washington, DC 20201

Re: Medicaid Commission recommendation on Asset Transfers

Dear Secretary Leavitt:

First, I want to thank you again for appointing me to the Medicaid Commission. I am honored to have been selected as a Commissioner and I feel encouraged that the group is energized and capable of tackling the difficult and complicated challenges associated with proposing reforms of the Medicaid system. **At the suggestion of Chairman Sundquist during our recent August 18 meeting, I want to provide some important information and a related request. This is done to provide you with a consensus of the Commission's discussions pertaining to an important aspect of the asset transfer matter contained in the Commission's recent recommendations to you.**

Since the long-term care profession has long advocated for many reforms within the Medicaid program, I especially appreciated the discussion in the Commission's meeting regarding asset transfer issues. My colleagues and I have long believed that there is little incentive for Americans to plan for their long-term care when, with the advice of elder law attorneys, they can structure assets in a way as to become eligible for Medicaid when they would otherwise have been using their own resources. The American Health Care Association and the American Association of Homes and Services for the Aging, on behalf of my organization and others, have advocated for change in this area. It was very encouraging to see the President's support for this matter by addressing it in his recent budget proposal.

The long-term care profession is in agreement with the underlying policy objective of strengthening our nation's laws on asset transfers in order to discourage Americans from practices that have abused the Medicaid system. **We are concerned, however, with the financial hardship that long-term care providers may bear as a result of changing the date when the penalty is incurred.** As I discussed with Dennis Smith during his testimony before the Medicaid Commission, if the penalty date is changed to the date on which an individual is otherwise seeking eligibility for medical assistance, long-term care providers may not receive payment for care being provided to individuals who are already residents in a facility at the time of application. This may have been an unintended consequence but is certainly a real and very damaging potential result for providers. Nursing facility providers may be forced to care for a significant number of beneficiaries without payment. In short, the total cost of care will be shifted from the federal and state government to providers – and not back to the individuals who have transferred their assets (or received these assets) so as to escape responsibility for payment.

Nursing facilities will have no option, due to a combination of law and reality, other than to absorb the cost of care for these residents. The current provisions of Federal law under OBRA 1987 prohibit nursing facilities from requiring a third-party guarantee of payment upon admission; thus, there is no one with resources to turn to for payment. While discharging residents under such circumstances may be permitted by law, it may take as many as six months or more to transfer or discharge a resident for non-payment. Even when a facility can legally transfer or discharge, there is often no place to send the resident. Families will not take them because they require nursing facility care and no other facility or hospital will accept them as they have an inability to pay for their care.

During the Medicaid Commission's August 17th meeting, CMS staff in attendance brought to the Commission's and Dennis Smith's attention that a recipient could file a "hardship exemption." The Commission's discussions that ensued about this matter made it clear that the consensus of the group was that providers should not be harmed by this change in policy. Furthermore, the "hardship exemption" information that was provided by CMS staff was understood to be an effective prevention to any such

potential harm. Subsequent to the meeting, I attempted to gather more information on this practice from CMS staff. As I have now learned, the facility must first give a notice of discharge for non payment to the resident. Then, the resident could file for a hardship exemption. This is a recipient appeal, not a facility appeal, and most likely the facility could not compel the resident to file. Any of these scenarios places the facility in a no-win situation.

Recommendations

While I agree with the underlying policy position, it is critical to ameliorate its negative impact on providers. Options include:

- a) Permit facilities to ask for more financial information than is currently allowed during the application process that could help discover if there was an impermissible transfer within the look-back period that could result in the imposition of a penalty. Under current regulations, facilities are severely limited as to the type of information and assurances that can be obtained at that time that would mitigate unfair risk to providers.
- b) Permit facilities to require a third-party guarantee of payment for the period arising from the imposition of a transfer penalty.
- c) Upon requests of the provider, grant the provider a hardship waiver of ineligibility in cases where individuals are already residents in long-term care facilities at the time of application for medical assistance.
- d) Permit facilities to charge this type of uncompensated care to bad debts if the facility obtained a statement prior to admission that the resident had not made a transfer that would result in a penalty and it is later discovered that the statement was inaccurate and the facility has provided care.
- e) Permit facilities to deny admission if the resident discloses a transfer that could be deemed improper by the State Medicaid Eligibility Worker.
- f) Permit facilities to deny admission if adequate financial information is not available or will not be provided by the prospective resident.
- g) Tighten up the time frame for determining medical assistance eligibility and enforce that time frame with counties to minimize the financial exposure to nursing facilities. This particular recommendation is only effective if done in conjunction with one or more of the other recommendations contained herein.

As I have indicated, my organization and others within the long term care profession share a strong conviction that improper transfers of funds to avoid payment for long-term care is inappropriate and damaging to the Medicaid program. However, shifting the financial burden of the care onto the provider does not achieve one purpose of the Social Security Act, which is for the state and the federal government through federal financial participation to pay for care for carious categories of individuals who legitimately cannot help themselves. In addition, such shifting puts into complete jeopardy the principles of both Medicaid law and Section 1115(a) calling for the preservation and enhancement of beneficiary access to quality services.

The long-term care profession agrees that Medicaid was never intended to be this nation's primary system for funding long-term care and the industry is in the forefront of efforts to encourage individuals to plan responsibly for their own long term care needs in advance. Our goal is enactment of national policy that, over time, replaces the current Medicaid long term care financing system with a national public/private, insurance-based program that provides financial support for individuals and their families to take responsibility for financing their own long term care planning needs; that will ensure access to quality services/supports at all points along the long term care spectrum for all individuals; and will provide financing stability in the marketplace and financial recognition for family caregivers.

Again, I greatly appreciate the opportunity to express my position on this issue. Because I feel so strongly about it and because it generated considerable discussion in the Commission meeting I ask that my viewpoint be included in some form in the report. This could be accomplished as my letter serving as an addendum or as a note in the report.

Sincerely,



Douglas A. Struyk
President and CEO

APPENDIX D

**SHORT-RUN
MEDICAID REFORM**

from the

NATIONAL GOVERNORS ASSOCIATION

August 29, 2005

Preface

On June 15, 2005, NGA released a preliminary policy paper that outlined recommendations for Medicaid Reform. This paper has a narrower focus in that it includes only those policies that could become part of the revenue and spending reconciliation bills that will be debated in September as part of the 2006 federal budget. The paper does provide more detail on the Governors' recommended proposals for the spending reconciliation bill, but is consistent with the policy recommendations in the June 15, 2005 paper.

The recommendations included in this paper were adopted by the Governors because they are good public policy not to satisfy any spending reduction target. It is also true that Medicaid will continue to grow in the high single digit rate even if these policies are enacted. Alternatively, from a state budget perspective Medicaid is still unsustainable. It is therefore critical that these recommendations be considered at the beginning, not the end, of the reform process. For Medicaid to be sustainable in the long-run, broader program and health care reforms must be considered.

The Governors appreciate the fact that the Medicaid Commission has come to many of the same policy conclusions that are recommended in this paper and they look forward to working with them over the next 16 months as they focus on the long-run restructuring of Medicaid.

I. Prescription Drugs

Increased transparency. Reforms are needed to bring greater transparency to pharmaceutical pricing methods for Medicaid. Currently, many states negotiate prices on prescription drugs according to the published average wholesale price (AWP). There is widespread acceptance that AWP is inflated and does not reflect a valid benchmark for pricing. A different reference price should be established and made available to the states that more accurately reflects the actual price for drugs.

The Average Manufacturer Price (AMP) should be used for this purpose; however, reforms need to be made before AMP can be used as the new benchmark for drug pricing in Medicaid. Reforms should include: 1) CMS issuing clear guidance on manufacturer price determination methods and the definition of AMP; 2) manufacturer-reported prices should be easily auditable so that systematic oversight of the price determination can be done by HHS; 3) manufacturer-reported prices and rebates should be provided to states monthly rather than the current quarterly reporting; and 4) new penalties should be implemented to discourage manufacturers from reporting inaccurate pricing information.¹ The AMP should be used to establish a federal ceiling for pharmaceutical reimbursement. States would still retain the ability to negotiate lower prices.

¹ Recent reports by the General Accounting Office (GAO) and the Office of Inspector General (OIG) identified problems with AMP, particularly in manufacturer price determination methods and reporting, and oversight by CMS. Improvements in these areas are essential to ensure that AMP is a reliable and accurate reference price for states.

Option for Closed Formulary. States should have the option of adopting closed formularies, just like the federal government does in the VA system and with the new Medicare PDPs. Adoption of a closed formulary would mean that the state would not be guaranteed a rebate or the “best price”; however, some states, with enough negotiating power and leverage, could negotiate lower overall drug prices than in the current system, even with supplemental rebates.²

Dispensing Fees. With the introduction of a new price methodology (AMP), states should have flexibility to determine appropriate dispensing fees for drugs. Dispensing fees should not be linked to the price of drugs, as was proposed by the President, nor should they be capped. Flexibility to determine dispensing fees is important to ensure that pharmacies are appropriately compensated and that pharmacists are encouraged to dispense the most cost-effective drugs for beneficiaries.

Increased Minimum Rebates for Brand Name Drugs. The minimum rebates that states collect on brand name drugs should be increased to 20 percent (from 15.1 percent) to ensure lower total costs that would not solely impact pharmacists. Medicaid’s “Best Price” provision should not be eliminated in exchange for this.

“Authorized Generics.” For those states that continue to rely on the Medicaid drug rebate and “best price” provisions, reforms should be made to ensure that all drugs be included in these calculations. “Authorized generics” should be included in calculations of best price for the brand name drug. In addition, an “authorized generic” should qualify a particular drug for having a CMS set FUL. Currently, if at least three versions of the drug are rated as therapeutically equivalent by the FDA and the drug has at least three suppliers listed in current editions of national compendia, an FUL should be set by CMS.

Medicaid Managed Care. As more and more states utilize managed care to help administer their program, managed care companies should be able to directly access rebates for prescription drugs purchased for their Medicaid population. States should have the option of collecting these rebates directly or allowing plans to access them in exchange for lower capitation payments.

Purchasing Pools. States should be given greater ability both within their state and between states in establishing purchasing pools. For those states that choose to forgo the “best price” and rebate in order to close their formulary for the Medicaid program, they should be automatically able to combine their Medicaid population in with other state populations (e.g. state employees) in order to negotiate greater savings. Amend OBRA ’90 to require drug companies to give Medicaid level prices to state funded drug programs, including Medicaid managed care plans, SPAPs, stand-alone SCHIP programs, state employees, prison programs, and other programs such as drug discount programs for low income residents of a state.

² No other entity in the health care system is required by law to maintain an open formulary. Medicaid law (OBRA 90) was written so that this open-ended requirement was to be balanced by guaranteed minimum rebates from manufacturers. Many states feel that this trade-off does not allow them the flexibility to manage their programs effectively or the ability to truly negotiate deep enough discounts. Currently, states do not have the option of withdrawing from the Drug Rebate Program without sacrificing federal financial participation for prescription drugs.

Federal Upper Limit. To ensure that states do not pay too much for prescription drugs, a new federal reimbursement ceiling for payment for all drug products should be established based on the AMP. In addition, the current practice of applying a Federal Upper Limit (FUL) to classes of drugs with three therapeutically equivalent products should be maintained; however, the current FUL in this instance is based on 150 percent of the AWP of the least costly therapeutically equivalent product, and should be revised to reflect 150 percent of the AMP of the least costly therapeutically equivalent product.³

Tiered Copay for Prescription Drugs. *(See this section under cost-sharing.)*

Allow Mail Order for Maintenance Drugs. States should be given the option to require Medicaid recipients to use mail order pharmacies to obtain their maintenance drugs. Under such an option, the Medicaid statute would need to be changed to allow "freedom of choice" to be waive-able in this case at a states request.

II. Long Term Care

Asset Transfer. States should have increased ability to prevent inappropriate transfer of assets by seniors to qualify for Medicaid. To that end, 1) the look-back period should be increased from 3 to 5 years; 2) penalty periods should begin at the time of application; and 3) the sheltering of excess resources in annuities, trusts or promissory notes must be prevented.

Accordingly, if at any time during the applicable five year look-back period an applicant, the applicant's spouse, or a fiduciary or person acting for the applicant, the applicant's spouse, or both, transfers or sequesters resources or the right to receive resources, income, or both, from any source, and as a result of the transfer or sequestration the funds available to pay for medical assistance are diminished, the applicant shall be ineligible for medical assistance for the period of time that would cause the transferred or sequestered resources, income, or both, to be fully expended at the weighted average nursing facility rate in effect when the transfer or sequestration occurred (either the monthly rate or the daily per diem multiplied by 30.42 and rounded to the nearest dollar). The disqualification period will begin with the date of application for Medicaid long term care services or if the individual is a recipient of Medicaid long term care services at the time of the transfer, the disqualification period shall begin with the month following the month of the transfer.

³ Currently CMS sets FUL for drugs with generic equivalents, when there are three therapeutically equivalent drug products. The FUL is set at 150 percent of the published AWP price for the least costly therapeutically equivalent product. A recent OIG report found that Medicaid could save hundreds of millions of dollars per year by basing FUL amounts on reported AMPs. According to the report, if Medicaid based FUL amounts on 150 percent of the lowest reported AMP rather than 150 percent of the lowest published price (AWP), the program may have saved up to \$300 million in just one quarter of 2004; an estimated \$650 million per year of savings. Previous reports by the OIG in 2004 found that CMS does not effectively add qualified drugs to the FUL list (e.g. OIG found that 90 drug products were not included on the FUL list in 2001 that met the criteria and had they been they could have saved \$123 million in 2001). CMS should ensure that a FUL is set for qualifying drugs in a timely manner.

If the transfer is between spouses this rule does not apply to the extent that the transfer does not cause the transferees' resources and rights to receive income, resources, or both, to exceed the maximum community spouse resource allowance in effect at the time of the transfer. This same exemption also applies to dependent disabled children. Furthermore, if a dependent disabled child is living in their parent(s) home at a time such parent is applying for Medicaid, that child has the right to stay in the home. In the event of death of the dependent disabled child or the spouse, the state then has the right to recover the asset of the home.

In the case of Community Care Retirement and "Life Care" Facilities (CCRCs), entrance deposits should be considered an available resource for purposes of determining Medicaid eligibility, as CMS guidance currently dictates.

Reverse Mortgages. Current law precludes the state to include certain assets as "countable" in determining Medicaid eligibility, including homes. This leads to the current "pay and chase" in estate recovery where states are left to recover funds after beneficiaries die. Reforms should be made to avoid trying to recover funds after the fact and instead have individuals be responsible upfront for their health care costs.

Home equity should be considered a countable asset in order to require individuals to use home equity to off-set long-term and other medical expenses that would otherwise be paid by Medicaid. Reverse mortgage loans are available to allow seniors (age 62 or older) to convert home equity into cash. To facilitate the use of reverse mortgages, however, reforms should be made to relieve seniors of the upfront costs of applying for such loans. For those seniors that are applying for Medicaid, reforms should be made to allow such costs be assumed into the annual payout of the mortgage.

Protections for seniors and their families should be put in place to allow a person who obtained a reverse mortgage to afford long-term care and medical expenses to shelter a certain portion of their home equity. The amount that would be sheltered would be 10percent of the market value of the home or \$50,000 (whichever is lower). States that can demonstrate that their current estate recovery programs are operating effectively, they should be able to opt-out of this provision.

Long-Term Care Insurance Partnership. To help the aging population plan for future long-term care needs all states should be allowed to participate in the Long-Term Care Partnership program. Federal law should be reformed to no longer prohibit the expansion of these partnerships.⁴

⁴ Currently four states have been operating such partnerships that provide an incentive to individuals to purchase long-term care insurance. Individuals who purchase insurance through such partnerships are able to shelter a portion of their assets. The Medicaid program saves money under such partnerships because Medicaid becomes the payer after the policy benefits are exhausted; making Medicaid the payer of last resort, not the first. However, it is critical that those LTC payments must be used to pay for LTC services.

Protections, such as suitability, rating standards, non-forfeiture clauses, and inflation protection are important for individuals and states as well as to the success and potential cost-savings of the Partnership program. As more states are given the ability to operate Partnership programs, flexibility to be innovative in such policies is important. New Partnership policies should not be prescriptively mandated into a single model that may become obsolete over time. Reciprocity between states that operate Partnership programs is an important goal. A nationwide standard of assets should be considered as models to implement expansion of the program are developed in order to ensure that the value of asset protection purchased in one state is comparable in value in another state.

III. Cost Sharing

Cost-Sharing Responsibility. States should be given the ability to implement common-sense, enforceable cost-sharing throughout the Medicaid program both to increase responsibility of Medicaid beneficiaries for the cost of their health care, and encourage cost-effective care in the most appropriate setting.⁵ This new flexibility would be completely at state option, and states could choose to further restrict the types of cost-sharing in the program by income level, beneficiary category, or service type.

- **At or Below 100 percent FPL.** Existing cost-sharing limits would remain for beneficiaries at or below the federal poverty level (*with the exception of tiered copays for prescription drugs as described below*); however, states would be given the authority to make cost-sharing enforceable. No beneficiaries in this group could be charged a premium (*see premium section below*).
- **Above 100 percent FPL.** States would be able to increase cost-sharing beyond nominal levels for all beneficiaries above the federal poverty level and be given the authority to make cost-sharing enforceable. For these beneficiaries, premiums may be appropriate as a cost-sharing option for states and states should be given flexibility to experiment with mechanisms to collect these premiums (*see premium section below*). Beneficiaries will be protected by a 5 percent cap on the total amount of cost-sharing they could be responsible for (5 percent of total family income). This could increase to 7.5 percent for those higher income households (defined as above 150 percent FPL).

Premiums. Although premiums may not be appropriate for some beneficiaries; if designed appropriately they are a worthwhile cost-sharing tool. States should be given flexibility to experiment with mechanisms to collect premiums in the Medicaid program. Using premiums, rather than a copays would prevent beneficiaries from being denied care that they need for failure to pay when they can least afford it. It also introduces an insurance principle into the Medicaid program. Nothing in this proposal would preclude states from continuing existing waivers that include premiums as a coverage mechanism or preclude other states from entering into such waivers with CMS.

⁵ Currently states are prohibited from implementing cost-sharing above nominal levels [deductible is \$2 per family per month; co-payment from \$.50 to \$3; co-insurance is 5 percent of the state's payment rate for the item or services) and are prohibited from requiring cost-sharing for certain categories of beneficiaries and certain services.

Cost-sharing would not be implemented on the following categories of beneficiaries or services, as under current law:

- Infants and children under age 18 that are provided “mandatory” coverage (0-5 133 percent FPL and 6-18 100 percent FPL)
- Preventive services for all children (well baby, well child care and immunizations);
- Pregnant women with respect to any services related to pregnancy or any other medical condition which may complicate pregnancy;
- Terminally ill individuals receiving hospice care with respect to any service;
- Inpatients in hospitals, nursing facilities, or ICFs/MR who as a condition of eligibility are required to apply most of their income to the cost of care;
- Emergency services, as defined by CMS; and
- Family planning services and supplies

Tiered Co-pays for Rx. Additionally, states should be given the ability to develop effective tiered co-pay structures to encourage cost-effective drug utilization where appropriate for all beneficiaries, regardless of income. Although states may currently operate tiered co-pays, Medicaid’s current cost sharing rules, with an unenforceable maximum co-pay of \$3 per drug is not conducive to encouraging cost-effective utilization. States should be able to increase co pays on non preferred drugs beyond nominal amounts when a preferred drug is available, to encourage beneficiaries to fill the least costly effective prescription for treatment. Such co pays must be enforceable to be meaningful.

For beneficiaries at or below the federal poverty level, co-pays for preferred drugs would remain nominal, although they would be enforceable. For this population, states would be able to increase these enforceable copays beyond nominal amounts for a non preferred drug. States should be given broad authority to waive these co-pays in unique circumstances and cases of true hardship.

IV. Benefits

Increased Flexibility to Tailor Benefits to Beneficiary Health Care Needs. The Medicaid population is very diverse and includes medically frail individuals as well as relatively healthy individuals that Medicaid serves as a traditional health insurance program. Currently “comparability” requirements limit states’ ability to tailor benefit packages to meet different health care needs of beneficiaries. Reforms are necessary to allow states to design programs to support the health care needs of the diverse Medicaid population in their state. For medically frail populations, chronic care management provided in a managed care model holds promise for improving the health care of these individuals. (*see discussion of comparability and state wideness in waiver reform section*).

For relatively healthy individuals, flexibility as is afforded states in the SCHIP program would allow states to design an appropriate benefit package for these beneficiaries. This flexibility includes the ability to choose *to provide the set Medicaid benefit package* or to provide a tailored benefit package with four options for coverage:

1. *Benchmark coverage*: This is a coverage package that is substantially equal to either the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan; or a health benefits plan that the state offers and makes generally available to its own employees; or a plan offered by a Health Maintenance Organization that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state.
2. *Benchmark equivalent coverage*: In this instance, the state must provide coverage with an aggregate actuarial value at least equal to one of the benchmark plans. States must cover inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, include age-appropriate immunizations.
3. *Existing state-based comprehensive coverage*: In the states where existing state-based comprehensive coverage exists (e.g. state-only funded programs; or waiver populations), the existing health benefits package is deemed to be meeting the coverage requirements.
4. *Secretary approved coverage*: This may include coverage that is the same as the state's Medicaid program; coverage provided in a Medicaid demonstration project approved by the Secretary; or coverage purchased by the state that is substantially equal to coverage under one of the benchmark plans through the use of benefit-by-benefit comparison.

SCHIP benefits flexibility is not being proposed for the following categories of beneficiaries:

- Pregnant women, infants and children under age 18 that are provided "mandatory" coverage (up to age 6 133 percent FPL and 6-18 100 percent FPL);
- SSI recipients;
- Dual eligibles;
- Terminally ill individuals receiving hospice care; and
- Medically frail and special needs populations

V. Waiver Reform

Increased Ease of Waiver Approvals. Waiver applications are time consuming and costly for states that seek waivers to better manage their Medicaid program and meet the needs of beneficiaries. Increased ease for states to bypass some federal Medicaid requirements without having to go through a lengthy waiver approval process would facilitate innovation in the program.

States believe they and their federal partners would benefit from states' increased flexibility to create programs that target special populations or limited geographic areas before expansion to entire states. In many situations, smaller pilots or experiments could iron out problems and keep research investment to a minimum before decisions on whether or not a program works are

made. With freedom to create smaller experiments states could test new care delivery and other concepts as well as assess demand and beneficiary/provider satisfaction before committing to an expensive and potentially risky new program.

For commonly waived portions of the Medicaid statute, states should be allowed to use the state plan amendment process. The state plan amendment process would include check boxes for typical waived items, such as those requiring that beneficiaries have “freedom of choice” of provider, and that services be comparable, statewide, and consistent with respect to amount, duration, and scope. States would realize cost savings because services would be implemented sooner and States would reduce administrative costs associated with waiver development and the waiver amendment/renewal process. The revised state plan amendment would also include a checkbox indicating limited geographic service area or other limitations. Similarly, 1915(b), 1915(c) and PACE waivers should also be administered through the state plan process. Certain protections in the waiver process should be maintained through this reform effort, such as the ability to control costs and utilization common to the 1915(c) waivers.

To ease the administrative burden for those states that have an existing waiver; it should automatically become a part of the state plan after it has been renewed once.⁶

States should be given more flexibility within waivers in provider contracting. Although states now may contract selectively for some services without waivers, there are many more services where the ability to contract with, say preferred providers, might enable states to cut costs while improving quality. Contracting flexibility will be important in pay-for-performance (P4P) approaches. Additional at-risk contracts that share savings with provider groups are valuable to stretch increasingly scarce resources as they can lower care costs while improving quality. State purchasing pools have been successfully utilized for pharmaceutical products, but the same concepts might be applied to other services and products if requirements can be adequately addressed under current regulations or waivers.

Requirements for waivers to be cost-neutral can be an unrealistic burden on new or experimental programs. States should be given a greater period of time for waiver programs to be budget neutral (e.g. ten years vs. the current five year requirement). These reforms would allow states to implement programs such as disease management and quality improvement that are expected to result in savings in later years, but have significant upfront costs. The statute should also allow for states to consider savings to Medicare and other federal programs when considering the impact of Medicaid changes. There are many promising innovations in Medicare/Medicaid integration or care coordination that are never implemented because of outdated notions of siloed budget neutrality requirements.

⁶ Through this mechanism, states would be able to expeditiously replicate waivers that have been implemented and sustained in other states. Some waivers are so commonplace and have been in existence for so long that they have become the standard of practice. Yet currently any new state that wanted to implement a similar program would be forced to submit and defend a lengthy waiver application and wait for a time consuming review. This process is lengthy and tends to discourage innovation by forcing states to make a substantial investment in any new programs without much benefit to anyone.

Current waivers should be grandfathered into the program in order to not undermine existing agreements between a state and CMS. However, states should be given the opportunity to revisit current waivers following implementation of new Medicaid laws at a state's request.

VI. Judicial Reform

The right of states to locally manage the optional Medicaid categories is clearly defined in both policy and law, and the federal government should remove legal barriers that impede this fundamental management tool. Also, U.S. Department of Health and Human Services officials should have to stand by states when one of their waivers or state plans is questioned in the judicial system and should work with states to define for the judiciary system that any state has a fundamental right to make basic operating decisions about optional categories of the program.

VII. Medicare Rx "Clawback"

Congress and the Administration should partner with the states to make regulatory changes and enact legislative fixes to the law to ensure that the congressional intent of the program is realized and all states gain some form of relief from passage of the MMA.

VIII. Reinvestment Options:

As Congress considers reforms to the Medicaid program, certain reinvestments of federal dollars should also be considered. However, Congress should not increase the Medicaid gross cut in the reconciliation bill to accommodate these or any other reinvestments. The following are some potential areas for reinvestment that need further discussion by the Governors.

Territories. The federal Medicaid partnership with U.S. commonwealths and territories has become increasingly unbalanced over a period of years, to the extent that some of the jurisdictions are financing over 80 percent of their Medicaid costs, and many of the Medicaid expansions such as transitional medical assistance are not available. The imbalance affects access, quality of care, and creates increased financial stress. Medicaid reform needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing of this partnership.

Quality and Technology Improvements. Grants to the states and/or an increased matching rate should be provided for quality improvement efforts in Medicaid, such as those being considered for Medicare. Such efforts include adoption of health information technology; improved patient safety; reduction of medical errors; chronic care management; and pay-for-performance.

Tax Credits and Deductions for Long Term Care Insurance. Some combination of a significant tax credits, e.g., \$2,000, and deductions, e.g., \$200, to provide an incentive for individuals to purchase long term care insurance.

Tax Credits and Purchasing Pools to Increase Access to Health Insurance. A combination of individual health care tax credits and tax credits for small employers combined with funding to create purchasing pools should provide assistance to low-income working individuals to enable them to obtain health insurance and avoid reliance on Medicaid.

Fraud and Abuse. Medicaid Directors have long asked for three items to help fraud and abuse efforts

- 1) Permit states the same opportunities as are currently afforded the federal government to limit, restrict, or suspend the eligibility of beneficiaries and providers, subject to due process, who have been determined in state proceedings to have engaged in fraud or abuse involving the Medicaid program, even if they have not been convicted in federal court of the listed federal crimes.
- 2) Amend Section 1903(a)(6) of the Social Security Act to provide the same federal match for all costs associated with fraud and abuse and Surveillance and Utilization Review Services (SURS) activities conducted by the state Medicaid agency as currently received by the Medicaid fraud control units (75 percent). This enhanced funding would apply to direct fraud and abuse and SURS functions that include, but are not limited to, identification, investigation, and administrative actions (e.g. recoveries and provider exclusions).
- 3) Provide that when a state discovers an overpayment and determines it to be attributable to fraud or abuse, the state should refund the federal overpayment in the quarter in which the recovery is made, regardless of when the overpayment is discovered.

APPENDIX E

APPENDIX F

SHORT-RUN MEDICAID REFORM

Report of The National Governors Association, August 29, 2005

Overview & Recommendations

On August 29, 2005 the National Governors Association released a report entitled Short-run Medicaid Reform. The report notes that the recommendations are proposed “as good public policy not to satisfy any spending reduction target.” The report also notes that the Governors Association looks forward to working with the federal Medicaid Commission as they focus on the long-run restructuring of Medicaid.

Subject	Recommendation
Prescription Drugs	<ul style="list-style-type: none"> • Switch the federal ceiling for drug pricing from Average Wholesale Price (AWP) to Average Manufacturer Price (AMP), allowing states to negotiate lower prices. Institute reforms to better inform states and ensure accuracy of manufacturer data. • Allow states to adopt closed formularies. • Allow states flexibility in determining dispensing fees. • Increase state’s minimum rebates on brand name drugs to 20%, retaining the “best-price” requirement. • Ensure that all drugs are included in “best-price” and “authorized generics” calculations, and that “authorized generic” qualifies a drug for the federal upper limit. • Allow Medicaid managed care companies direct access to drug rebates, allowing the state to collect the rebate directly or to allow the plan access to the rebates and to lower capitation payments. • Allow states greater flexibility in establishing purchasing pools – allowing combining of populations and Medicaid level prices for state funded drug programs. • Establish a new federal reimbursement ceiling for drugs, retaining the federal upper limit, based on AMP. • Allow states to require use of mail order pharmacies for maintenance drugs.
Long-term Care	<ul style="list-style-type: none"> • With regard to asset transfer, increase the look-back period from 3 to 5 years, begin penalty period on date of application and prevent sheltering of excess resources in annuities, trusts and promissory notes. Tighten asset transfer rules. Include as assets entrance deposits for continuing care retirement community and life care facilities. • Include home equity as a countable asset, allowing reverse mortgage upfront costs to be assumed into the mortgage annual payout. Give states an option to allow partial sheltering of home value in exchange for reverse mortgaging that pays for medical and long-term care expenses. • Allow states to participate in the Long-term Care Partnership Program, providing flexibility while providing national standards.

Subject	Recommendations
Cost Sharing	<ul style="list-style-type: none"> • Give states the option to implement enforceable cost sharing. Maintain existing cost sharing at or below federal poverty level. Allow states to implement enforceable cost-sharing and premiums for beneficiaries above federal poverty level. Allow states to develop tiered, enforceable prescription drug co-pays for all beneficiaries.
Benefits	<ul style="list-style-type: none"> • Allow states flexibility to tailor benefit programs to different populations. For relatively healthy persons, the benefit package could be (1) the federal package or another benchmark, (2) coverage at an actuarial benchmark equivalent, (3) existing state-based comprehensive coverage, or (4) coverage approved by the Secretary of CMS.
Waiver Reform	<ul style="list-style-type: none"> • Streamline the waiver process, allowing more limited population or geographic area pilots and changes by state plan amendment instead of waiver. • Allow renewed waivers to become part of the state plan and current waivers to continue, with state opportunity to revisit the waiver later. • Allow more flexibility within waivers for provider contracting. • Extend time period for waiver cost neutrality and allow consideration of savings to Medicare and other federal programs.
Judicial Reform	<ul style="list-style-type: none"> • Remove federal legal barriers to state management of optional Medicaid categories. • Require federal DHHS to stand by states when their waivers or state plans are challenged in court.
Medicare Rx Clawback	<ul style="list-style-type: none"> • Make changes on federal level to ensure that congressional intent of Medicare Modernization Act is realized and all states gain from its passage.
Reinvestment Options	<ul style="list-style-type: none"> • Consideration of certain reinvestment on the federal level, without increasing Medicaid gross cut. • Review and rebalance partnership of federal government with the territories. • Fund quality and technology improvements in the states, through grants or increased matching rates. • Provide significant tax credits as incentives to purchasing long-term care insurance. • Provide tax credits for individuals and small employers and fund purchasing pools. • Allow states the tools for fraud and abuse prevention – through suspending eligibility of beneficiaries and providers, increase federal match for Surveillance and Utilization Review Services, and allow state repayment of federal match for overpayment due to fraud or abuse in the quarter that the overpayment is discovered.