The Future of Medicaid

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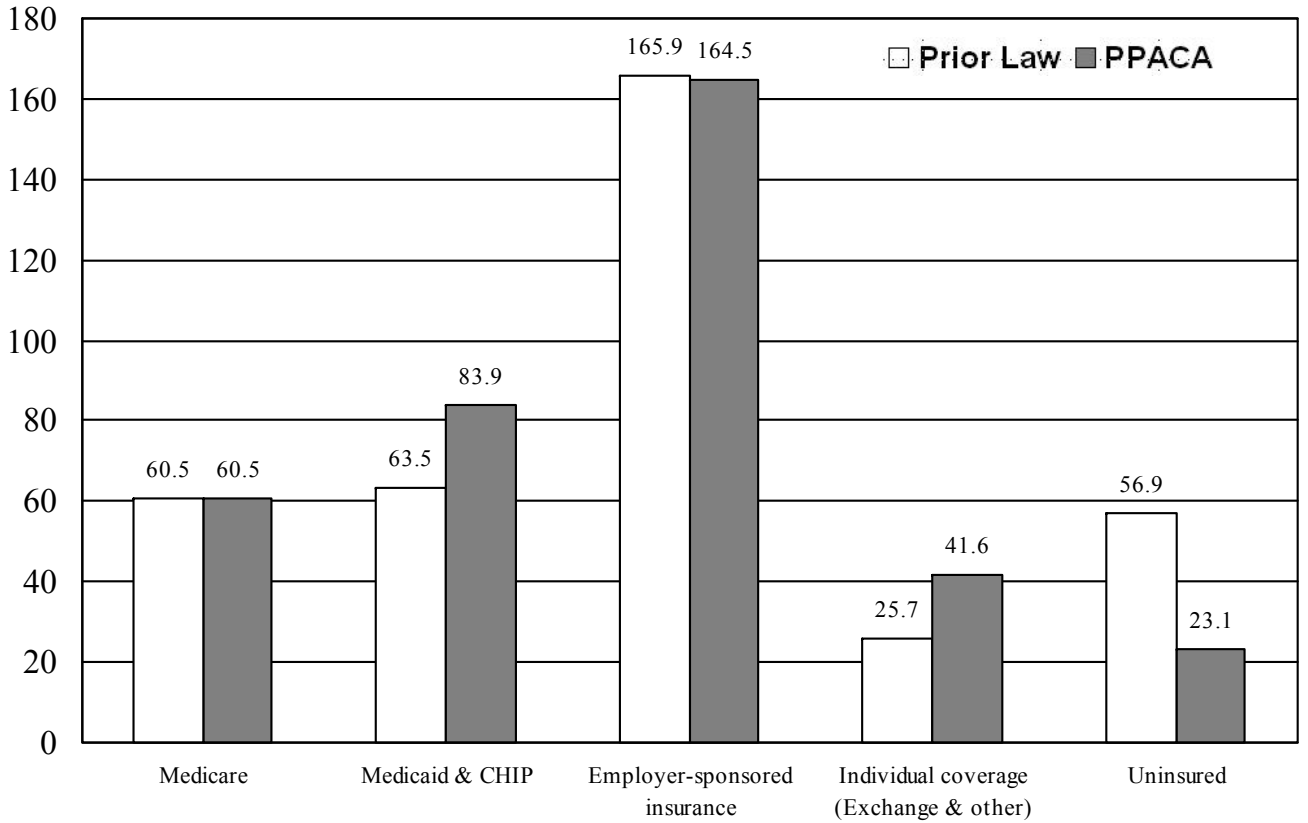
Medicaid Plays a Key Role in Health Care Reform

- The goal of expanded health care coverage is largely achieved through the Medicaid program
  - Nearly 20 million of the 57 million expected to be newly insured by 2019 will be covered under the Medicaid program

Medicaid Plays a Key Role in Health Care Reform

Estimated Effect of the Affordable Care Act on 2019 Enrollment by Insurance Coverage (in millions)*



*Source: HHS Office of the Actuary, April 2010.

Medicaid Plays a Key Role in Health Care Reform

- Medicaid policy changes are designed to move toward
  - more effective and efficient delivery systems
  - a healthier population

- Medicaid changes will be implemented through numerous federal and state policy decisions.

Medicaid Plays a Key Role in Health Care Reform

- This presentation will focus on:
  - Medicaid coverage expansion
  - Changes in the scope and type of Medicaid covered services
  - How Medicaid financing is being restructured and redirected
  - Demonstration project and grant opportunities

Medicaid Coverage Expansions

- In 2014 states will be required to expand coverage to those childless adults who have been historically excluded from Medicaid eligibility whose income does not exceed 133% of the federal poverty level.
- First 3 years funded with 100% federal dollars.
- States may phase in this new group beginning April 1, 2010, but at the normal federal matching rate.

Medicaid Coverage Expansions

- Eligibility limits for other coverage categories must be increased from current state levels up to 133% of federal poverty level.
- States can extend coverage until age 26 to a new category of young adults who received Medicaid while in foster care.
- States may create a new coverage group with adopt higher income limits for family planning services.

Changes Designed to Maintain Medicaid Coverage

- Changes in eligibility determinations designed to simplify the process and encourage enrollment by eligible individuals.

- States required to maintain current eligibility levels until 2014 when new mandatory coverage is effective, with limited exceptions to recognize fiscal problems at the state level.

Benchmark Coverage

- The Newly Eligible population must be provided with “benchmark” or “benchmark-equivalent” coverage
  - Applies in 2014 as well as to any early implementation
  - Traditional Medicaid benefit package v. benchmark benefit package
  - Certain groups are exempt; traditional benefits must be available to them

Benchmark Coverage (cont.)

- What can states do with benchmark coverage?
  - Can differ among populations
  - Can differ in different parts of the state
  - Can be less than the traditional minimum Medicaid benefit package; benchmark rules create a new floor
- May be higher or lower than the standard Medicaid package.

Benchmark Coverage (cont.)

- Has been used to:
  - Tailor benefits to specific conditions (e.g., care coordination, condition-specific education)
  - Tailor benefits to specific populations
  - Impose requirements on beneficiaries
  - Medicaid benefit package has been approved as benchmark coverage
- Can be used with employer-sponsored health plans
  - Plan must meet all benchmark rules
  - Medicaid pays premiums; may add “wrap-around”
  - Medicaid limitations on cost-sharing apply

Benchmark Coverage (cont.)

- Multiple routes to benchmark coverage
  - 3 commercial plans and 1 large exception
  - Benchmark-equivalent option

- Three commercial benchmark plans:
  - Federal Employees Health Benefit Plan equivalent
    - Standard Blue Cross/Blue Shield PPO
  - Benefits generally available to state employees
  - Largest commercial plan offered by an HMO in the State

Benchmark Coverage (cont.)

- Secretary-Approved Coverage
  - Apply to HHS for approval of a proposed benefit package
  - Approved if “appropriate” for the population
  - Include benefit-by-benefit comparison with one of the above plans, or to the standard Medicaid package, and a description of the population to be covered

Benchmark Coverage (cont.)

- Benchmark-Equivalent Coverage
  - Has an aggregate actuarial value that is at least equivalent to a benchmark package
    - Must submit an actuarial report
    - May not consider reduced cost-sharing under Medicaid when calculating value
  - Includes basic services
    - Inpatient, outpatient, physician, lab and x-ray, well-baby and well-child care, designated preventive services
    - ACA added: prescription drug services, and mental health services

Benchmark Coverage (cont.)

- Minimum required services for all options
  - Access to rural health clinic and FQHC services
  - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for children under 21
    - Allows children under 21 a broad range of benefits, even if not covered by the benchmark plan
  - Family planning services and supplies for individuals of child-bearing age
  - Medically necessary transportation
  - Mental health parity
    - Financial and treatment limitations on mental health and substance abuse disorder benefits may not exceed limitations imposed on medical or surgical benefits

Benchmark Coverage (cont.)

- Beginning Jan. 1, 2014, all benchmark coverage must provide the "Essential Health Benefit Package"
  - Ambulatory patient services
  - Hospitalization
  - Prescription drugs
  - Emergency services
  - Maternity and newborn care
  - Laboratory services
  - Mental health and substance use disorder services (including behavioral health treatment)
  - Rehabilitative and habilitative services and devices
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care
- Same package required for all plans on the Exchange
  - Forthcoming definitions must be equal to the scope offered by a typical commercial employer plan (based on HHS survey)

Health Homes

- Beginning January 1, 2011, states have the option to provide "health home services" to individuals with chronic conditions
  - Comprehensive care management
  - Care coordination
  - Comprehensive transitional care (including appropriate follow-up, from inpatient to other settings)
  - Referral to community and social services
  - Patient and family support
  - Use of HIT to link services
- Provided by a "health home" – may be a physician, clinic, clinical practice, interdisciplinary team, or entity designated by the State
  - CMS to publish qualifications for health home providers

Health Homes (cont.)

- Eligible individuals are Medicaid eligible and have:
  - 2 chronic conditions;
  - 1 chronic condition and be at risk for a second; or
  - 1 serious and persistent mental health condition.
  - Chronic conditions: mental health condition; substance use disorder; asthma; diabetes; heart disease; being overweight (BMI > 25).

- If State implements health homes, hospitals must establish procedures to refer eligible individuals to a health home when they seek or need treatment in a hospital emergency department

Health Homes (cont.)

- State chooses method of payment
  - May be tiered based on severity or number of chronic conditions
  - FMAP is 90 percent for the first 8 fiscal quarters
  - State implementing this option must track avoidable hospital readmissions and calculate savings from use of health home services
- Planning grants for states available January 1, 2011
  - Up to $25m; State contribution required
- Separate program provides funding for the establishment and payment of interdisciplinary health care teams that support patient-centered medical homes (ACA § 3502)

Other Covered Services

- Effective January 1, 2013, states will have the option to cover
  - Preventive services that the U.S. Preventive Task Force assigned a grade of A or B; and
  - For adults, vaccines recommended by the Advisory Committee on Immunization Practices.

- If the state prohibits cost sharing for these services, FMAP is increased by 1%.

Other Covered Services (cont.)

- Effective October 1, 2010, states required to provide tobacco cessation services to pregnant women
  - Diagnosis, therapy, counseling services and pharmacotherapy
  - Cost sharing is prohibited for these services
- States required to provide freestanding birth center services
  - Freestanding birth center is a health care facility licensed for prenatal labor and delivery or postpartum care that is not a hospital or a residence

Medicaid Financing

- CMS Office of the Actuary projects that increased Medicaid spending over the next 10 years due to the ACA is:
  - $3.6 billion for states (combined)
  - $459.9 billion federal

Medicaid Financing

- Federal assistance to states
  - ARRA temporary FMAP increase
    - 6.2% + unemployment adjustment (through 12/10)
  - State aid package
    - 6 month phase down of ARRA increase

Federal Matching

- FMAP for the Newly Eligible
  - Current FMAP rate if implemented early
  - 100% in 2014, 2015 and 2016
  - 95% in 2017
  - 94% in 2018
  - 93% in 2019
  - 90% thereafter
- Different matching for pre-existing expansion states

Federal Matching

- State Maintenance of Effort Requirements
  - Eligibility, Enrollment Standards
  - State vs. Local Government Contributions
  - No MOE for provider rates

Disproportionate Share Hospitals (DSH)

- Designed to compensate for increased costs incurred by hospitals that serve a disproportionate share of Medicaid and other low-income individuals
- Aggregate DSH reductions
  - Phased annual reductions up to $18.1B by 2020
- Allocation of reductions via DSH Health Reform Methodology

Medicaid Payments

- No federal review of State Medicaid rates
  - Medicaid and CHIP Payment and Access Commission (MACPAC) assessment of payment policies
- Some federally supported incentives
  - Primary Care Services (Medicare rates)
  - Adult preventive services (1% increase)
  - Health Home (90% FMAP)
  - Health-Care Acquired Conditions

Grants, Demonstration Projects, & Other Opportunities

- New Medicaid demonstration projects
  - Bundled payments for integrated care
  - Global payment for safety net hospital systems
  - Pediatric ACO
- New federal grants
  - Trauma centers
  - Community-based collaborative care networks

Grants, Demonstration Projects, & Other Opportunities (cont.)

- New Center for Medicare & Medicaid Innovation (CMI) within CMS
  - Purpose: Test innovative payment and service delivery models that (1) reduce program expenditures under Medicare, Medicaid, and CHIP and (2) enhance the quality of care furnished to individuals
  - $10 billion over 10 year period
  - To be operational January 1, 2011

Grants, Demonstration Projects, & Other Opportunities (cont.)

- Many suggested CMI models involve payment reforms
  - Shift from fee-for-service to salary or comprehensive payments
  - Direct contracting with providers
  - Allow states to test “all-payor” reform, including for dual-eligibles
  - Pay for performance

Grants, Demonstration Projects, & Other Opportunities (cont.)

- Section 1115 waiver authority
  - Used in the past to expand Medicaid coverage
  - Will continue to be an important tool in the implementation of health reform
  - CMS to issue regulations governing the approval process
- Example: California “Bridge to Reform”

Questions and Answers

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