Opportunities for Medicaid Reform in Texas

A Look at State Medicaid Waivers and Congressional Action

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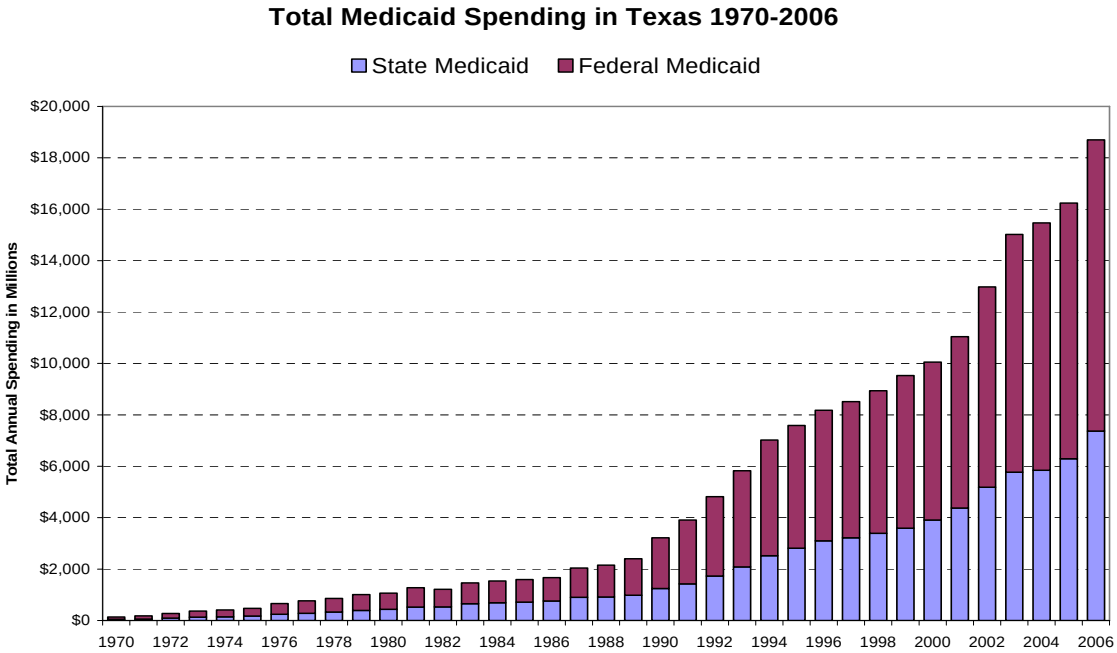
As Texas considers opportunities for Medicaid reform in the upcoming legislative session, other state reform efforts and changes at the federal level have begun to change the way states manage their Medicaid programs, opening up new opportunities for reform.

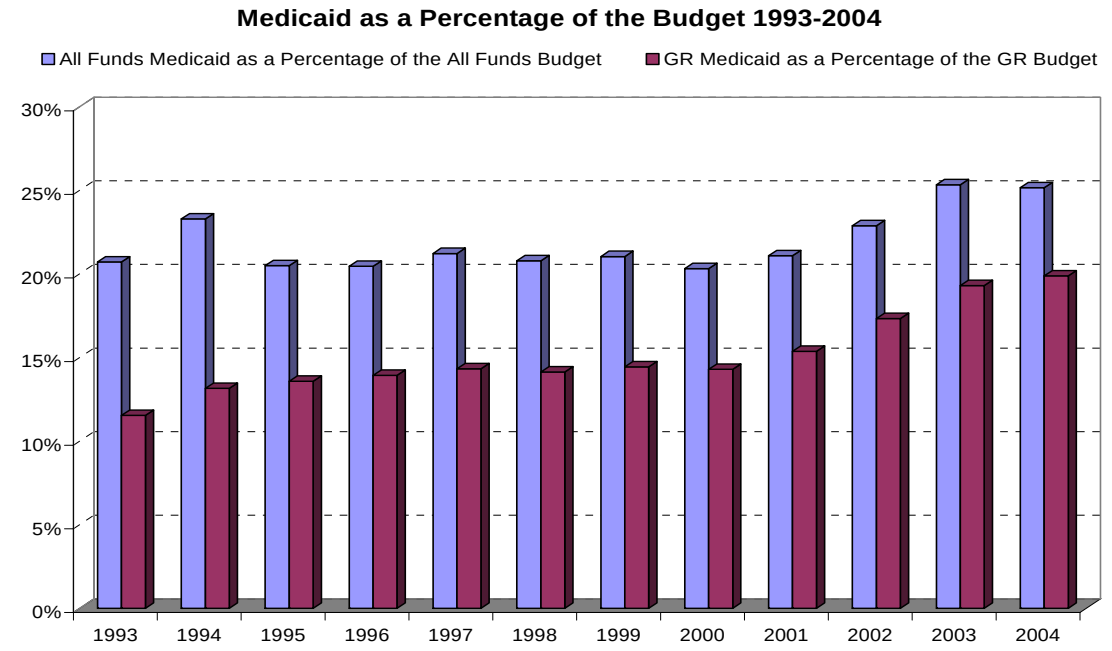
In many respects, Texas is an unsung leader in Medicaid reform: consolidating agencies to streamline administration in an effort to direct more money to care rather than bureaucracy, leading the way in curbing fraud and abuse with the Office of the Inspector General, and looking for new, efficient, and more convenient ways of determining eligibility and interacting with Medicaid recipients. Yet Texas, like other states, faces a growing Medicaid budget that threatens other budget priorities. This is not simply a growing concern for budget writers in Austin trying to balance the budget, but also a growing burden for taxpayers around the state.

The figure below illustrates actual Medicaid spending from 1970-2006 (estimated), distinguishing between the share of state and federal funds.

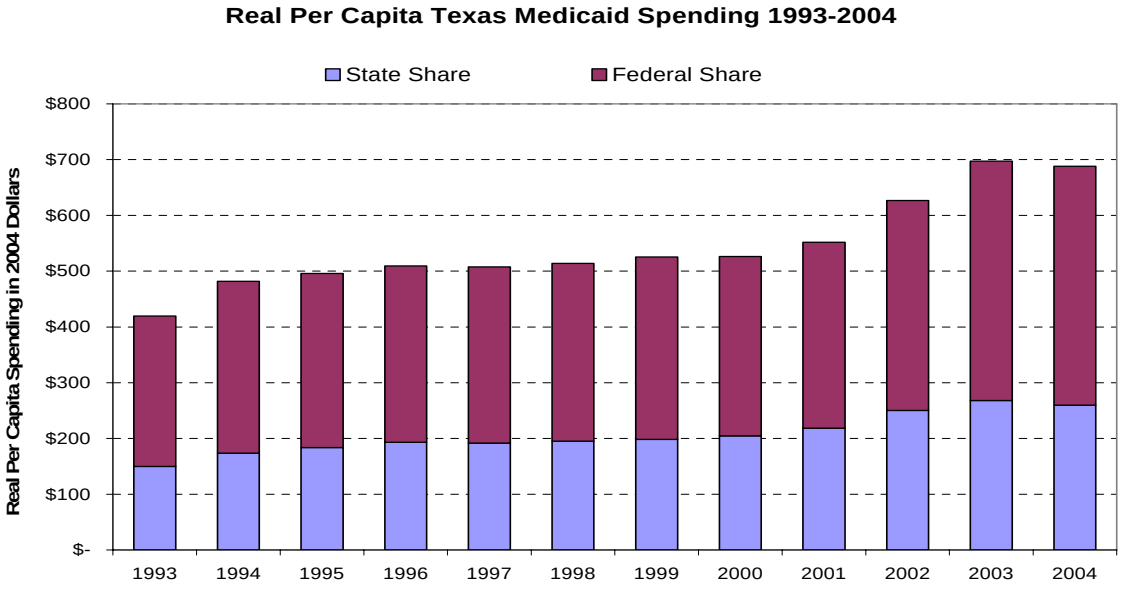


While this graph shows skyrocketing Medicaid spending, it neither captures Medicaid as a growing percentage of the state's budget, nor does it convey the substantial growth in the program when adjusted for inflation.

The figure below shows both General Revenue and All Funds spending on Medicaid as a percentage of the General Revenue and All Funds budgets.



The graph below shows inflation-adjusted per capita spending on Medicaid from 1993-2004. In 2004, this amounted to almost $700 for every man, woman, and child in the state.



It is also important to consider the amount of new revenue that Medicaid consumes each year. From 1994-2004, the state budget grew by more than $31 billion (All Funds) and Medicaid grew by almost $8.5 billion, accounting for almost 27 percent of all new spending over the 10 year period. Similarly, Medicaid consumed almost 33 percent of all new General Revenue dollars in the same 10 year period, fueled, no doubt, by the continuing quest to maximize federal funds.

However, the need for reform is not simply an issue of dollars and cents, it is also one driven by past experience, the need for sound management, and common sense. When Texas was forced to make major changes to health and human services in 2003 due to a $10 billion budget shortfall, it had to react and respond to a program that had grown beyond the state's means. Although the state's financial picture has improved, there is little doubt that day will come again, and it is likely that it will be accelerated by a budget buckling under the weight of Medicaid.

Texas cannot afford to wait and reform Medicaid as a reaction to dire financial straits, which will undoubtedly make it a painful exercise. By considering the opportunities for reform outside the heat of a budget shortfall, Texas can better identify the role for Medicaid and the responsibilities of the state to both the taxpayers and those who rely on such a safety net.

Opportunities for Reform

Several states, most notably Florida and Kentucky, have taken the lead in driving reform through the waiver process. Their experience provides an example for states to consider not only in terms of specific policy decisions, but also in evaluating the waiver climate and the likelihood a waiver will be approved once it arrives in Washington.

Congress has also given many states new opportunities for flexibility, allowing many changes to be made through plan amendments, rather than the through the waiver process. Texas may find opportunities to reform Medicaid within allowable state plan amendments, or may use the new flexibility in the *Deficit Reduction Act of 2005 (DRA)* to explore new waivers.

This document provides a high-level overview of both the Florida and Kentucky waivers and the reforms they are currently implementing, as well as a look at notable aspects of the DRA and options for state plan amendments. In some cases, such as the concept of Money Follows the Patient, Texas is already considered a leader and an example for other states to follow.

While the DRA and the waivers from Florida and Kentucky begin to push reform in an important new direction based on state flexibility, Texas will not simply be able to follow in their footsteps. Texas must consider their example and lessons in pursuing reform at home that reflects Texas' current program and unique needs.

Florida Medicaid Reform

Florida's 1115 Medicaid waiver was approved October 19, 2005.

Key Concepts of Florida Medicaid Reform:

1. Risk adjusted payments to providers
2. Enhanced benefit accounts
3. Ability to purchase employer-sponsored insurance
4. Development of low-income pools

Eligibility

There are two categories of Medicaid beneficiaries that are mandatory participants in reform: TANF and TANF-related groups (mostly families below poverty and children above poverty up to 200 percent FPL; aged and disabled. Current beneficiaries will move in as they come up for renewal. All new beneficiaries must enroll in the new plan.

Other populations, including those in nursing homes, ICF-MRs, foster care, hospice, pregnant females above the poverty level, and the elderly covered by Medicare, are all excluded from Florida's reforms, but will have an option to participate voluntarily.

Plans: Enrollment, Coverage, Cost Sharing

Beneficiaries enroll in a plan, have 90-days to change plans, and stay in their selected plan for 12 months unless they can show that the plan no longer serves them. They may join an employer-sponsored plan at any time, using the amount the state would have paid under Medicaid for the employer plan instead (and aggregating family member premiums to pay for family coverage in the employer plan).

The plans must cover mandatory services and optional services required by the beneficiary, but the plan may vary the amount, duration, and scope of the services.

All plans will offer "comprehensive" coverage to be paid an actuarial amount to reflect 90 percent of historical expenditures. Some plans will also offer "catastrophic" coverage and receive an additional premium if they are at risk for higher expenses. Beneficiaries will see no difference in their plan as they pass from one to another, and the state acts as a re-insurer above comprehensive amounts. The state will also establish a maximum benefit level, that fewer than 5 percent of beneficiaries would reach annually, which will be considered "uncompensated care."

Nominal cost sharing is allowed under an established fee schedule, and a 5 percent co-payment is allowed for emergency room visits for acute care needs in an effort to minimize ER use. Some plans have waived those co-payments, which are the responsibility of the plan to collect. Children under 18, pregnant women, institutionalized, those seeking legitimate ER needs, and family planning services do not pay co-payments.

Enhanced Benefits

The Enhanced Benefits program allows beneficiaries to earn contributions (up to $125 annually) for healthy behavior and use the funds for certain health care purposes. For instance, children making all primary care visits, receiving age-appropriate screenings and immunizations, can earn up to $25 for each; adults making all of their primary care visits or getting a dental exam can receive $15 for each, and getting a mammogram will earn $25. In addition, among the services that anyone can earn credit for is $15 for six months of an exercise program and $25 for participation in a smoking cessation program. The funds in the account remain available up to three years after leaving Medicaid.

Preliminary Results

Enrollment began September 1, 2006.
Broward County: 13 plans
Duval County: 5 plans

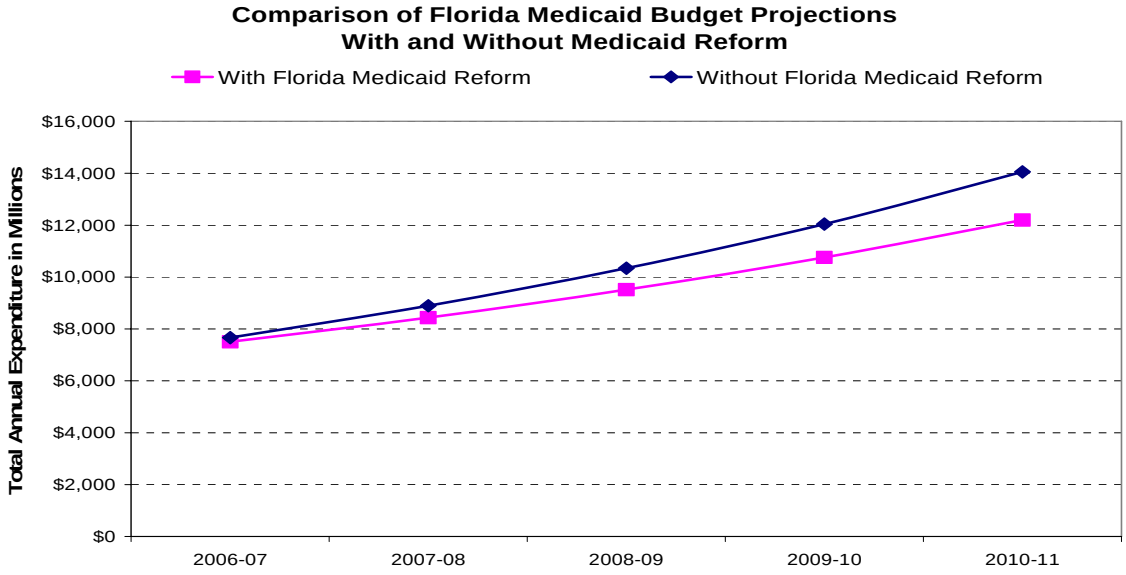
- Some plans have eliminated cost sharing, even when allowed.
- Additional services offered in some plans include: over-the-counter drug coverage up to $25/month per household, vision tests and upgraded eyeglasses, some adult dental services, circumcision for newborns, home delivery of meals (aged and disabled).

The Low Income Pool

Florida's Upper Payment Limit has become the Low Income Pool (LIP), securing $5 billion over five years that will be used to fund hospitals serving a significant number of Medicaid beneficiaries and uninsured individuals.

Budget Impact

Florida's waiver identified the projected budgetary impact of Medicaid reform, projecting reform would result in savings of almost 9 percent in 2010-11.



Sources: Florida Medicaid Reform Application for 1115 Research and Demonstration Waiver, Approved by CMS as updated on October 19, 2005, available: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.
Thomas Arnold, Deputy Secretary for Medicaid, presentation July 27, 2006 available: http://www.fachc.org/mem_Arnold%20presentation.ppt.
Florida's Medicaid Reform Choice Counseling General Information, http://www.flmedicaidreform.com/english/generalInfo.html.

Kentucky Medicaid Reform

Kentucky received approval for its 1115 Medicaid waiver on May 3, 2006. Much of the *KyHealth Choices* waiver could have been done administratively through flexibility in the *Deficit Reduction Act of 2005*.

Key concepts of Kentucky Medicaid reform:

1. Varied benefit packages tailored to Medicaid beneficiaries with a separate CHIP program
2. Improve integration of care
3. Improve Health Insurance Premium Program
4. Get Healthy Benefits to encourage healthy practices

Eligibility

Sixteen counties in the Louisville region have an 1115 waiver allowing beneficiaries to be served in a managed care plan; none of the beneficiaries served under the waiver through Passport Health Plan are affected.

Plan Options, Coverage, Cost Sharing

KyHealth Choices offers four benefit packages based on the population they are geared to serve. All offer a set of standard benefits and choose from additional optional services. Within each of the four packages there are different levels of care covered. The plans continue to offer all mandatory Medicaid services, but vary the amount, duration, and scope of those services. Limits placed on the amount, duration and scope of services may be waived with prior authorization.

The four packages under *KyHealth Choices* are:

- Global Choices: the benchmark package suitable for the general Medicaid population and offered in all other plans
- Comprehensive Choices: Global Choices plus services appropriate for beneficiaries in a nursing facility or with high risk of institutionalization
- Optimum Choices: Global Choices plus services appropriate for beneficiaries with ICF-MR needs, including services to help the individual stay at home longer
- Family Choices: designed for children and intended to cover children in Kentucky's CHIP program (KCHIP) and some children in the Medicaid program. Phase II of *KyHealth Choices* may expand this coverage to KCHIP parents, allowing the family to pay the difference between child coverage and family coverage. Note: this will move KCHIP from a Medicaid administered program to a managed care administered program

Cost sharing for all plans is capped at $225/year and established on a sliding scale. Cost sharing may include co-payments or co-insurance, as well as premiums. Children under 18, pregnant women, persons receiving inpatient services in a nursing facility, ICF-MR or admitted to a hospital from such facilities, or persons receiving hospice make no co-payments.

Beneficiaries receiving services through Optimum and Comprehensive plans are eligible to participate in consumer directed options, allowing an added ability to choose non-traditional Medicaid goods and services (ex: home adaptations to remain in home).

KyHealth Choices will also allow individuals with disabilities eligible for long term supports to participate in a self-directed option through the Comprehensive benefit plan. The self-directed option will provide individual allocations to be spent at the beneficiaries' discretion to purchase services such as financial management assistance, employment support, adult educational services, and support services to allow an individual to continue living at home.

Integration of Care

To improve Kentucky's MHMR services, *KyHealth Choices* provides for better integration of care using the existing Community Mental Health Centers (CMHCs) throughout the state. Kentucky will make capitated payments to the CMHCs throughout the state, and each center will submit plans on how they will strengthen the local provider network. Core services through the CMHCs will be provided without cost sharing (ex: targeted case management, individual and group therapy, crisis stabilization), while additional services determined locally may be subject to cost sharing requirements.

Health Insurance Premium Program

Kentucky's Health Insurance Premium Program serves only 14 people statewide, highlighting the poor performance of this effort to date. Kentucky plans to better identify Medicaid recipients with the option to purchase employer-sponsored insurance to evaluate whether it is cost effective for the individual to purchase at the employer's option; however, the state indicates that this will not be an option on the Family Choices Plan (designed for children to replace KCHIP).

Get Healthy Benefits

Medicaid recipients with pulmonary disease, diabetes, and cardiac conditions are eligible for Get Healthy Benefits that include additional dental or vision benefits, nutritional counseling, or smoking cessation programs. The state may expand the program to additional Medicaid recipients or other conditions with time.

In addition, Kentucky has worked to develop and begin implementation of disease management programs for cardiac disease, diabetes, and pediatric asthma and obesity.

Sources: KyHealth Choices, Kentucky's Medicaid Transformation Initiative, May 2, 2006, available: http://www.chfs.ky.gov/NR/rdonlyres/70AC8C04-BDEF-4A64-AB06-45FEE8285A04/0/1115waiver.pdf.

Deficit Reduction Act 2005

Long-Term Care Under Medicaid

- Transfer of Assets
  - Lengthened look-back period for the transfer of assets from three years to five years.
  - Changed the date for the period of ineligibility from the date a transfer of assets was made for less than fair market value, to the date the individual is otherwise eligible for medical assistance and would receive institutional care.

- Home Equity
  - Individuals with home equity of $500,000 or more are ineligible for Medicaid. States have the option to raise that limit, not to exceed $750,000. Does not apply if the applicant's spouse or child under age 21, blind, or disabled also resides in the house.

- Expansion of Partnership Program (state plan amendment)
  - The Long-Term Care Partnership Program allows owning approved, tax-qualified long-term care insurance policies to qualify for Medicaid without spending down all of their savings.
  - May disregard any assets or resources in an amount equal to the insurance benefit payment made to, or on behalf of, the individual beneficiary under the policy.
  - The program was previously limited to five states; DRA lifted the five state limit.

Eliminating Fraud, Waste, and Abuse

- Documented evidence of citizenship for Medicaid eligibility.

Flexibility on Cost Sharing and Benefits

- Gives states the option of imposing premiums and cost sharing, and varying the amount by recipient group or type of service. (state plan amendment)
  - 100-150 percent FPL: no premium, cost sharing not to exceed 10 percent of the cost of the item/service and total amount not to exceed 5 percent of the family income on a quarterly or monthly basis.
  - >150 percent FPL: premiums and cost sharing not to exceed 5 percent of family income on a quarterly or monthly basis, cost sharing not to exceed 20 percent of the cost of the item/service.
  - Exceptions to premiums and cost sharing:

No Premiums	No Cost Sharing
• Certain children under age 18 • Pregnant women • Inpatient hospital, nursing facility, ICF-MR who spends down all but income for personal needs • Women eligible for Medicaid due to breast or cervical cancer	• Services to certain children under age 18 • Preventive services • Services related to pregnancy or conditions that will complicate the pregnancy • Services for terminally ill patients receiving hospice • Services for anyone who is in an inpatient hospital, nursing facility, ICF-MR who spends down all but income for personal needs • Emergency services • Family planning services • Services to women who are eligible for Medicaid due to breast or cervical cancer

  - States may condition provision of assistance on payment of premiums, and may terminate eligibility for assistance for failure to pay premiums; however, termination of eligibility may not occur unless failure to pay continues for 60 days or more. States may waive the requirement in cases of hardship, as well as apply to selected beneficiaries.
  - States may allow Medicaid providers to condition provision of care or services on payment of cost sharing. Providers may reduce or waive the cost sharing requirement on a case-by-case basis.
  - Indexes "nominal" cost sharing amount using the medical care component of the CPI.

- Emergency Room and Non-Emergency Care (state plan amendment)
  - Allows states to permit hospitals to impose cost sharing for non-emergency services delivered in the emergency department if:
    - there are alternative non-emergency providers accessible, and
    - if the hospital gives the individual notice after screening, but before providing the service.
  - Limitations on the cost sharing exist, but populations otherwise exempt from cost sharing may be required to share in the cost of non-emergency care in an emergency department if the alternative outpatient setting will deliver the care at no cost.
  - States may receive payment for establishment of alternate non-emergency service providers, giving preference to states that
    - establish or provide for non-emergency service providers, or networks that serve rural or underserved areas, or
    - partner with local community hospitals.

- Benchmark Benefits (state plan amendment)

- Allows states to establish a benchmark benefits package equivalent to the Federal Employees Health Benefits Plan, a state's state employee health plan, or the largest HMO in the state. State must also provide wrap-around benefits consistent with EPSDT services.
- States may not require enrollment in a benchmark package if an individual: qualifies as mandated coverage for pregnant women, is blind or disabled, is dually eligible for Medicare, is a terminally ill hospice patient, is eligible due to institutionalization, is medically frail or medically needy, qualifies for long-term care services, is a child in foster care, qualifies due to TANF eligibility, or qualifies due to breast or cervical cancer.

- State option for families to purchase Medicaid coverage for disabled children, not to exceed families with incomes of 300 percent FPL.
  - States may elect a higher income eligibility limit, but may only provide services with state funds.
  - States choosing to offer this coverage must require a parent to accept employer-sponsored coverage if the parent is eligible and the employer pays half of the cost of the coverage, and the state may provide payment for any portion of the premium for such family coverage as the parent is required to pay.
  - States may establish a sliding scale for income-related premiums for Medicaid coverage for disabled children.

- Federal grants to states for Money Follows the Person demonstration projects.

- Medicaid Transformation Grants for "innovative methods to improve the effectiveness and efficiency in providing medical assistance."

- Health Opportunity Accounts (awarded by Secretary)
  - Demonstration limited to 10 states for the first five years of the program.
  - Program must include:
    - creating patient awareness of high cost of medical care
    - incentives to seek preventive care services
    - reduce inappropriate use of health care services
    - enable patients to take responsibility for health outcomes
    - provide enrollment counselors and education activities
    - electronic transactions involving the accounts
    - access to negotiated provider payment rates
  - No requirement for program to be statewide.
  - Beneficiaries who are 65 years of age or older, disabled, pregnant, or eligible for medical assistance for a continuous period of less than three months may not participate.

- Expanded Access to Home and Community Based Services For the Elderly and Disabled (state plan amendment)

Opportunities for Medicaid Reform in Texas

Flexibility from the *Deficit Reduction Act* allows Texas the opportunity to make changes to the Texas Medicaid program. Some of these changes may be handled by application to the Secretary, while others require a plan amendment (rather than a waiver).

Undoubtedly, opportunities for Texas to gain flexibility through *DRA* are more limited than many other states, given Texas' comparatively low eligibility levels. However, Texas must demonstrate its interest in reform by embracing every opportunity for flexibility in managing the Medicaid program.

Note that not all of the changes in the DRA are at the state's option. Some changes may require the state to make conforming changes to comply with federal law, but must be made at the federal government's directive.

Texas should consider:

1. Establishing a Long Term-Care Partnership Program.
2. Establishing or increasing cost sharing for eligible populations, including cost sharing requirements for non-emergency services delivered in the emergency department.
3. Strengthening the premium payment assistance program in Medicaid and examining flexibility in benchmark packages.
4. Establishing Health Opportunity Accounts as a demonstration project.
5. Pursing a waiver to model a Low Income Pool similar to the Florida LIP.

Unfortunately, these changes will only begin to help Texas transform its Medicaid program, but they will not be enough. Texas must be a leader for reform at the federal level, working for more equitable financing, and freedom from administratively burdensome and time consuming waivers in order to get additional flexibility.