Partnership for Medicaid

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MEDICAID POLICY OPTIONS

September 2012

THE PARTNERSHIP FOR MEDICAID – a nonpartisan, nationwide coalition of safety net providers and other key organizations with a role in delivering services to Medicaid enrollees – would like to offer these ideas for strengthening and improving the Medicaid program as Congress and the president consider Medicaid changes with an eye on deficit reduction. The Partnership recognizes the importance of reducing the deficit, and would offer these solutions that are not budget-driven but would create efficiencies in the program and improve care.

Recognizing there are inefficiencies in the program and improvements that could be made, the Partnership has been an active participant in offering practical solutions for many years. This document builds on prior proposals and includes perspectives for the future, in a good faith effort as providers and stakeholders, to offer viable solutions for the Medicaid program.

The Partnership for Medicaid offers solutions for various aspects of the Medicaid program to help create system efficiencies and improve care for patients:

Long-Term Services and Supports (LTSS)

The Partnership supports substantial long-term services and supports reform that lead to an easing of the burden of LTSS expenses on the Medicaid program and improvement in access to critical services for vulnerable patients, including supportive housing. *(Page 4)*

Coordinating Care

The Partnership supports expanding care coordination for all patients, especially those with chronic conditions, and strengthening linkages among preventive, primary, acute, and LTSS. *(Page 7)*

Improving Quality

The Partnership supports aligning enrollment periods and developing comparable data to ensure Medicaid beneficiaries are provided the highest quality of care. *(Page 8)*

Caring for Dual Eligibles

The Partnership supports policies that will facilitate and support the integration and coordination of care and services provided to dual eligibles. *(Page 10)*

Long-Term Services and Supports

Options for Financing

Currently, the vast majority of Americans rely upon Medicaid to finance their long-term services and supports (LTSS) needs. Although Medicaid was never intended to be the primary provider of LTSS coverage, the lack of other options has caused the program to evolve into the leading reimbursement source for these services, accounting for approximately 43 percent of all LTSS spending. Demand for LTSS will continue to increase in the coming years, driven primarily by the baby boom generation and increasing numbers of young persons with disabilities. There are, however, significant misconceptions about Medicaid's involvement in long-term care financing, and surveys show that a majority of the public believes that Medicare covers nursing home stays. To ensure Medicaid programmatic and fiscal stability and viability, the Partnership supports the creation of LTSS financing options for Medicaid. The Partnership also supports restructuring Medicaid-financed LTSS to ensure stability of the Medicaid program and foster Medicaid programmatic efficiency, quality, access, and positive outcomes.

Estimates suggest the future number of just the older adult population who are unable to perform basic activities of daily living without assistance may as much as double from 2000 through 2040, resulting in a large increase in LTSS. Additionally, recent research points to higher than previously estimated numbers of older adults with disabilities who likely will need LTSS. Due to demographics alone, LTSS spending for just older adults may increase by more than 2.5 times between 2000 and 2040, and could nearly quadruple spending between 2000 and 2050 to $379 billion, according to some estimates.

Two additional factors will further drive up demand. First, while the number of private long-term care insurance (LTCI) policies in force has grown, at approximately 7 million, the market remains small in comparison to Medicaid. And, recent U.S. Department of Health and Human Services (HHS) research points to ongoing challenges with public perception of LTCI. Second, three of the four major, national LTCI companies no longer are selling policies; furthermore, monthly premiums have significantly increased, causing a notable number of older adults to allow policies to lapse. Third, the vast majority of LTSS is informally delivered by family caregivers. The economic downturn and the aforementioned aging demographic will significantly erode informal family caregiving capacity and drive up demand of publicly financed services.

Without fundamental financing changes, Medicaid will remain one of the largest LTSS funding sources, which raises serious questions about the financial viability of the program. To ensure Medicaid remains a viable safety net for low-income, vulnerable people who need LTSS, financing reform must encompass federal, state, and private roles. The Partnership for Medicaid will pursue and/or support policies that

- reform public and private long-term care financing to better support high-quality care delivery and to expand consumer choices;
- enable and encourage personal responsibility in planning for LTSS needs;

- facilitate and support the integration and coordination of Medicare and Medicaid; and
- support quality and efficiency in both Medicaid and private LTSS.

The Partnership encourages a thoughtful dialogue of additional policy issues around Medicaid and LTSS to protect – and not undermine – the current system of care. One such example is the transfer of assets and the real-world impact of this policy. Current Medicaid law is designed to prevent the transfer of assets in order to gain Medicaid eligibility. Unfortunately, this policy has unintended consequences for providers, consumers, and the Medicaid program writ large. This example is one reason why a comprehensive approach to LTSS and Medicaid must be undertaken.

Choice and Access to the LTSS Continuum

As noted above, the Medicaid program is under significant budgetary pressure. The most notable budgetary pressure point is LTSS financing both for Medicaid-only beneficiaries and for duals. Faced with such challenges, states are exploring an array of policy and program options including Affordable Care Act (ACA) programs and options that offer an enhanced federal medical assistance percentage (FMAP), Section 1115 research and demonstration waivers to restructure LTSS eligibility and delivery systems, and implementation or expansion of Medicaid managed LTSS.

States also are establishing higher level of care (LOC) eligibility criteria and creating home and community-based service (HCBS) programs available to persons who do not meet an LOC (i.e., hospital, nursing facility, or intermediate care facility for persons with intellectual or developmental disabilities). The latter are intended to enable people to remain in their homes and communities and delay entry into HCBS residential or facility-based service settings. States may establish such sub-LOC programs without violating statutory maintenance of effort requirements. These programs often include family support benefits packages. In particular, the 1915(i) HCBS state plan amendment – which allows states to target specific sets of services to specific diagnostic groups prior to needing institutional care – can be a resource for assisting individuals whose disability or chronic illness has resulted in housing instability or homelessness. These individuals frequently utilize emergency departments and often experience prolonged and costly inpatient hospital stays. States planning for Medicaid expansion are considering how 1915(i) HCBS can be provided in Permanent Supportive Housing programs aimed at increasing housing and health stability and reducing anticipated Medicaid costs associated with frequent hospitalizations for this population.

Regardless of program or LTSS setting, person-centered service design and delivery has become an essential component of a modern LTSS system. States and LTSS providers have embraced person-centered services in both HCBS and facility-based settings (e.g., nursing home culture change).

The Partnership for Medicaid will pursue and/or support policies that

- foster the proliferation of person-centered service models and empower individuals to choose and shape the array of services and service setting most appropriate to their needs and preferences;
- ensure people have access to and may move seamlessly among all levels of services and all settings as their needs and preferences change;
- recognize family caregiving and the role of family caregivers; and
- ensure entities coordinating and delivering services have expertise in and understanding of LTSS populations' needs and preferences, as well as the entities directly delivering such supports.

Supportive Housing

Community-based supportive housing combines health services with stable and permanent housing, and has been shown to reduce Medicaid (and other public) expenditures when homeless frequent users are targeted for intervention. Two additional options recognize the role the Department of Housing and Urban Development (HUD) could play in reducing health expenses related to lack of housing. HUD could be directed to collaborate with the Centers for Medicare and Medicaid Services (CMS) to target the highest-cost, homeless Medicaid beneficiaries for supportive housing programs. HUD could also extend mortgage insurance to supportive housing programs, as is currently allowed for hospitals and skilled nursing facilities, to better enable these cost-savings programs to meet start-up capital expenditures.

Coordinating Care

Care Coordination for Chronic Conditions

Medicaid and other health programs, including Medicare, the Veterans Health Administration, and TRICARE – as well as private health insurance –face a common baseline cost trend: patients with chronic diseases (e.g., diabetes, HIV/AIDS, heart disease) account for a disproportionate share of overall health care expenditures. In Medicaid – according to the Kaiser Commission on Medicaid and the Uninsured – seniors, persons with disabilities, and individuals with special health care needs "make up 25 percent of enrollees but about two-thirds of total spending." Better coordination of care for these populations holds the potential to improve care while simultaneously producing significant savings. By taking a multidisciplinary and integrated approach to care, a children's hospital–based medical home program for medically complex children in Arkansas was able to reduce total Medicaid costs by $1,179 per patient per month. A recent Milliman Research Report notes that failing to coordinate care for Medicaid recipients with mental illnesses and addiction disorders alone may cost the system $300 billion annually.

The Partnership for Medicaid supports expanding care coordination for all patients, especially those with chronic conditions, and strengthening linkages among preventive, primary, acute, and LTSS. These efforts can include the following:

- Enrolling beneficiaries with chronic conditions in programs that coordinate care by providing services including drugs and care management and ongoing health condition monitoring
- State initiatives under the new Medicaid Health Homes option
- New Medicaid accountable care organization (ACO) models including a pediatric ACO model
- Innovative managed care arrangements
- Shared savings models involving state Medicaid agencies, hospitals, and health plans to reduce emergency department (ED) utilization
- Other models of care integration

At the same time, any care coordination requirement must be accompanied by risk adjustment and payment mechanisms to counter adverse risk selection and ensure adequate provider and plan reimbursement; these mechanisms may take the form of new statutory provisions or rigorous implementation of existing Balanced Budget Act of 1997 requirements.

Care Coordination for Pregnant Women

Pregnancy medical homes hold great promise for achieving cost-savings and improved outcomes. The North Carolina Department of Medicaid's pregnancy medical home program is expected to save the state $10 million in the second year of implementation, with increased savings as the program expands to cover all Medicaid-eligible pregnancies. Program quality markers will ensure against elective deliveries before 39 weeks of gestation, decrease the rate of cesarean sections among this

patient population, facilitate provider use of interventions to prevent premature deliveries, and guarantee patients risk screening and local care and case management. This innovative program has been embraced by the medical community and by patients. The Partnership supports programs like this that benefit patients while reducing costs.

Improving Quality

Simplify and Align Enrollment Periods for Health Coverage to Improve Quality

Typical private coverage and other public programs such as Medicare have an annual or 12-month enrollment period that allows for continuous, stable coverage for enrollees. In contrast, after their initial application and enrollment, Medicaid enrollees must periodically prove they are eligible for Medicaid. Because of the complex administrative processes, families often do not know when their Medicaid certification periods expire, may be dropped without knowing it, and do not know why they lost coverage. Those who have been disenrolled typically say they wanted to retain their insurance coverage, but did not know how to do so. This trend leads to what is commonly known as "churning." Churning happens when people enroll in Medicaid, only to subsequently lose their coverage because of inefficient and cumbersome paperwork requirements and short-term income fluctuations. While new regulations effective in January 2014 should streamline the Medicaid and Children's Health Insurance Program (CHIP) eligibility processes, frequent interruptions in coverage are still expected to occur. The interruptions in coverage affect the continuity and effectiveness of health care received, particularly for patients with chronic conditions. Medicaid enrollees would be especially likely to benefit from an annual enrollment period. Currently the average Medicaid beneficiary is enrolled for only three-quarters of a year. This number is even smaller for adults – the most significant population of new Medicaid beneficiaries that will soon be covered under the Medicaid expansion.

Medicaid enrollees with coverage interruptions are more likely to be hospitalized for illnesses such as asthma, diabetes, or cardiovascular disease – which can be effectively managed through ongoing primary medical care and medication – are less likely to be screened for breast cancer, and may have poorer cancer outcomes. Thus, interruptions in insurance coverage can impair the receipt of effective primary care and lead to expensive hospitalizations or ED visits. Interruptions also impair quality monitoring and improvement activities because many Medicaid enrollees are not enrolled long enough to assess the quality of their care. The presumption is that people who have been enrolled for less than a year have not been exposed to enough care to measure quality or to experience health-promoting quality effects.

Not only does churning result in worse health outcomes for patients, its costs are often borne by providers such as community health centers and hospitals that find themselves having to treat uninsured patients who are often sicker because of a lack of continuous access to care. Improving retention in Medicaid is a cost-effective way to reduce the number of uninsured people, make their health insurance coverage more secure, improve the measurement of health care quality, and ultimately improve people's health.

The Partnership for Medicaid supports giving states the option to establish a 12-month continuous eligibility period for all Medicaid enrollees, and potentially a longer eligibility period for some categories of enrollees, such as seniors and dual eligibles. This option is consistent with a draft document compiled by the National Governors Association's (NGA's) Health Care Task Force, which called for a similar policy to allow states to increase the time period for eligibility redeterminations to no more frequently than 12 months for certain Medicaid enrollees, including elderly

beneficiaries and people with disabilities. The NGA's document states that it is expensive to annually redetermine eligibility for individuals whose eligibility status does not often fluctuate. In fact, many states have already implemented an annual enrollment period for children in their state's CHIP and Medicaid program.

Develop Comparable Data About the Quality of Medicaid Services

Policymakers and providers have many powerful tools to ensure the highest quality of care is provided to Medicaid enrollees. These tools could be further strengthened through the collection of comparable data on the quality of care that is provided to enrollees, regardless of whether they are enrolled in a Medicaid fee-for-service program, primary care case management (PCCM), or managed care organization. Federal law already requires that there be procedures for quality monitoring and improvement for capitated managed care organizations. These requirements have allowed enrollees and Medicaid officials at the state and federal level to evaluate the value and quality of care provided. Since a substantial number of Medicaid enrollees are still served under fee-for-service or PCCM arrangements, information about the quality of care provided under Medicaid is available for a minority of those enrolled, and it is not possible to get an overall perspective of the quality of care in Medicaid.

The Partnership supports policy changes to encourage reporting of comparable quality measures for all Medicaid enrollees. Quality reporting changes should be implemented in a way that does not add administrative burden to already stretched providers. These changes will move Medicaid in the direction of other major payers by establishing standardized quality reporting for all providers. The Partnership also supports standardization of quality measures across all payers to the greatest extent possible to reduce the reporting burden on providers.

Currently, the Agency for Healthcare Research and Quality is developing a set of quality measures appropriate for adult Medicaid enrollees, in addition to the measures already developed for the pediatric population. The Partnership supports the adoption of meaningful and standardized measures for all enrollees.

Caring for Dual Eligibles

Integrating Care for Duals

More than 9 million individuals are currently enrolled in both the Medicare and Medicaid programs. Commonly called dual eligibles, they tend to be among the poorest, most frail, and most medically needy among us. These individuals, of whom approximately two-thirds are low-income elderly and one-third are younger than 65 and disabled, receive acute care and pharmaceutical services from the Medicare program, while also receiving supplemental benefits, including LTSS, from Medicaid.

Due to the significant variation in the nature and complexity of their conditions, dual eligibles have a wide range of long-term care, acute care, behavioral health, and support service needs. It is critical that dual eligibles have access to an appropriate array of providers to meet their multiple and complex needs.

On average, dual eligibles have higher medical expenses than other beneficiaries in either program. They make up approximately 15 percent of Medicaid's enrollment, but 39 percent of its spending. In the Medicare program, they represent approximately 16 percent of Medicare's enrollment and 27 percent of its spending. Dual eligible–related spending in both programs totals more than $300 billion annually.

But because Medicare and Medicaid are administered separately, dual eligibles are often poorly served by the two programs. Strong incentives for cost-shifting between the two programs lead to unnecessarily high spending across both programs. Most beneficiaries receive care through separate fee-for-service programs and separate Part D drug plans, or through separate Medicaid and Medicare Advantage managed care contracts. These approaches are unnecessarily complicated; they provide little coordination between states and the federal government, to say nothing of coordinating care to address dual beneficiaries' unique needs.

The ACA renewed focus on dual eligibles with the establishment of the new Federal Office of Medicare-Medicaid Integration, or the "Duals Office." The Partnership for Medicaid supports this office, which is currently working on demonstrations with numerous states scheduled to begin in 2013 and 2014.

Adequate reimbursement is imperative to ensure the effectiveness of any program that strives to ensure both access and quality, but it is particularly important for programs serving the dual eligible population. Rates in the managed fee-for-service, capitated, risk-based, and hybrid approaches must reflect the depth and breadth of services required for this population. Furthermore, if a state elects to use managed care, adequate rates should be accompanied by risk adjustment/risk corridors and payment mechanisms to counter adverse risk selection. These mechanisms may take the form of new law, new regulation, or rigorous implementation of current statutory requirements and are necessary to guarantee an appropriate array of providers to serve the full range of dual eligible needs.

The Partnership for Medicaid supports policies that will facilitate and support the integration and coordination of care and services provided to dual eligibles by managed care plans, managed fee-

for-service programs, or other approaches. Integration will better meet the needs of the involved individuals and will be more cost-effective than the current uncoordinated environment. The Partnership stands ready to work with the Duals Office and states to identify and implement program changes to address these needs.

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