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A REVIEW OF MEDICAID REFORM EFFORTS IN OTHER STATES

by

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INTRODUCTION

Reforming the structure of a state Medicaid program is a difficult undertaking. States are constrained by Federal standards influencing the structure of health benefits provided through the program, limiting the amount of financial participation that states may require of recipients, and directing that certain populations be covered through the program. Additionally, the financial and health care status of a significant proportion of Medicaid enrollees, including individuals needing long-term care services, the disabled, and those with very low income, makes identifying effective cost saving reforms difficult. Many Medicaid recipients enter the program with pre-existing health needs and few financial resources to devote to their care. Because of the regulatory constraints placed upon the states and the vulnerable nature of the populations covered through the program, many reform strategies that would be effective for private insurers are ineffective for Medicaid programs.

The need for strategies to provide medical services for Medicaid recipients more effectively is growing. The cost of operating a Medicaid program has risen significantly over the past five years, an average of 9.4% per year from 2000 to 2005. Although expenditure growth on Medicaid has been driven by a number of factors, perhaps the most significant is enrollment growth. From 2000 to 2005, national Medicaid enrollment rose on average 5.8% per year. This growth has been driven by economic difficulty in many states and a decrease in the number of working individuals who have access to employer-sponsored insurance benefits.

Another factor driving increasing Medicaid program expenditures (as well as the cost of all health insurance products) is the increase in the cost of providing medical services. This increase is generated, to a large extent, by technological innovation in how medical and diagnostic procedures are conducted and growth in the number and sophistication of pharmaceutical products available to beneficiaries.

An additional factor that does not affect total Medicaid spending but has placed increased pressure on states is greater scrutiny by the Federal government on "special financing" arrangements. Previously, states had exploited loopholes in Federal Medicaid regulations that allow states to generate additional Federal matching funds through complex payment arrangements with medical providers and public medical facilities. The net result of many of these arrangements was increased Federal support for Medicaid with a corresponding reduction in state financial effort. The Federal government has closed several of these loopholes, resulting in greater state Medicaid expenditure. In fiscal year 2005-06, the State of Michigan will be forced to increase General Fund support for Medicaid by $208 million to make up for lost Federal funding previously generated through special financing.

The Federal government has expressed greater willingness to grant states more flexibility in the operation of their Medicaid program through the "1115 waiver" process. In response to this change in stance by the Federal government and the cost pressures described above, a number of states have submitted 1115 waiver applications to the Federal Centers for Medicare and Medicaid Services (CMS). This paper will provide some background information on the 1115 waiver process and some reform strategies that are common in these applications, and then examine in greater depth six 1115 applications. The paper will explore the strategies described in these applications, identify some of the advantages and disadvantages that the structure described in these documents may present, and discuss the applicability of these strategies to Medicaid in the State of Michigan, as it is currently formulated.

1115 WAIVER PROCESS

Under Section 1115 of the Social Security Act, the director of the Federal Department of Health and Human Services may authorize individual pilot, experimental, or demonstration projects within the Medicaid program. The structure of these projects may violate requirements specified in the Social Security Act. States seeking the authority to establish these projects must participate in an application and review process administered by CMS.

Section 1115 waiver programs may be designed to test a new Medicaid policy concept, increase eligibility to populations not previously eligible for coverage, or permit states to contract with managed care organizations to cover enrollees. CMS evaluates the progress of these programs, measuring their impact upon use of health services, the cost and quality of medical services, and recipient satisfaction. These programs tend to be approved for a period of five years, although states can file for extensions of programs beyond this initial period.

States also have to meet a standard of Federal budget neutrality in the design of their program. States must demonstrate that over the life of an 1115 waiver program the operation of the program would not increase Federal Medicaid expenditures. Budget neutrality does not have to be achieved in each individual year during the life of the program but must, at minimum, be demonstrated cumulatively through the life of the 1115 waiver.

The amount of time and administrative effort a state will have to devote to garnering CMS approval for an 1115 waiver is difficult to predict. Some waivers have gained approval with a relatively modest amount of time and negotiation while other application processes can be quite involved. The application process is fairly straightforward. A state provides CMS with documents generally outlining its 1115 proposal and gets feedback from CMS on the concepts presented in these documents. The state then submits a formal proposal for review by CMS, which provides information on any issues or concerns related to this proposal. If these concerns are addressed, CMS negotiates conditions governing the administration of the waiver program. CMS remains involved in the process of implementing the waiver program, conducting site visits confirming that the state is ready to administer the waiver under the guidelines established.

COMMON REFORM STRATEGIES

While each of the six 1115 waiver concepts outlined in this paper is unique in its structure, these plans tend to use some common strategies aimed at increasing program efficiency and controlling cost. Some of the more common reform strategies present in recently submitted 1115 waivers are discussed in further detail.

Differing Benefit Packages

States are largely constrained by current Federal regulations from modifying the medical benefits offered across Medicaid enrollment categories. States, generally, must provide the same benefit to each Medicaid recipient, regardless of his or her reason for eligibility. The majority of the waivers examined in this paper would grant the state or a private insurer the ability to structure medical benefits for each Medicaid enrollment group differently. States are seeking the ability to modify cost-sharing requirements between enrollment groups and impose benefit caps on some services that a Medicaid enrollment group would be less apt to use.

Expansion of Cost Sharing

Federal Medicaid regulations currently restrict states from imposing cost-sharing on certain enrollment groups, limit the services that are eligible for copayments, restrict copayments to "nominal" amounts (defined as $3), and limit the ability of a provider or the state to deny services based upon nonpayment of cost-sharing. The 1115 waivers examined in this paper are universal in their request for the ability to avoid one or all of the restrictions currently placed on cost sharing.

Capitated State Reimbursement

Several states are seeking the ability to negotiate Federal financial reimbursement for Medicaid for the next few years based upon current expenditure and anticipated program growth, instead of matching state financial effort. The state would be liable for any costs above the negotiated level but could retain any savings it generated. In exchange for this cap on Federal Medicaid funding, the state would be permitted to modify the structure of its program without asking for Federal approval.

Use of Private Insurance

Another approach present in several of the waiver applications is the use of private insurance entities to provide coverage to Medicaid recipients. A number of states, including Michigan, contract with managed care organizations to provide Medicaid benefits but the reform proposals use different approaches to increase private participation in the Medicaid program. States would have the ability to provide all or a portion of the premium for employer-sponsored insurance to Medicaid-eligible individuals with access to this coverage. A more radical approach would permit states to allow private insurers to make benefit packages available to Medicaid enrollees who would have the ability to enroll in a plan of their choosing.

Health Savings Accounts

Each of the waiver proposals makes use of health savings accounts (HSAs). These accounts, (depending upon state requirements) would be available to an enrollee to purchase health products, additional insurance, health club dues, and enrollment fees for smoking cessation programs. The use of these accounts is becoming more common for private employers and HSAs are a convenient tool for private companies and public sector insurance plans to provide financial inducements for behavioral changes.

FLORIDA MEDICAID REFORM PLAN

In October 2005 the State of Florida requested, and received, permission from the Centers for Medicare and Medicaid Services to restructure its Medicaid program dramatically through the 1115 waiver process. These changes are intended to shift much of the state's Medicaid infrastructure to private insurance organizations, provide financial incentives for Medicaid recipients to practice healthy personal behavior, and create greater predictability of future Medicaid program cost for the state.

The State of Florida intends to accomplish these goals through three major programmatic changes: 1) The state will move the vast majority of Medicaid recipients from fee-for-service and less comprehensive managed care plans to private insurers; 2) the state will provide Medicaid recipients who practice desired behavior access to an account from which they can purchase

noncovered medical services and products; and 3) Florida will provide a subsidy for Medicaid-eligible individuals to purchase insurance through their employer or other private sources.

The most extensive modification included in the reform plan submitted to CMS is a proposal to increase greatly private insurance participation in the Medicaid program. Currently, the State of Florida places about one third of its enrollees into managed care plans. The state will increase this number considerably, eventually having little to no fee-for-service enrollees.

Participating insurers will receive risk-adjusted premiums for all enrolled recipients based upon their age, gender, and current health status. These insurers will have the opportunity either to bear the full risk for the medical costs for these recipients in exchange for a secondary catastrophic capitation rate, or to opt to have the State of Florida maintain the risk for catastrophic medical costs. The state believes that the option of having it retain risk for catastrophic cases will make private insurance participation in rural areas more feasible.

Insurers will have greater latitude in how health benefits are structured and can modify benefit packages to meet the needs of certain populations. Insurers can modify the amount and scope of some covered benefits and can establish coverage limits for some services. The extent to which benefit packages can be modified is limited by Federal mandates on services that must be provided to pregnant women and children (Early Periodic Screening, Diagnosis and Treatment) and additional state requirements. Any benefit plan offered to a Medicaid recipient must be deemed "actuarially equivalent" to current Medicaid benefits and only slight reductions in any type of major benefit (inpatient, primary care etc.) will be permitted.

Insurers also will have some flexibility in determining cost-sharing requirements for some enrollees. Copayments and deductibles will be capped at the cost-sharing levels currently described in the State Plan. Any copayment or deductible established by a private insurer must meet Federal standards of "nominal" cost-sharing and may be imposed only upon nonexempt enrollee groups.

The reform proposal also will allow Medicaid enrollees to have access to separate cash accounts, called "enhanced benefit accounts". The state will contribute incentive payments to these accounts if Medicaid enrollees complete activities that are likely to improve health status. Examples of such activities include covered children attending all necessary medical appointments and remaining up to date on needed immunizations, participation in a disease management program, and completion of a weight loss or smoking cessation program.

Funds in enhanced benefit accounts will be available for the purchase of health-related products not covered in the Medicaid program, such as over-the-counter drugs or health insurance after the loss of Medicaid eligibility. These funds will be available to an enrollee for up to three years after disenrollment from the Medicaid program if the individual's income is not above 200% Federal Poverty Level (FPL). Individuals who no longer receive Medicaid coverage but have funds remaining in their enhanced benefit accounts will be treated as a Medicaid expansion population.

The waiver approved by CMS also will allow the State of Florida in some instances to treat Medicaid more like a cash benefit. Medicaid enrollees with access to insurance through their workplace may use their Medicaid benefit to participate in employer-sponsored insurance or purchase insurance through a private plan if the recipient is self-employed. The state will contribute the equivalent of an enrollee’s risk-adjusted premium toward the private plan. If the enrollee's risk-adjusted premium is not sufficient, the enrollee will be responsible for the

remainder. If a Medicaid premium is higher than what is necessary for a private premium, the remainder may be used to purchase supplemental coverage or upgrade a plan to family coverage.

The plan also will increase the Disproportionate Share Hospital pool, known in Florida as the Low Income Pool, made available to safety net providers from about $650 million to $1.0 billion.

The modified Medicaid program structure will be gradually implemented by the state over the next five years. Florida will establish this structure in several predesignated pilot counties in 2006 and 2007, adding counties deemed prepared between 2008 and 2010 with a goal of statewide implementation by 2011.

SOUTH CAROLINA HEALTHY CONNECTIONS

In November 2005, the State of South Carolina resubmitted to CMS an 1115 waiver proposal that would bring about several dramatic changes in how its Medicaid program is structured. This proposal is currently being reviewed by CMS, and reflects changes to an application submitted in June. The 1115 waiver would grant Medicaid recipients greater influence in how Medicaid premiums are to be directed toward their health coverage through the use of personal health accounts (PHAs).

Currently, the State of South Carolina largely administers its Medicaid program through a fee-for-service (FFS) system; Medicaid recipients are treated by providers who bill the state for the services they provide. The reformatted structure, called South Carolina Healthy Connections, would be applied to all Medicaid enrollees, except those dually enrolled in Medicare and in foster care. Recipients would receive a personal health account that would be used to purchase medical coverage and other health-related products. Each recipient would receive a subsidy from the State of South Carolina, based upon his or her age, sex, and eligibility category. This subsidy would be calculated by using current fee for service data on expenses for similar recipients.

Personal Health Account funds either would be used to purchase a partial or full-service medical plan or in some cases could be used for self-directed medical coverage. The self-directed option would be available in a small geographic area at first to test the effectiveness of this approach and could be expanded to other areas in the coming years. Individuals using the self-directed option would be required to purchase a major medical benefits plan that covered inpatient hospitalization and laboratory services. Hospitals would bill the state Medicaid program in a manner similar to the current FFS system and would withdraw payment from the PHA for noncovered services. This option would be available only to recipients who have not had a history of acute hospitalization need and have a primary care physician.

Medicaid recipients could enroll in a managed care organization, preferred provider organization, provider-managed medical home network (MHN) or opt out of Medicaid and use their premium to enroll in a group insurance plan, most likely employer-sponsored insurance. Insurance plans participating in Healthy Connections would have to provide benefits for children consistent with current mandatory and optional Medicaid coverage levels in South Carolina and provide adults with Medicaid mandatory services, pharmacy coverage, and durable medical equipment.

Private insurers would have to demonstrate that the premium they would charge a Medicaid recipient was actuarially equivalent to the services they were providing. In an instance in which a PHA subsidy was larger than the benefit package offered by an insurer, the insurer would be prohibited from increasing the cost of the premium to collect the entire PHA allocation.

Coverage for pharmacy services would vary depending upon the plan option a Medicaid recipient chose. Enrollees purchasing private insurance products would have access to full pharmacy coverage through their insurer, those choosing the self-directed option would pay for pharmaceuticals out of their PHA, and enrollees in MHNs would have pharmacy covered through the state's current pharmacy fee-for-service structure.

After recipients were no longer eligible for Medicaid, they would be able to use a portion of any remaining balance in their PHA to purchase health insurance or products. The unused balance for a recipient re-enrolled in the program would be made available to him or her up to 12 months after the recipient last left the program.

The structure of this plan is further designed to allow greater cost-sharing for Medicaid recipients. The Healthy Connections program would increase copayments imposed through the self-directed option and the medical home networks. South Carolina also would strongly encourage insurers participating in the program to establish similar copayments as well. Cost-sharing would be imposed only on nonexempt recipients (which exclude children, pregnant women, and individuals in institutions) and an out-of-pocket maximum would be established at $250 per individual and $400 per family per year.

Healthy Connections would implement some accountability measures for participating health insurers. Health plans participating in the Healthy Connections program would be rated on measures of customer satisfaction, beneficiary medical service, and ability to create incentives for members to engage in healthy personal behavior. Plans would be required to submit information on their accreditation status, qualifications of providers in their network, utilization data, and financial incentives available to network providers. The data would be provided in the form of a report card to new enrollees. Plans more highly rated in these factors also would receive a higher proportion of automatically assigned enrollees (those not making a plan choice).

VERMONT GLOBAL COMMITMENT TO HEALTH

The State of Vermont has historically been aggressive in providing access for its citizens to Medicaid coverage. In previous years Vermont has used the Federal waiver process to provide Medicaid eligibility for uninsured adults below 150% Federal poverty level and provide prescription coverage for some Medicare recipients through the Vermont Health Access Plan (VHAP). The state also provides health coverage for children under 300% FPL through the Dr. Dynasaur SCHIP program. The expansive nature of Vermont's Medicaid program has generated concerns about its future financial viability. In FY 2006, the State of Vermont projects a deficit between designated revenue to support Medicaid and anticipated expenditures of almost $80.0 million. This number is projected to grow to about $170.0 million in FY 2010.

In response to these financial pressures, the State of Vermont submitted an 1115 waiver, titled the Global Commitment to Health, to CMS in April 2005. CMS approved this application in September 2005. The goal of this waiver is to enable the state to restructure the design of its Medicaid program free of the bureaucratic processes normally associated with these

modifications. In exchange for this freedom, the State of Vermont will accept financial liability for any cost increases above a predetermined level.

The wavier permits the Federal government to capitate payment for Medicaid services for the State of Vermont over the next five years, based upon current expenditures and a mutually agreed upon trend rate. Vermont will be financially at risk for any costs above this level but will enjoy the savings if it spends funds below the Federal reimbursement. The State of Vermont must continue to serve all mandatory populations with the standard Medicaid benefit and may not remove any Federally mandated consumer protections, such as grievance procedures or appeals rights.

Medicaid funds will be allocated to the Vermont Agency of Human Services who will engage in an inter-governmental contract with the Office of Vermont Health Access (OVHA) to operate the state Medicaid program. OVHA will serve as a public managed care organization and will be responsible for the care of the state's Medicaid enrollees.

In the waiver application, the State of Vermont specifically states that it is not the state's goal to reduce coverage for current Medicaid beneficiaries. The state is exploring some steps to make these programs more financially viable. The modifications discussed in the application include increases in cost-sharing for some enrollees, shifting some recipients from public sector coverage to employer-sponsored insurance plans, and using health savings accounts.

Vermont noted that it is currently examining creating or increasing cost-sharing for higher-income enrollees in the VHAP and Dr. Dynasaur programs. Premiums would be established for Dr. Dynasaur enrollees below 185% FPL and increased for enrollees between 185% and 300% FPL. Depending on income, these premiums would run between $20 and $90 per month. Enrollees in VHAP also would see an increase in premiums, as the income-based scale would shift from $10 to $45 per month, to $25 to $60 per month.

In addition, the state will support efforts to shift some uninsured adults from public programs to employee-sponsored insurance. The state is considering proposals to mandate that adults between 50% and 150% FPL with access to employer-sponsored insurance use this option. Instead of enrolling these recipients in VHAP, the state would provide a subsidy to eligible individuals based upon their income for the purchase of this coverage. The state also is exploring providing subsidies for unemployed workers between 150% and 300% FPL for high deductible health coverage. Families in the Dr. Dynasaur program with income over 100% FPL, with access to employer-sponsored coverage would face a similar requirement.

Vermont is currently discussing permitting, and encouraging those individuals accepting premium subsidies to use health savings accounts. The state would deposit the subsidy into the account, and individuals would have to meet minimum financial effort requirements based upon income. These accounts will be linked to a high deductible health insurance plan. This option may be used by uninsured adults between 150% and 300% FPL and premium subsidy recipients waiting for an open enrollment period at their workplace.

The application further notes that depending upon available funding the state may offer a pharmacy benefit program for low income individuals without access to coverage for prescription drugs. This concept was not discussed in depth.

The state also will explore some minor changes in reimbursement and design of Medicaid programs targeted to the mentally ill, those enrolled in the home and community-based waiver

program, individuals in need of substance abuse services, and enrollees with developmental disabilities. These changes would be focused upon greater efficiency in payment to providers and increasing access for these populations.

The waiver application mentions the implementation of a statewide chronic disease management initiative that will be partially used by the Global Commitment to Health. This initiative will focus upon identification and enrollment into disease management programs of those with chronic conditions.

Vermont requested authority under the waiver to modify its eligibility determination process for Medicaid enrollees. The state would like to offer partial access to Medicaid resources for individuals in need of specific services (such as substance abuse treatment). Vermont also requested authority to apply more stringent personal and financial resource standards for individuals seeking Medicaid long-term care coverage.

MEDICAID MODERNIZATION FOR A NEW GEORGIA

The State of Georgia has been forced to significantly increase financial support for its Medicaid program over the past five years. This increase in annual state Medicaid appropriations (about 83% from 2000 to 2005) is largely driven by growth in caseload that approached 530,000 people over this time period. The state has projected that an increasing proportion of state revenue generated over the next five years would have to be allocated to cover projected increases in Medicaid program costs.

These anticipated financial difficulties inspired the state to compile and submit a concept paper to CMS describing the structure of an 1115 waiver proposal. The expressed goal in this paper is to give the state greater flexibility to modify program benefits and create benefit and enrollment limits to meet available revenue. This greater program flexibility would be granted on the condition that Georgia operate its Medicaid program within the constraints of a predetermined cap on Federal financial participation.

Under the plan, the Federal government would cap Medicaid reimbursement to the state over the next three to five years. Federal reimbursement for Medicaid would be provided in a manner similar to a block grant. The funding amount would be established at an agreed upon base and with a predetermined, annual adjustment for projected enrollment growth and medical inflation. The State of Georgia would be completely liable for any cost above the predetermined level of Federal participation but may retain any savings generated over this time period below this fixed amount of Federal participation.

In exchange for a cap on Federal financial participation, the State of Georgia would be allowed greater flexibility in the administration of the program. In the concept paper, the state provides specific examples of concepts it currently is exploring.

One major concept outlined is permitting greater cost-sharing to be imposed upon Medicaid enrollees. Individuals who qualify for Medicaid under Federally mandated enrollment groups could be assessed copayments above the $3 "nominal" Federal standard. This copayment would be applied at a rate higher than $3 and be eligible for application to more Medicaid services than currently allowed under Federal law. The state also would be allowed to establish a sliding scale premium for mandatory Medicaid enrollees. Cost-sharing would also be imposed upon optional recipients. Copayments may be established for prescription drugs with a tiered

structure favoring greater use of generic drugs. Enrollees who are unable make the copayment would not have their prescription filled.

The state also included in its proposal a plan that would make health savings accounts available to Medicaid enrollees. The State would make contributions to these accounts to individuals practicing healthy behavior or using preventative care; these funds may be used to pay cost-sharing obligations.

The State of Georgia also discussed obtaining the authority to avoid several Federal mandates in program design. Under the waiver, the state would not have to comply with Federal Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements. Federal law requires that children receive medical, dental, hearing, and vision screening services and that Medicaid provide coverage for any medically necessary service for this population. Georgia is requesting that EPSDT be replaced with a defined benefit without coverage for any nonspecified medical service. Georgia further requests a change in current law that requires that an individual be eligible for nursing home services before becoming eligible for community-based services.

Under the waiver, the State of Georgia may cap funding for optional services or populations. As written in the concept paper, this plan permits the state to customize benefit packages to different optional eligibility groups.

Georgia also would explore providing greater information to Medicaid recipients on the cost and quality of health services available through Medicaid. The state would make available to Medicaid recipients a website that would provide information on the price of prescription drugs. The state would establish through this website the amount it will reimburse for a pharmaceutical product within each drug class and ensure that in each drug class there is one drug that will require no cost-sharing by a recipient.

IOWACARE

The State of Iowa recently completed a process examining possible Medicaid program reforms; these reforms were targeted toward decreasing program costs and reducing the number of uninsured in the state. These reforms were deemed necessary because of the significant financial pressure the operation of the Medicaid program had placed upon the state. The increase in the cost of operating Medicaid in Iowa was due to growth in caseload, increases in the cost of providing medical services, and the loss of special financing revenue that would force the state to contribute a larger share of financial resources to the program. The legislature, using concepts brought forward in this process, passed legislation enabling changes in the structure of the state Medicaid program contingent upon Federal approval.

In May 2005, the State of Iowa submitted an 1115 waiver application to CMS. The waiver application included a number of program changes. The most significant element in this waiver is a plan to expand Medicaid coverage (with a limited benefit package) to moderate income adults and newborn children using publicly affiliated health facilities. These facilities will be reimbursed through funds previously distributed through state hospital Disproportionate Share program (DSH) and Indirect Medical Education (IME) payments. The waiver was approved by CMS in July 2005.

The Medicaid expansion program, called IowaCare, covers adults who are not otherwise eligible for Medicaid under 200% Federal poverty level and pregnant women and newborn infants under

300% FPL. The provider network available to IowaCare recipients will be limited to the University of Iowa hospital and clinics, state-operated mental health facilities, and Broadlawn Hospital (a public hospital in Des Moines).

IowaCare enrollees will receive a benefit package less comprehensive than that of mandatory Medicaid enrollees. Members will be covered for inpatient hospitalization, outpatient services, physician and licensed nurse practitioner services, prescription drug coverage, and dental care. Recipients will be required to complete a comprehensive medical examination, create a personal health improvement plan and complete a web-based health risk assessment. Enrollees will be further required to have "medical home", a primary care provider who will provide and coordinate needed medical care. If the state does not have the financial resources necessary to continue full support of this program, it can reduce the benefit package or cut or freeze enrollment.

The benefit provided to pregnant women and newborns will be available to individuals up to 300% FPL who have medical costs that would force a reduction of resources to 200% FPL. Benefits will be available through any licensed hospital or health care facility unless the recipient resides in a county with a hospital or clinic administered by the University of Iowa; residents in these counties must use the University of Iowa facility. Each county will receive an allocation based upon historic costs, resources may be redistributed during the year based upon current utilization.

Cost-sharing is permitted for IowaCare members. Providers may request that enrollees contribute copayments for medical services and have the authority to deny treatment to individuals seeking nonemergency services who refuse to provide a copayment. Copayments also will be established for prescription drugs; drug copays will range between $1 and $3 depending upon the cost of the drug to the state.

Recipients enrolled in IowaCare also will be required to pay a monthly premium for their health coverage. Individuals with incomes above 100% FPL may be assessed premium payments that will add up to 5% of their annual income. Enrollees with income below 100% FPL may have premiums assessed up to 2% of their annual income. Premiums may be reduced as an inducement or a reward for enrollees who participate in activities that promote healthy living, such as chronic disease management or smoking cessation programs.

Eligible individuals placed in state mental institutions also will be covered by the expansion benefit. These facilities treat people with mental illness, developmental disabilities, and mental retardation. The state received a waiver from CMS to provide reimbursement for medical services for individuals in these facilities and for the ability to treat the network of state mental institutions as a single hospital for the purposes of Medicaid DSH payments.

The waiver application included several concepts not currently ready for implementation. One of the concepts the state is exploring is providing a subsidy for employer-sponsored insurance. IowaCare members with access to private insurance through their employer would receive a subsidy for the employee share of the premium instead of coverage through Medicaid. Employers would be required to contribute at least 50% of the cost of the premium for an employee to receive this benefit.

The state also is exploring creating health care accounts for IowaCare enrollees. Health care accounts would be available only to members who have been enrolled for at least 12 months previously. A recipient would trade one year of IowaCare coverage for a cash subsidy

deposited into his or her account. These funds could be used to purchase necessary health services and products over the year. Any account balance available at the end of the year could be withdrawn by the recipient.

The waiver application contains additional Medicaid policy changes not associated with the IowaCare program. These include modifications in long-term care reimbursement, expansion of state Home and Community-Based Waiver services for the elderly, mentally disabled and children with behavioral difficulty, Medicaid reimbursement for dietary services and smoking cessation, the creation of financial incentives to increase provider use of medical records, exploration of Medicaid provider incentive payments, and a mandate that each Medicaid enrollee under the age of 12 have access to dental services through an assigned provider.

KYHEALTH CHOICES (KENTUCKY)

In November 2005, the State of Kentucky submitted an application to CMS to modify its Medicaid program, and CMS approved the waiver in January 2006. The reform proposal, called KyHealth Choices, was submitted after over 18 months of study by state Medicaid administrators and advocacy organizations of possible Medicaid program reforms. The waiver seeks to align Medicaid benefits better to recipient needs, provide greater opportunities for Medicaid-eligible individuals to gain access to health insurance through private sources, reform the structure of long-term care in the state, and create financial incentives for Medicaid recipients to manage chronic disease. KyHealth Choices applies to all Medicaid recipients except those dually eligible for Medicare, covered working disabled and ventilator-dependent enrollees.

Kentucky began the process of Medicaid restructuring before the submission of its 1115 waiver application. The state focused its efforts on enhancing the efficiency of the administration of the Medicaid program. The state invested in a new information technology system, contracted with a private pharmacy benefit manager, enhanced utilization management activities, better enforced guidelines for care management and disease management programs, and improved communication with Medicaid providers and recipients.

KyHealth Choices proposes to have four separate Medicaid benefit packages available to enrollees instead of one standard package. The structure of covered benefits and cost-sharing provisions will be targeted to the needs of the population it serves. The application includes four benefit packages.

- Global Choices: This option is targeted to enrolled parents and pregnant women, including those on Supplemental Security Income (SSI), caretaker relatives, and women with breast or cervical cancer. Kentucky describes this option as the "standard" benefit package that would be offered to the majority of Medicaid recipients. This package includes more extensive cost-sharing measures and specified caps on benefits than any of the plans.
- Family Choices: This plan is targeted to Medicaid and State Children's Health Insurance Program (SCHIP) covered children. This package contains the fewest restrictions on covered services and cost-sharing measures. Kentucky is planning on eventually turning administration for this group over to a private insurer to manage this benefit as a separate SCHIP program.

- Comprehensive Choices: This package is targeted to nursing home-eligible elderly. The package includes all the benefits included in the Global Choices option with additional long term care services. There are two levels of coverage within this package: Basic, targeted to individuals who can receive services in the home, and High Intensity for individuals in nursing homes or hospice facilities.
- Optimum Choices: This package includes all the benefits included in the Global Choices package with additional benefits targeted towards the developmentally disabled, those in intermediate care facilities and those in facilities for the mentally retarded. Kentucky is planning on having three levels of coverage within this package: Basic for individuals who can be served in the home; Targeted for individuals who cannot be placed full-time at home but do not need full-time institutional care; and High Intensity for individuals who need full-time institutional care.

Each of the four packages provide coverage for all mandatory Medicaid services including inpatient and outpatient hospitalization, primary care services, family planning and pregnancy services, durable medical equipment, and home health. Each of the plans also contains cost-sharing measures including a tiered copay structure for pharmaceutical drugs. Children in mandatory eligibility groups, pregnant women and individuals residing in nursing facilities and hospice are exempt from many of the cost sharing provisions. Although there are copays required for a number of services, each of the packages includes an annual $225 out-of-pocket maximum amount of financial participation for Medicaid recipients.

All the plans contain coverage limits, including a limit on covered prescription drugs to four per month (three brand name). Recipients who have need for medical services above the established caps must go through a prior authorization process through the state. These caps on services are termed a "soft cap" in the waiver application. Individuals with chronic illness, who prove that these drugs are medically necessary or who use atypical antipsychotic drugs are exempt from this limit. Additional coverage limits present in these plans are a $500 per month cap on services related to autism, and a limit of long-term care services to those enrolled in the Comprehensive Choices and Optimum Choices eligibility groups.

The State of Kentucky currently has a program in place to provide subsidies to Medicaid-eligible individuals who have access to private insurance and then wrap Medicaid services around this program. This program, called the Health Insurance Purchasing Program (HIPP), currently has fewer than 20 people enrolled. The State of Kentucky is planning to put measures in place to more aggressively identify and enroll individuals eligible for this subsidy.

KyHealth Choices also will make use of chronic disease management programs. Currently, the state is developing programs for pulmonary disease, cardiovascular disease, diabetes, and obesity. These programs will use education and assessment tools to identify and treat these chronic conditions better. Financial incentives for Medicaid recipients to enroll in this program will be provided through contributions to individual health savings accounts, called "Get Healthy Accounts". The balance from these accounts may be used for Medicaid cost-sharing, or for costs associated with health clubs or smoking cessation programs.

The waiver also includes a number of proposals to modify how long-term care services are provided through Medicaid. Individuals with mental retardation, developmental disabilities, or need for nursing home services will be enrolled in either the Optimum or Comprehensive Choices plans and receive an individual plan of care. The State of Kentucky is planning to allow individuals in Optimum Choices or Comprehensive Choices to move between institutional care

and home- and community-based care as their needs change. The state is further planning to allow enrollees control over some portion of their Medicaid subsidy to direct toward services that best fit their needs.

ANALYSIS OF REFORM STRATEGIES

The 1115 waiver proposals explored above make use of common strategies to bring about greater program effectiveness or cost savings. These strategies provide a number of associated advantages and disadvantages for the respective states, Medicaid recipients, and medical providers. This section of the paper explores some of the common strategies used in the six state plans and discusses the likely advantages and disadvantages of these changes.

Using private insurance for covering Medicaid recipients is a concept presented by the states of South Carolina and Florida. These states would make risk-adjusted premiums available to enrollees for the purchase of private insurance products (in South Carolina, this allocation also could be used for self-directed coverage or enrollment in a provider-sponsored plan.) The private insurer would have some leeway to modify the structure of offered benefits.

States that shift Medicaid recipients to private coverage will benefit from a decrease in their financial exposure associated with enrollees with abnormally high medical costs, fraudulent billing practices from medical providers, and provider network maintenance.

Access to private insurance coverage also could increase recipient satisfaction (if the benefit level is similar to Medicaid coverage). Medicaid enrollees would have a greater variety of plan choices, may have the ability to pick plans that meet their anticipated health needs, and may avoid some of the stigma associated with receiving Medicaid benefits. Providers might be more willing to participate in the Medicaid program through contracts with private insurers, since contract terms could include access to patients outside of the Medicaid program with higher reimbursement rates.

States may have difficulty making participation in Medicaid financially attractive to private insurers. States that use private managed care organizations (MCOs) in Medicaid take steps to guarantee these organizations a sufficiently large pool of enrollees to guard against financial problems that can be brought on by a small number of high-cost cases. South Carolina's and Florida's plans are structured to include a larger number of organizations competing for members. Private insurers might not risk covering Medicaid members without some safeguards against high-cost cases. This may be an issue especially in South Carolina, which is exploring granting healthier enrollees the option to self-direct their care, while recipients with poorer health history would be mandated to purchase a private plan.

Each of the six states reviewed in this paper proposed more aggressive cost-sharing requirements as part of its reform strategy. The advantage of this approach is that it permits states to create financial incentives for Medicaid recipients to use health services efficiently. This could be accomplished through aligning copayments to emphasize use of generic prescription drugs or discourage inappropriate emergency room use. This is also a way to defray the cost of operating the Medicaid program.

The disadvantage associated with cost-sharing is increased risk that implementation of copayments and premiums would lead to harmful changes in recipient behavior. The income status of most Medicaid recipients is fragile and the imposition of cost-sharing has to be done

carefully to ensure that the standards imposed are within the financial resources of recipients. Studies of Medicaid cost-sharing requirements in other states have suggested that copayments and premiums improperly implemented can lead to significant reductions in the number of individuals enrolled in the Medicaid program, and reductions in necessary as well as improper use of medical services.

The waiver applications also included proposals to increase employer-based insurance coverage for Medicaid-eligible individuals. Florida and South Carolina would provide the equivalent of the enrollees' risk-based premium toward the purchase of employer-sponsored insurance. The States of Vermont, Iowa, and Kentucky also included provisions to create or expand programs providing funds for employer-based insurance for Medicaid recipients.

The use of employer-sponsored insurance for Medicaid recipients provides several significant advantages. Enrollees who take advantage of employer-sponsored insurance with a Medicaid premium in excess of their private premium may have the opportunity to extend coverage to their entire family or purchase supplemental coverage. The creation of this subsidy may provide incentive to some employers to provide some form of private health insurance for their employees, especially if they employ a large number of Medicaid enrollees. Medicaid recipients who participate in private insurance plans through their workplace will likely have access to a larger and more sophisticated provider network than the Medicaid program can provide.

Providing a subsidy for employer-sponsored insurance to Medicaid enrollees may induce organizations with high numbers of Medicaid-eligible employees to modify their premium-sharing requirements in order to maximize state participation, making insurance less affordable for other employees. Individuals previously enrolled in Medicaid who take advantage of this option may likely see increases in cost-sharing requirements and reduction in benefit levels.

Another common feature in the reviewed waivers was use of some form of health savings account. In South Carolina, this account would be used to provide a financial subsidy to cover the complete cost of purchasing health insurance. The States of Florida, Vermont, Georgia, Iowa, and Kentucky also explored using these accounts as a tool to provide financial inducement for members to practice desired behavior.

Funds in health savings accounts, depending upon the state requirements, could be used to purchase health-related products and services such as over-the-counter medication and supplemental insurance, and to cover medical copayments. Medicaid enrollees, most of whom are low-income, would certainly benefit from having access to these funds. States also would have the opportunity to use payments to these accounts as a tool to encourage positive health behavior (participation in smoking cessation or disease management programs) which could lead to cost savings for a Medicaid program.

There are a few issues associated with administering HSAs that would have to be resolved. The most significant drawback to using these accounts is administrative complexity. The state (or a contractor) would have to track the payments and balances of a large number of these accounts. This may be difficult if individuals are re-enrolled after some time out of the program. The amount of funding states would have to make available to these accounts may not be sufficient to provide enough incentive for individuals to practice the desired behavior, especially since these funds could be spent only for certain goods and services. This system also could be susceptible to fraudulent actions by some enrollees.

The States of Vermont and Georgia proposed to the Federal government that in exchange for greater freedom to modify the structure of their Medicaid program, they would accept Federal Medicaid reimbursement as a block grant. The states will be financially liable for 100% of all costs exceeding the amount of Federal reimbursement and will be able to keep Federal funds saved if their Medicaid costs are below the Federal grant.

The most significant advantage associated with this approach is flexibility. These states could modify their Medicaid program without submitting for Federal approval a state plan amendment, which is often a timely and complex process. Over the life of this agreement, the state can act quickly to modify its Medicaid program design if unanticipated needs suddenly arise. This flexibility may allow the state to operate a more efficient Medicaid system.

This structure also gives the state a greater sensitivity to the price of providing health services through Medicaid. In discussions at the state level about whether Medicaid benefits should be expanded or reduced, the variable of Federal matching funds creates an incentive for expansion or retention of services. With Federal funding established at a fixed amount debate on the proper amount of state resources that should be allocated to Medicaid will not be influenced by the specter of lost matching funds or the prospect of only financing 40% to 50% of the cost of expansions.

The most significant disadvantage a state will face with this Federal reimbursement structure is the risk associated with having Federal funds fixed for the near future. If elements outside the state's control such as inflation or changes in utilization patterns affect the price of providing medical services, the State will be forced to reduce the number of people covered through the program or pay a larger share of these costs through state funds.

This system also establishes an incentive to reduce the number of people and services covered through the Medicaid program or provider reimbursement rates. This structure creates economic incentive to reduce state Medicaid program expenditures and use excess Federal financing to supplant state effort in other policy areas.

States also are seeking more freedom to tailor medical benefits to fit the needs of different enrollment groups. This concept is explored to some extent by the States of Florida and South Carolina by permitting private insurers some ability to modify benefits. This concept is explored to a much larger extent in the proposal submitted by the State of Kentucky. Kentucky is seeking the authority to provide Medicaid benefits in four different benefit package designs. These packages include different standards for cost-sharing and caps on the use of certain benefits.

Permitting states flexibility to offer variable Medicaid benefit packages will enable them to design a Medicaid benefit that fits the needs of each enrollment group better. This approach seems to be more efficient than the use of a universal benefit across all Medicaid recipients. Cost-sharing and benefit limits can be imposed on services for each enrollment group that will lead to the most efficient use of services but also allow these groups access to the medical services that are likely most necessary to them.

The state requests through this waiver offer greater flexibility to define Medicaid benefits but also built into this program design flexibility to meet the needs of each beneficiary. The use of "soft" caps on medical services in Kentucky will allow the state to limit use of some medical services while ensuring that all medically necessary services covered through Medicaid are still available to those who need them.

Offering differing medical benefits based upon enrollment group is likely to create some confusion and more administrative complexity. The use of multiple benefit designs with differing copay requirements presents additional complexity for providers, enrollees, and the state.

This complexity becomes more apparent when a Medicaid recipient qualifies for the program through multiple categories. The state would have to determine whether an enrollee would be permitted to choose the benefit package that best fits his or her medical needs or receive the package associated with the first eligibility category the individual is determined eligible for. Recipients also could become confused if they were disenrolled from the program and then regained Medicaid eligibility through another eligibility group.

In addition, states would have to ensure that they have structures in place for recipients who need to appeal restrictions in their coverage. If the state is inefficient in determining the medical necessity of capped services, it could create a significant burden for recipients seeking coverage for needed medical services.

APPLICABILITY OF REFORM STRATEGIES TO MICHIGAN

The 1115 reform programs described in this paper are designed to overcome challenges unique to each individual state's Medicaid program. The demographics, economic conditions, private insurance market, and history of Medicaid reform efforts over the past 10 to 15 years will influence the needs a state is forced to address when designing an 1115 reform program. Because of these differing factors, reform strategies that may fit the needs of other states might not be effective or even relevant in the State of Michigan. This section discusses some of the common strategies proposed in the waiver applications described above and examines their relevance to the State of Michigan's Medicaid program, as it is currently formulated.

The strategy of using private insurance entities to cover Medicaid recipients was included in the applications submitted by the States of Florida and South Carolina. Both of these states will likely see a reduction in program cost and administrative burden through shifting enrollees from fee-for-service coverage to private insurance plans. It should be noted that Michigan Medicaid would not see this change in program cost and administrative effort by using a similar model. Michigan currently places a significant proportion (nearly two thirds) of Medicaid enrollees in private Medicaid-only managed care organizations. The majority of Michigan Medicaid enrollees who are not enrolled in managed care plans are dually eligible for Medicare benefits. Most of the positive impacts that the States of Florida and South Carolina anticipate from their waiver programs are already being enjoyed by Michigan Medicaid.

It should be further noted that the State of Michigan currently generates over $100 million in revenue and provides a significant portion of its reimbursement rates to Medicaid managed care organizations because of provider tax revenue. The provider tax in its current form is imposed upon Medicaid-only managed care organizations, maximizing the financial benefit of this plan. Any modification in the type of organization that may participate in Medicaid probably would require a change in the basis of the provider tax or would lead to a reduction in provider tax revenue available to the State of Michigan.

Another reform strategy that strongly matches current policy in the State of Michigan is the proposal submitted, and accepted by CMS, from the State of Iowa. Iowa will create an expansion population for the Medicaid program using special Federal payments to the hospitals to finance this expansion.

The State of Michigan currently operates a similar benefit. The Michigan Adult Benefits Waiver (ABW) uses unspent Federal Title XXI funds and State General Fund dollars to provide a limited medical benefit to very low income uninsured adults. Michigan in many cases makes use of county-administered health plans to provide this coverage. The major difference between current effort in the State of Michigan and the Iowa program is the eligibility requirements. Michigan makes ABW available to individuals at or below 35% FPL while the Iowa benefit is available to some people at 300% FPL.

A number of states are exploring creating or expanding programs that would provide subsidies to Medicaid-eligible individuals to purchase health insurance through their work. Michigan currently does not provide this option to recipients and could explore this as a way of creating moderate cost savings and reducing total program enrollment.

If Michigan were interested in more efficiently linking covered medical benefits to each enrollment category, the model proposed by the State of Kentucky would be a viable one to follow. Kentucky provides caps on benefits with processes in place to ensure that medically necessary services are still covered and cost-sharing that will create financial incentive to use medical services in a cost effective manner linked with an out-of-pocket maximum that keeps cost-sharing requirements from becoming overly burdensome on enrollees. Since Michigan makes use of managed care organizations to cover a significant proportion of its Medicaid population, a portion of the administrative burden associated with this more complicated benefit structure would be shared with private insurers.

It should be noted that the use of multiple benefit packages to fit each enrollment category better is a concept that is being explored on a smaller scale by the State of Michigan. The State has submitted a waiver asking that Group 2 caretaker relatives and 19- and-20-year-olds receive a benefit package with more aggressive cost-sharing and benefit caps. The implementation of these caps was largely driven by a need to generate cost savings to continue coverage to these optional groups and was not motivated by fitting needed benefits to each enrollment group.

The concept of rewarding healthy behavior with payments made to health savings accounts would fulfill a policy goal previously expressed by the Senate in the FY 2005-06 Department of Community Health (DCH) budget process. The Senate proposed providing variant cost sharing requirements to Medicaid enrollees based upon their health behavior. This concept could be another approach to create financial incentives for Medicaid recipients to engage in healthier personal behavior.

Another concept included in the FY 2005-06 Senate-passed DCH appropriation was more aggressive reliance upon cost-sharing for Medicaid recipients. Several of the states that submitted 1115 waiver applications asked for greater authority to impose copayments and premiums on Medicaid recipients.

CONCLUSION

The Medicaid reform programs discussed in this paper reflect a variety of ideas on how to better provide health coverage to the low income and disabled. Themes are evident in the substance of the proposals: A review of these applications suggests that states are seeking greater freedom to define the benefit they provide to recipients, use private sector and employer-

sponsored insurance to supplement state coverage, and impose greater financial participation on Medicaid recipients.

The Federal government seems willing to give states the flexibility to make these modifications to their programs. Aggressive waiver plans have been approved in Florida, Iowa, Kentucky and Vermont. The current climate to identify and implement more radical approaches to providing Medicaid benefits is quite favorable.

The State of Michigan has seen significant growth in enrollment in its Medicaid program and a corresponding increase in the need for financial resources to maintain the program. Over the past few years, the State has implemented numerous cost-saving program changes in an attempt to bring about some level of cost containment in the program. The majority of these programmatic changes have been small in scope, designed to save a small percentage of program costs.

The current structure of the Medicaid program in Michigan, which transfers a significant portion of the program population to managed care organizations, makes some of the reform proposals outlined in this paper unfeasible. Other concepts presented in these plans, such as exercising greater control over the structure of health benefits offered through the program, the use of small contributions to health savings accounts to create incentives for healthy behavior, and making funds available for the purchase of employer-sponsored insurance, could conceivably fit within the structure of the current Michigan Medicaid program and may generate a moderate cost savings.

The FY 2005-06 DCH budget process included significant discussion on finding new and creative ways to make health coverage available to low-income individuals in the State, permitting Medicaid recipients to have increased financial participation in their care, and creating incentives for Medicaid recipients to practice healthier personal behavior. The proposals outlined in this paper describe some of the avenues used by other states to achieve these programmatic goals.

SOURCES

Centers for Medicare and Medicaid Services. *Steps in the 1115 Demonstration Proposal Process.* Retrieved November 15, 2005, from www.cms.hhs.gov/medicaid/1115/gensteps.asp

Centers for Medicare and Medicaid Services. *1115 Waiver Research and Demonstration Projects.* Retrieved November 15, 2005, from www.cms.hss.gov/medicaid/1115/default.asp

Florida Agency for Healthcare Administration. *Florida Medicaid Reform, Approved 1115 Research and Demonstration Waiver Application.* Retrieved October 26, 2005, from http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/index.shtml

Iowa Department of Human Services. *State of Iowa Department of Human Services, IOWACARE Concept Paper: Section 1115 Waiver.* Retrieved November 15, 2005, from http://www.ime.state.ia.us/IowaCare/index.html

Kentucky Cabinet for Health and Family Services. *KY Health Choices.* Retrieved November 15, 2005 and February 2, 2006 from http://www.chfs.ky.gov/NR/rdonlyres/70AC8C04-BDEF-4A64-AB06-45FEE8285A04/0/1115waiver.pdf

Office of Governor Sonny Perdue. *Medicaid Modernization for a New Georgia.* Retrieved November 7, 2005 from http://www.wvdhhr.org/medRed/agenda/Aug16/ConceptPaper05-20.pdf

Smith, V. et al. (2005). Medicaid Spending and Policy Initiatives in State Fiscal Years 2005 and 2006, Results from a 50 State Survey. *Kaiser Commission on Medicaid and the Uninsured*

South Carolina Department of Health and Human Services. *South Carolina Medicaid Choice, An 1115 Demonstration Waiver Proposal.* Retrieved October 27, 2005 and January 12, 2006 from http://www.dhhs.state.sc.us/dhhsnew/HealthyConnections/Related.asp

Vermont Office of Health Administration. *Global Commitment to Health: 1115a Federal Medicaid Waiver.* Retrieved November 1, 2005 from http://www.ovha.state.vt.us/Globalhome.cfm

Wright, B. et al. (2005). The Impact of Increased Cost Sharing on Medicaid Enrollees. *Health Affairs, 24, 1106-1116.*