

The Need for Medicaid Reform: A State Perspective

*Responses to Committee on Energy & Commerce -Subcommittee on Health
Prepared By Seema Verma
SVC, Inc.*

The Honorable Joseph R. Pitts

- 1. Most states have implemented Medicaid managed care to some degree, but there remain certain areas of the program that do not have much managed care penetration, such as long-term care and behavioral health. Obviously, there are valid concerns about these especially vulnerable populations, but as Medicaid costs continue to balloon, do you see a need for more managed care in these areas? If so, what kind of rules, if any, should the Congress or the Administration give states with regard to Medicaid managed long-term care and/or behavioral health? Are there particular state programs that serve as an effective model for how to implement managed care in these areas of Medicaid?**

Medicaid managed care is an effective tool to achieve a variety of quality goals such as improved coordination of care and reduction in duplication of services. Managed care has also been utilized by states because it can provide budget certainty and assure adherence to specific goals and quality measures that may not exist in state run programs. Managed care can drive quality improvements due to introducing competition into the marketplace allowing health plans (MCOs) to compete for members by providing the best quality services at the most cost-effective price for the state. Managed care also allows the state to leverage private market innovation and introduce best practices to the Medicaid population. These innovations need to be paired with safeguards to assure that beneficiaries are appropriately served, quality is maintained, and utilization management efforts are not burdensome to providers. In managed care, the state retains control and has the ability to sanction or terminate MCOs that are not up to par with state standards giving even further focus on quality outcomes and compliance.

These strategies can be successfully implemented by states to manage behavioral health and long term services and supports and should be encouraged. States have been increasingly turning to Medicaid managed long-term services and supports (MLTSS) with 26 states projected to have such a program by 2014.¹ Program design varies significantly across states with different approaches such as which populations are included, whether enrollment is mandatory and what services are covered under the managed care arrangement.

¹ Truven. (2012). The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update. Retrieved online: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf

The variation of program design across states is due in part to the current delivery system, funding mechanisms and political factors which vary across states. For example, MLTSS target populations are receiving services from a variety of providers and agencies; there may be multiple entities, providers and case managers engaged in managing care. Additionally, these services and provider types have complex funding mechanisms which vary by state and influence what services are carved-out, what populations are enrolled, how rates are set and how services are coordinated. Provider availability and the urban versus rural make-up of the state are also key factors in considering managed care. Due to the complexities and variation across states, the federal government must ensure rules are flexible and allow states options to develop programs which are aligned with the unique characteristics of their state, delivery system and financing models.

There are many examples of successful managed care programs, and there are key characteristics of an effective program that should be encouraged in all models. This includes reimbursement and payment structures that require adherence to quality and operational metrics and penalties for non-compliance. Contracts that include pay-for-performance, shared savings or capitation withholds and bonuses are also effective tools to assure quality. Additionally, where appropriate based on enrollee needs, program design should facilitate the use of home and community based services over reliance on institutional services. Program design should also facilitate comprehensive and integrated care to reduce the fragmentation of service delivery with sufficient flexibility to respond to unique enrollee needs.

The federal authority to operate an MLTSS program is very complex and can include a combination of waivers and Medicaid State Plan amendments. Typically the state is required to select an authority for managed care such as a Section 1115, 1915(b) or 1915(a) waiver as well as an authority for the long term services and supports such as Section 1915(c), 1915(i) or 1915(j). The selection of the operating authority is based on the program design and policy options selected by the state. This creates a lengthy and cumbersome approval process. Reform efforts should include allowing maximum state flexibility with a streamlined federal approval process.

Additionally, states must be given more flexibility to operate these programs. For example, there are complex Medicaid managed care regulations regarding populations which may be mandatorily enrolled, limits placed on cost-sharing and requirements on the number of plans that must be offered. Additionally, disabled children and duals are exempt from mandatory enrollment. States may seek waivers for these requirements, but as previously discussed this poses a significant burden. Each state has unique characteristics and must be given the flexibility to implement managed care accordingly, taking into account considerations such as rural versus urban issues and the prevalence of managed care entities within the state.

Finally, Medicaid managed care strategies should be hinged on quality outcomes. It would be helpful for CMS to provide technical assistance by identifying potential measures of quality

related specifically to MLTSS from which states can select measures identified as most appropriate for their program.

2. Much news has been made in recent months about using Medicaid dollars to enroll individuals in private coverage through the state exchanges. What federal barriers exist for states to exercise this option, and what unanswered questions do states have with regard to premium assistance?

States looking to use a premium assistance option to cover individuals eligible for Medicaid under the expansion may implement premium assistance either as a Medicaid State Plan option or through an 1115 waiver application. While a few federal barriers and outstanding questions are relevant to both options some requirements are unique to either the Medicaid State Plan premium assistance option or the 1115 waiver option.

Table 1: Federal Requirements to Premium Assistance Options for Individual Market Coverage

Requirements	Medicaid State Plan Premium Assistance	1115 Demonstration Premium Assistance Option
State must allow choice between premium assistance and traditional Medicaid coverage	X	
Burdensome and administratively complex application, reporting, and evaluation requirements		X
Option only available through 2016		X
Cost sharing limitations	X	X
Cost-effectiveness requirements	X	X
Wrap around services and payments	X	X
Coordination with qualified health plans	X	X
Medically Frail	X	X

Medicaid Expansion through Premium Assistance as a State Plan Option: Under the Medicaid State Plan premium assistance option to implement premium assistance for individual market health insurance, whether purchased inside or outside of an Exchange, enrollees must be offered a choice of the premium assistance option for a commercial market plan or coverage through Medicaid. Options implemented through the Medicaid State Plan are not subject to the same burdensome 1115 Waiver reporting and administration requirements; however, the federal requirement to offer individuals eligible for premium assistance through the individual market premium assistance a choice between the commercial market option and Medicaid effectively requires that the implementation of two programs, a premium assistance Medicaid expansion and a traditional Medicaid expansion.

Medicaid Expansion through Premium Assistance as an 1115 Demonstration Waiver Option:

Under the 1115 demonstration waiver option a state may apply for a waiver to implement a premium assistance program for coverage in qualified health plans on the state Exchange. Through the waiver, a state may require eligible individuals to enroll into premium assistance for commercial market coverage provided that enrollees have the option of at least two commercial health plans. States apply to the Centers for Medicare and Medicaid Services (CMS) to receive 1115 demonstrations, and as a condition of the receipt of these demonstrations compile quarterly and annual reports for CMS, maintain a waiver program that is budget neutral, and conduct or contract for evaluations of the effectiveness of the innovations of the demonstration. Along with CMS, states have interest in understanding the effectiveness of their demonstrations and, in general, being able to identify what is working and what is not working and targeting areas for improvement are of key importance to all program administrators. However, the 1115 process from the initial application, to the negotiations with CMS, through program administration and reporting, can be a tremendous effort for state Medicaid agencies. Of key concern, is that in addition to the challenges of these requirements, guidance released in relationship to premium assistance demonstrations indicates that only a limited number of these demonstrations will be approved by CMS, that premium assistance demonstrations that are targeted to individuals with income between 100% of federal poverty level (FPL) and 133% of FPL² will be more likely to be approved, and that these demonstrations will only be approved through 2016, as states are eligible for innovation waivers beginning in 2017.³

Concerns With Premium Assistance Options: Under both Medicaid State Plan and 1115 Demonstration options for implementing Medicaid Expansions through premium assistance in the individual market, states must consider how they will address the restrictive federal cost sharing requirements, the requirement to provide wrap around coverage for Medicaid services that are not provided on the commercial market plan, determinations of cost-effectiveness, coordination with qualified health plans including receiving data for quality reporting, impacts to the qualified health plans on risk adjustment, reinsurance, and risk corridors, and requirements around medically frail individuals.

Cost sharing requirements

For premium assistance on the Medicaid State Plan, cost sharing may be no more burdensome for the enrollee than it would be under the Medicaid State Plan. While state Medicaid cost sharing amounts vary, the maximum amounts states may apply vary by FPL level and service description.

² In 2013, 100% of FPL is \$11,490 annually for an individual and \$23,550 annually for a family of four; 133% of FPL is \$15,282 annually for an individual and \$31,322 annually for a family of four.

³ <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>

Table 2: CMS Allowable Cost Sharing by FPL 42 CFR PART 447

	≤ 100% FPL	101% - 150% FPL	>150% FPL
Outpatient services	\$4	10% of cost the agency pays	20% of the cost the agency pays
Inpatient stay	\$75	10% of the total cost the agency pays for entire stay	20% of the total cost the agency pays for entire stay
Preferred drugs		\$4	\$4
Non-preferred drugs		\$8	20% of cost the agency pays
Non-emergency use of the emergency department		\$8	No Limit
Premiums		Not allowable	Allowable
Combined cost sharing may not exceed 5% of monthly or quarterly income.			

One of the key issues surrounding Medicaid expansion through premium assistance is the requirement that the commercial market health plans charge cost sharing that is no more than the limits under Medicaid. As commercial market health plans are developed to serve commercial market populations and not Medicaid plans, their cost sharing amounts are different than the Medicaid cost sharing amounts, and there is no ‘Medicaid’ cost sharing variation implemented for plans offered on the Exchange. Thus, implementing any cost sharing for participants under a premium assistance Medicaid expansion in a manner foreseen by CMS presents a challenge for states. Since cost sharing will be different than the CMS allowed amounts on the commercial individual market health plans, states have the options of (1) covering all member cost sharing, and charging cost sharing amounts to members on the back end after examination of claims data or (2) not requiring cost sharing for individuals in premium assistance. The first option is not only operationally difficult for states but also would result in individuals paying a copayment or coinsurance amount with a significant time-lag; this time-lag will make it less likely that members will associate the payment of the cost sharing with the service received and thus works against the intent of cost sharing which is to promote awareness among enrollees of the cost of care. The second option discounts the ability of cost sharing to impact care seeking behavior and potentially creates inequities between populations covered on traditional Medicaid that may be subject to cost sharing and the expansion group covered through premium assistance.

To make premium assistance demonstrations more attractive and more operationally feasible for states, federal policy needs to give states more flexibility in the area of cost sharing. There is a significant federal barrier in implementation of innovations around cost sharing under an 1115 demonstration with states not being able to receive cost sharing waivers for these demonstrations, especially as applies to monthly premiums or enrollment fees for enrollees

with income under 150% FPL. Cost sharing waivers that make the most sense in the context of a premium assistance demonstration are: (1) a waiver of all of the CMS allowable cost sharing amounts for the purpose of allowing the Exchange qualified health plans to charge Medicaid premium assistance enrollees the amounts charged to other enrollees of the same plan variation, limited to the enrollee's 5% of income out-of-pocket maximum amount and (2) implementing individual monthly financial contributions or premiums limited to the enrollees maximum 5% of income out-of-pocket amount that could be paid to the Medicaid agency or the qualified health plan and would assure that the enrollee is contributing towards their health. The first option assures that individuals on premium assistance demonstration are treated similarly to individuals with slightly higher incomes covered through Exchange plans and will reduce the learning curve for individuals that churn from Medicaid premium assistance to premium tax credits and cost sharing reductions on the Exchange while simultaneously assuring that Medicaid premium assistance enrollees are protected by the 5% of income out-of-pocket limit. The second option ensures that all enrollees are contributing to their health care without creating additional burdens on qualified health plans to comply with Medicaid cost sharing requirements, or requiring enrollee payment of cost sharing for services after an extensive time-lag. In addition, a required monthly payment in place of the CMS allowable copayment and coinsurance schedule offers more predictable cost sharing for enrollees and required monthly payments may be more affordable for enrollees than the allowable CMS cost sharing amounts. Under this model states have the ability to implement innovative incentive programs that provide for the elimination or reduction of the required monthly cost sharing for the completion of targeted healthy behaviors. Monthly contributions may be a more beneficial and less burdensome implementation of cost sharing under a premium assistance Medicaid expansion for enrollees, states, and qualified health plans.

Wrap Around Services and Payments

For premium assistance Medicaid expansions implemented either through the Medicaid State Plan or through an 1115 demonstration waiver, CMS requires that states provide wrap around services to beneficiaries for benefits that are covered on the Medicaid State Plan but not on the commercial market qualified health plan. The services that may be required to be wrapped around include Early Periodic Screening, Diagnosis, and Testing (EPSDT) for individuals aged 19 and 20, assurance of non-emergency transportation services, and potentially behavioral health services. Individuals enrolled on premium assistance through state Exchange qualified health plans are receiving coverage that is deemed adequate for all individuals that qualify for a premium tax credit or cost sharing reduction. Individuals receiving premium tax credits and cost sharing reductions are not a substantially different population than the Medicaid expansion population that may receive premium assistance. Requiring these wrap around services creates administrative difficulties for states as individuals enrolled in premium assistance through qualified health plans would also have to be issued a Medicaid member card to access wrap around services. The ACA indicated that Medicaid expansion populations should be provided benchmark or benchmark equivalent coverage based on section 1937 of the Social Security Act;

these coverage packages are in general more aligned with commercial coverage than Medicaid coverage. The requirement to wrap benefits for benchmark or benchmark equivalent coverage basically makes this coverage equal to Medicaid coverage instead of being aligned with commercial coverage. This requirement also serves as a disadvantage to participants and may be confusing as they may remain in the same plan but will lose these benefits if their income increases and they become eligible for premium tax credits. In light of this and considering the similarity of the populations, especially the Medicaid expansion population with income from 100% to 133% of FPL that would be eligible for premium tax credits and cost sharing reductions if a state did not expand Medicaid, the requirement to offer wrap around services should be reconsidered.

In addition to the requirement to wrap around services, Medicaid programs that are interested in premium assistance expansions are required to wrap around payments to federally-qualified health centers. In Medicaid, these health centers are required to be paid based on the prospective payment system (PPS) which bases payment on the cost of providing services for the individual health center, not on the established Medicaid fee schedule. This policy assures that these essential community providers have sufficient funds to cover the cost of serving the low income populations. However, in the context of a premium assistance demonstration, this policy becomes redundant. Qualified health plans are required at 45 CFR §156.235(e) to pay federally-qualified health centers at least the Medicaid PPS rate or another mutually agreed upon rate that is not less than the PPS rate. When Medicaid enrollees are served through qualified health plans under premium assistance, any services they receive will already be paid at a minimum of the PPS rate, thus the requirement to wrap around payments to these health centers is unnecessary. To streamline the process for states seeking premium assistance demonstrations, CMS should make clear that this requirement does not apply to individuals whose services at federally-qualified health centers are reimbursed by qualified health plans.

Coordination with Qualified Health Plans

Qualified health plans on state Exchanges that may be leveraged under a premium assistance expansion in an Exchange are required to meet quality, transparency, benefit, network adequacy and non-discrimination requirements. Qualified health plans may offer coverage to individuals that are eligible for premium tax credits and cost sharing reductions with income at or above 100% FPL. To assure that qualified health plans are willing and able to participate in Medicaid premium assistance demonstrations it is essential to minimize additional reporting or administrative requirements on these plans that are above and beyond what the qualified health plan would be required to report in the Exchange. It is currently unclear exactly what reporting will be required of qualified health plans serving Medicaid premium assistance recipients in an Exchange as CMS has not defined this; the guidance only indicates that ‘appropriate data’ will be required.⁴ However, imposition of burdensome reporting

⁴ <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>

requirements on qualified health plans that enroll Medicaid premium assistance enrollees would serve as a federal barrier to implementation of a premium assistance demonstration as qualified health plans may decline to accept Medicaid premium assistance enrollees.

Risk Adjustment, Reinsurance, and Risk Corridors

Risk Adjustment, Reinsurance, and Risk Corridors are programs initiated by the ACA that aim to stabilize premium cost. Risk Adjustment is a permanent program that transfers money from health insurance plans with lower enrollee morbidity to health insurance plans with higher enrollee morbidity and applies to all individual and small group health plans inside and outside the Exchange. Reinsurance is a temporary program that collects funds from all self-insured and fully insured commercial health insurance plans and uses these funds to provide reinsurance for high cost claims to individual market health insurance plans. Risk Corridors is also a temporary program that protects against losses for individual health insurance plans in the Exchange. How these programs apply in the context of utilizing Medicaid to provide premium assistance in Exchanges has not been clarified. For example, will Reinsurance apply for the Medicaid population enrolled into qualified health plans or are Medicaid agencies required to provide a similar program for the qualified health plans for their enrollees? Is the Medicaid population eligible for the Risk Corridor program and will they be included in the Risk Adjustment program? Will the federal government pay for costs related to these programs on behalf of States? For states interested in setting up premium assistance for Medicaid eligible individuals to enroll in state Exchanges these are key questions and without understanding the implications it may be difficult to attain the buy in of qualified health plans.

Medically Frail

All states implementing Medicaid expansions, whether through premium assistance or other methods, are required to come up with a definition for medically frail individuals and assure that these individuals are given a choice between Medicaid expansion coverage and coverage that offers all of the benefits available on the Medicaid State Plan. The importance of providing appropriate services and care coordination to individuals with serious or disabling health conditions is not questioned. Care that is not appropriate for individuals with serious and disabling health conditions can lead to increased cost and decreases in health outcomes. However, the CMS requirements around how states must treat populations considered 'medically frail' make it more difficult for states to appropriately address the needs of these populations.

While not mentioned in the ACA, in promulgating regulations for implementation of Medicaid expansions CMS updated the definition of medically frail individuals to make it more specific. In defining medically frail, based on the final regulations,⁵ states must at least include individuals with: (1) a disabling mental disorder, (2) a chronic substance use disorders, (3) serious and

⁵ 42 CFR §440.315(f)

complex medical conditions, (4) a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, or (5) individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the Medicaid State Plan criteria.

Individuals qualifying as medically frail may not be mandatorily enrolled into an alternative benefit plan that provides less than the Medicaid State Plan benefits states, including the alternative benefit plan that would cover individuals receiving premium assistance in state Exchanges. To meet this requirement, states have to develop processes to identify medically frail individuals at enrollment, and will likely have to develop at least two alternative benefit plans, one indexed to the Medicaid State Plan for medically frail individuals and one indexed to the commercial market essential health benefits for individuals receiving premium assistance. Policies should be explored on how to ensure appropriate care for medically frail individuals through qualified health plans and states should be allowed more flexibility in designing programs for the medically frail. The current policy of requiring a choice between benefits equal to the Medicaid State Plan and the benefits offered to non-medically frail individuals in a Medicaid expansion creates additional complexity for states and enrollees but does not assure the provision of appropriate services to this population.

Cost- Effectiveness

Implementing a Medicaid expansion through premium assistance in the individual market either through the Medicaid State Plan or through an 1115 demonstration waiver requires that the state show that the coverage on the individual market is cost-effective when compared with Medicaid expansion coverage. Traditionally, cost-effectiveness has required that the commercial market coverage is no more expensive than Medicaid coverage, inclusive of administrative costs and any wrap around services or cost sharing. However, due to higher provider reimbursements and administrative costs among state Exchange qualified health plans, total health care costs in a state Exchange plan may be 20% to 40% higher than in a Medicaid operated plan.⁶ While covering Medicaid individuals through Exchange plans may have benefits beyond total cost including improved access to providers, improved outcomes related to individuals that churn between Medicaid and Exchange coverage, and greater efficiency overall in the Exchange due to the provision of coverage for more Exchange lives, it is unclear how to incorporate these concepts under a traditional Medicaid premium assistance cost-effectiveness model.

For Medicaid premium assistance expansions implemented through 1115 demonstrations, alternative budget neutrality or cost effectiveness models have been developed that will allow states to include analysis of systematic impacts of premium assistance programs; however, what

⁶ <http://publications.milliman.com/publications/healthreform/pdfs/considerations-for-medicaid-expansion.pdf>

the expectations will be for states regarding reporting and data analysis on cost-effectiveness if a demonstration premium assistance demonstration is approved remains unknown. In general, expectations around the budget neutrality process have been unclear for states seeking 1115 waivers and for all demonstrations CMS needs to provide additional guidance on how the budget neutrality process works and what submissions are required to show budget neutrality.

Outstanding Questions

What cost-effectiveness methodology applies to the Medicaid State Plan premium assistance option?

How will states that are conducting premium assistance demonstrations under 1115 authority, show they have met their cost-effectiveness/budget neutrality requirements over the course of the demonstration?

What provisions around cost sharing may be waived under an 1115 premium assistance demonstration?

What provisions regarding wrap around services may be waived under an 1115 premium assistance demonstration?

How do the Risk Adjustment, Reinsurance, and Risk Corridors apply for qualified health plans that enroll individuals through Medicaid premium assistance?

Recommendations

The following actions would help to ameliorate some of the federal barriers to implementing Medicaid expansion premium assistance options.

- Allow states to mandate enrollment into a Medicaid State Plan premium assistance option for the individual market as they can for premium assistance in the group market.
- Streamline and make more transparent the 1115 application and approval process and the budget neutrality and cost-effectiveness requirements.
- Allow states to review 1115 premium assistance demonstrations for the full demonstration period of 5 years, instead of limited to a coverage period through 2016. Innovation waivers will be available beginning in 2017, however, states will have to invest significant resources into the analysis and development of such waivers.
- Allow for states to use monthly required contributions or premiums for individuals at all income levels, including those with incomes below 150% of FPL.
- Allow states to use the qualified health plans standard cost sharing limited to 5% of income maximum out of pocket as an alternative to CMS allowable cost sharing under premium assistance demonstrations.

- Clarify the provisions that may be waived and those that may not. The granting of waivers is inconsistent at best. One state may receive a waiver of a certain provision and another state may be denied a waiver on the same provision.
- Allow states to be exempt from the requirement to provide wrap around services for EPSDT and non-emergency transportation.
- Clarify that wrap around payments to federally-qualified health centers are not required under a premium assistance option, as qualified health plans are already required to pay at least this rate.
- Clarify reporting expectations for qualified health plans covering Medicaid participants under premium assistance options.
- Clarify the policy around Risk Adjustment, Reinsurance, and Risk Corridors for qualified enrolling individuals through Medicaid premium assistance.
- Provide detail on how cost-effectiveness will be determined through a Medicaid State Plan option and how states will be required to demonstrate ongoing cost-effectiveness under an 1115 premium assistance demonstration.

The Honorable Michael Burgess

1. **In your testimony, you cite reduced provider reimbursement rates as a reason behind the decreasing number of primary care providers willing to accept Medicaid patients.**

How can the federal government ensure provider rates are set at levels that encourage provider buy-in?

States have been forced to make the difficult decision to reduce provider reimbursement rates as there are few alternative models under the current regulatory structure available which can provide such short-term and immediate cost-savings. The ACA maintenance of effort (MOE) requires states to maintain eligibility levels. Additionally, there are not many optional benefits to cut. States must also be cautious to ensure that reductions in covered benefits do not lead to shifting care to more expensive settings. For example, cuts in primary care can lead to increased visits to the emergency department.

States need better tools to manage costs. Any federal efforts to set rates must consider financing and should not be an unfunded mandate placed on states. Strategies designed to better manage care and in turn generate cost savings through improved coordination of care, increased efficiencies and reduction in duplication of services are difficult and lengthy to implement. Specifically, the State Plan Amendment and waiver review process for such program changes are onerous and delay states' ability to realize savings. By reducing the length of time required for these review processes, states would be better positioned to implement innovative management strategies likely to generate cost-savings. This would reduce states' tendency to utilize provider rate cuts as the first go-to strategy for cost-containment.

- 2. As one of the major architects of Indiana’s Medicaid 1115 Waiver program, “Healthy Indiana”, you helped the state implement a consumer-driven approach to Medicaid reform, enabling Medicaid beneficiaries to get a high-deductible health plan and a health savings account.**

How did this consumer-driven approach to Medicaid affect patient access to providers?

The state legislation mandates that providers be paid at Medicare rates. One of the goals of requiring these rates (which are higher than those paid to providers for traditional Medicaid enrollees) is to ensure adequate provider network access for HIP members. HIP networks are assessed by State staff on a quarterly basis to ensure primary and specialist adequacy meets standards. If a provider is not available in network within program allowed distances (30 miles for primary and 60 miles for specialists), members are allowed to visit out-of-network providers. This ensures members receive needed care. During the first year of HIP MCOs worked diligently to build networks and continue these efforts on an ongoing basis. No significant gaps in network adequacy exist currently.

Additionally, outcomes data indicates enrollees are appropriately accessing and utilizing services. Unlike traditional Medicaid, HIP decreases inappropriate ER usage. HIP enrollees pay copayments for inappropriate (non-emergent) ER use. During a 12 month enrollment period, HIP enrollees on average showed a 14.8% decline in non-emergent ER use and increased their physician office visits by 25%, demonstrating that the consumer-driven structure of the plan does not discourage participants from seeking needed care. HIP helps members understand the importance of where and when they seek health care services. Use of care among new and established HIP members over a 6 month time period demonstrates high growth in preventive care and primary care services, and a decrease in non-emergent use of the ER. Data indicates 90% of established enrollees utilize primary care.

Indiana has received confirmation of the greater access to much needed care provided by the HIP program for uninsured, low income Hoosiers from the managed care organizations for HIP, health care providers, and professional associations representing health care providers.

For example, the CEO of MDwise, one of the managed care organizations for HIP, reported that the company’s market research shows very high member satisfaction with HIP, and 83% of MDwise’s HIP members received care as soon as they thought they needed it. In addition, MDwise reported that 76% of its HIP members take medications and are compliant with medication regimens and 96% of members are being treated for a chronic condition: thus, showing that these individuals are getting much needed access to care as compared to before they were enrolled in HIP. Lastly, MDwise informed Indiana that it has received numerous member stories regarding HIP members’ access to care that they had not received before enrolling in the program.

3. **Nearly 10% of Medicaid beneficiaries have third-party coverage, in addition to their Medicaid coverage. In these circumstances, the third party payer is required to pay prior to Medicaid, as Medicaid, by statute, is the “payor of last resort.” The Deficit Reduction Act of 2005 worked to ensure Medicaid is the payer of last resort by requiring states to amend their Medicaid programs with certain provisions.**
 - a. **Are you aware of what challenges states continue to face in recovering third-party payments?**
 - b. **What impediments prevent third-party payers from following through on their payments?**

States face a number of challenges with regards to recovering third party payments. These challenges come in the form of administrative and enforcement complexities for the state Medicaid agency, providers, and third party payers.

Medicaid Agency

In order to be in compliance with state and federal laws, Medicaid agencies are required to perform a number of functions that are complex and difficult to enforce. First, agencies must collect information on any third party payers. While other state agencies can provide verification mechanisms (i.e. the Bureau of Motor Vehicles for accident compensation or a Department of Child Services to see if a parent has received health coverage for a child), Medicaid applicants and beneficiaries may not be forthcoming with information about third party payers – especially if they believe that admission of such coverage may jeopardize their eligibility for Medicaid. The state makes efforts to locate member third party liability (TPL) coverage and providers also provide this information at times. However, there is no guarantee that TPL information will be found prior to claims payment.

Once the Medicaid Agency has managed to collect information about these third party payers, they must also capture and process information regarding the third party payer coverage. This coverage may be complex and highly varied from person to person. Before the state Medicaid agency decides to pursue payment from a third party, it should verify that the services or items for which it is requesting payment are also covered by the Medicaid State Plan. If the services are not covered by the Medicaid State Plan, the third party payer is not obligated to provide the Medicaid agency with compensation.

Even when the services or items are covered by the Medicaid State Plan, payment collection can be difficult, as there is rarely any penalty for non-compliant third party payers. In an effort to address this issue, Kentucky has begun to seek implementation of monetary fines and penalties, license suspension, and/or revocation; and the state has classified non-compliance as an unfair trade practice.

Providers

Providers have a set period of time within which they must submit their claims; and many may delay claim submission. When a payment is recovered from a provider, it may not be within the filing deadline, and it would be too late to file a new claim.

Third Party Payers

It is the objective of the third party payers to retain as much of their income as possible, so third party payers impose a number of barriers for Medicaid agencies that would seek to recover funding. Some of these barriers are as basic as refusing to acknowledge that the organization meets the definition of a “third party” as outlined in the Deficit Reduction Act (DRA) legislation. If the organization recognizes that it is in fact a third party payer, it may use HIPAA’s privacy focus as an excuse to deny requests for sharing membership files. This denial poses a challenge to Medicaid agencies in spite of a letter from CMS to Patrick Ryan, Illinois Medicaid TPL Director dated July 8, 2009 in which CMS clarified that this sort of data sharing is permissible under HIPAA. Third party payers also resist sharing information with third parties acting on behalf of the state Medicaid agency, such as contractors or managed care entities, in spite of the fact that these parties are supposed to be considered an extension of the state Medicaid agency.

Even when third party payers do acknowledge their beneficiaries and the entity tasked with funding recovery, it can still be difficult for Medicaid agencies to recover all of the funds they should. Information-sharing from third party to Medicaid agency may be incomplete, and service coverage may be sparse, so identifying matches between service provided and service covered by the third party payer may be difficult. In addition, payers may confuse, delay, or halt the recovery process by misusing Prior Authorization denials, requesting additional information, or by simply refusing to respond to recovery requests.

4. How does the recent increased use of managed care in Medicaid influence third-party liability issues?

The increased use of managed care has presented state Medicaid agencies with a series of options on how they would like to designate the responsibility of reimbursement recovery from third party payers. While some states have opted to exclude beneficiaries with third party payers from managed care, other states have allowed enrollment with managed care, in which the state may either retain the TPL responsibilities or designate the Managed Care Organization as responsible for recovering compensation from third party payers. In the latter, the state would adjust the capitation payment to recognize other funding sources for provider reimbursement.

Regardless of whether funding recovery is subsequently handled by the state Medicaid agency or the Managed Care Organization, there are some unique challenges to coordinating that funding recovery. For example, in a commercial market, third party coverage may change and claims may be sent to the wrong carrier or contain outdated or incorrect information (i.e. old

group numbers or policy numbers). Third party payers may also fail to provide sufficient information to the claims processor regarding the beneficiary. This means that the recovery efforts may require more extensive research and processing time, which can create a significant administrative burden for the entity attempting to recover funding.

Managed care influences TPL differently state to state. In some states if the recipient has other coverage they cannot be on a Managed Care plan so that the State can recover any TPL savings on the Fee for Service (FFS) recipients. For example, Massachusetts structures their TPL program in this manner today.

In most states where MCO recipients can have other coverage, MCOs are required to perform TPL functions. There may be a lack of incentive for the MCOs to identify TPL and recover as it may reduce their claims and ultimately affect future capitation rate setting. Additionally, many MCOs have a parent company that also has a FFS population. These MCOs may choose not to recover from within their own corporation as they should.

Additionally, in states where Medicaid MCOs have been delegated authority to perform their own TPL identification and recovery, they run into roadblocks collecting from other payers. TPL providers do not recognize the right of the Medicaid MCOs to collect. They reference DRA language which gives the states the right of recovery and not the MCO. As a result, CMS has recently posted guidance on their website empowering MCOs, stating that they are to be recognized as an agent of the state Medicaid agency; some states, for example Ohio and Colorado, have made compatible statutory updates.

5. The dramatic expansion of Medicaid under ACA exacerbates the administration complexity of determining eligibility and tracking enrollees. How would this additional complexity influence the ability of states to ensure third-parties pay what they are responsible for?

Expansion of Medicaid under the ACA may have two very different impacts on a state's ability to ensure third parties pay what they are responsible for: 1) the increased caseload and increased variety of coverage options may make it even more difficult to track beneficiary coverage; and 2) the increased coordination between the federal and state governments, particularly in the area of technology and information-sharing may help states to identify possible third party payers that they might not have identified otherwise. The identification of these third party payers will only be helpful, however, if states are able to translate that information into increased service and item cost recovery.

In order to improve third party payments, federal and state governments will likely need to coordinate to send a clear and consistent message to third parties, addressing the common excuses for avoiding or denying payment. Failure to address these excuses while proceeding with a Medicaid expansion will only lead to expanded failure to recover funding from third party payers, and Medicaid will continue to, in practice, serve as the payer of first resort.

- 1. In your testimony you highlight the fact that current Medicaid regulations “disempower individuals from taking responsibility for their health” and that within the Medicaid program “there are no incentives for states to achieve quality outcomes.” These two areas must be addressed in order to achieve better health outcomes and responsible state and federal healthcare spending.**

The concept of patient activation and the robust science behind it is rooted in the notion of empowering individuals. By definition, activated patients effectively manage their own health to the degree that they are competent to do so. Once a provider understands what an individual is and is not capable of, the provider can identify behavior change opportunities that are realistic and achievable. Through tailored support and education, patients become more successful managers of their health and healthcare. This approach has proven to reduce emergency room visits, hospital admits and readmission, increase medication adherence and improve chronic condition management.

A limited number of Medicaid programs are utilizing the Patient Activation Measure survey in order to improve allocation of resources and provide real patient-centered care-to treat the individual, not simply their symptoms. Organizations using PAM have demonstrated improved outcomes and cost savings of \$300 to \$3,700 per patient per year depending on the program. Cost savings are driven by fewer ER visits and hospital admits.

Do you agree that in order to substantially improve outcomes and lower healthcare spending, patients must be engaged in managing their own health? Should federal Medicaid regulations facilitate the incorporation of patient activation measurement in state’s Medicaid programs?

Medicaid beneficiaries must be engaged in managing their own health; an essential component of Medicaid programs should be to improve health outcomes and lower health care spending. There are different ways to incentivize Medicaid beneficiaries to be more proactive in their health care decision making. States I have worked with have used high-deductible health plans with financial responsibility along with incentives to waive such financial responsibility with the completion of certain healthy behaviors, such as obtaining preventative services or participating in a weight loss or smoking cessation program. Other measures that can be taken to encourage beneficiaries to become more engaged in managing their care and making better health care decisions are education, coaching, and involving beneficiaries in the management of their care or, otherwise, making them an integral part of their health care team. However, the member must have “skin in the game,” and a vested interest and incentive to improving their health.

The Patient Activation Measurement (PAM), a survey that measures how “activated” or involved a patient is with their care, could be a useful tool for health care providers to utilize in understanding where their patients fall on the “activation” or involvement scale. This better understanding could assist health care providers in knowing how much encouragement or

coaching patients might need to become more “activated” or involved in their health care decisions and management and in tailoring the patients’ care to better meet their needs.

While I do believe the PAM survey could be beneficial, the current federal Medicaid regulations do not call for States to implement any type of patient survey similar to the PAM survey, and States would need to evaluate how it could be implemented within their programs.

In sum, we need to do better than simply paying Medicaid beneficiaries’ claims. In order to bend the cost curve and improve health outcomes, we need to employ multiple strategies, and such strategies cannot exclude incentivizing beneficiaries to be directly involved with and responsible for their health care decisions and disease management. The current facade of Medicaid is outdated and must change in order to include the up-to-date knowledge we have gained from the private market and studies regarding the benefits of beneficiary accountability and involvement in their health care decisions.

The Honorable Gus Bilirakis

- 1. Can you talk about your work with states and working with CMS on obtaining an 1115 waiver? Florida took almost two years to get an 1115 Medicaid waiver for a state wide managed care plan. What have other states tried through the waiver process? How was interacting with CMS during this process, and how long did it take for CMS to approve the waiver?**

The timing, process, and resulting waived provisions for states going through an 1115 waiver process varies greatly and is inconsistent across different states and 1115 demonstration applications. Some States have seen their waivers go through in a matter of weeks, or months, whereas other States may take years to receive responses, if there is a response. Another concern is the demonstration periods. More recently, in the case of waiver extensions, CMS is granting 1-year waiver, as opposed to the maximum 3 year waiver periods. While they indicate this is due to wanting to understand the impact of the ACA, waiver applications represent a significant effort for States and having to develop and negotiate the applications within a year is a large undertaking. The short periods also do not allow for relevant data to be collected to inform CMS of the waiver’s impact.

States can also be faced with the challenge of CMS’ shifting position on policy issues during the waiver approval process. For example, Louisiana submitted a 1915(c) waiver request in May 2008 for an Adult Residential Care (Assisted Living) Waiver. The waiver included a provision to convert empty nursing home stock into new residential settings as has been done with CMS approval in many states. The state responded to a CMS Request for Additional Information, and upon submission was given the impression that the only outstanding issue was migration of the waiver application to a new version. In the time that elapsed while the state migrated to the new version, CMS’s position changed and the state was informed verbally that the waiver would not be approved as the conversion option would not meet the new CMS definition of a home

and community based setting. While the state argued that the proposal met all the published guidelines at the time, CMS formally denied the waiver in August 2011, over three years past the original submission.

Many states have noted slow progress in negotiations with CMS including consistent back and forth in questions, clarifications and requests for revisions. It is not unheard of for waiver negotiations to take upwards of a year or more. However, some states do experience a more streamlined approval process with CMS, and approvals for 1115 demonstrations can be granted quickly. For example, in 2010 Louisiana received approval in approximately 30 days for an 1115 waiver to provide primary and behavioral health care benefits to uninsured adults in the greater New Orleans region which was put together to serve as a bridge from the expiration of a post-Katrina federal primary care grant.

2. The recent Oregon Medicaid study published in the New England Journal of Medicine seemed to show that individuals on Medicaid did not have better health outcomes than individuals without health insurance. Have you seen the study and what are your thoughts on it?

Despite the growing investment of states in their Medicaid programs, this study in the New England Journal of Medicine “showed that Medicaid coverage generated no significant improvements in measured physical health outcomes.”⁷ Medicaid coverage alone does not guarantee improved care or outcomes. This is a key issue for states to consider as they contemplate Medicaid expansion.

The focus of Medicaid reform must be on rethinking how care is delivered and ensuring access and quality outcomes. Providing a Medicaid card to new recipients, without fundamental restructuring of the program will only increase taxpayer spending without delivering results. Medicaid must be transformed to focus on access, outcomes and quality. This requires a realignment of incentives for states, providers, and recipients; for maximum effect all health system actors must have common goals. Federal policy should support this realignment and provide states with the tools to implement innovative strategies such as shared savings models, provider bonuses, financial incentive, and bundled payments.

⁷ Baicker, K., Taubman, S., Allen, H., Bernstein, M., Gruber, J., Newhouse, J., Schneider, E., Wright, B., Zaslavsky, A., & Finkelstein, A. (2013). The Oregon Experiment – Effects of Medicaid on Clinical Outcomes. *New England Journal of Medicine*, 368, 1712-22. Retrieved online: <http://www.nejm.org/doi/full/10.1056/NEJMsa1212321#t=abstract>