

# Partnership for Medicaid Partnership for Medicaid

## Medicaid Policy Options June 2011

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

Recognizing there are inefficiencies in the program and improvements that could be made, the Partnership has been an active participant in offering practical solutions over the last six years. We proposed an emergency room diversion program that was included in the Deficit Reduction Act of 2006, supported allowing Medicaid MCOs to participate in the Medicaid drug rebate program (which was included in the ACA), worked with the Medicaid Commission, and most recently offered detailed proposals to the National Commission on Fiscal Responsibility and Reform. This document builds on our prior proposals and is a good faith effort on the part of providers and other stakeholders in the program to offer viable solutions.

### **Long Term Care Financing**

The Partnership supports substantial long term care financing reform. Medicaid was never intended to be the primary provider of long term care coverage, but that's how things have evolved. Surveys show that a majority of the public believes that Medicare covers nursing home stays and other long term care. There needs to be significant public education about this gap in financing for LTC to build understanding of the need for reform.

Current Medicaid law that is designed to prevent the transfer of assets in order to gain Medicaid eligibility can be circumvented by people with sufficient means to establish trusts and other instruments that are legal and may be an appropriate estate planning approach. Even for persons who use all their assets for LTC, the cost of LTC is so disproportionate to income and savings that Medicaid necessarily becomes the primary payer. A more universal approach is needed for both funding and eligibility.

Long term care financing reform must include incentives for individual responsibility to relieve the burden on Medicaid, but it must also include a safety net for those who are genuinely needy. With the baby boom generation aging, other reforms should begin immediately.

### **Home and Community-Based Services**

States have considerable flexibility in designing and expanding HCBS. In particular the 1915(i) state plan amendment allows states to target specific sets of services to specific diagnostic groups

prior to needing institutional care. This approach would reduce Medicaid spending in the short term through reduced ER visits and hospital re/admissions and in the long term by preventing institutional care for those with debilitating chronic conditions such as hepatitis, HIV, developmental disabilities, severe mental illness and complications from long-untreated chronic illnesses. There are three changes to current law that would increase state flexibility for the HCBS 1915(i) option:

- First, current law requires the 1915(i) to be implemented statewide, but further flexibility might allow for a regional approach instead (targeting high need and/or high cost areas).
- Second, the law could permit states to expand the types of HCBS services allowable without needing Secretary approval, such as adding chronic disease management, health education, or other services.
- Third, the law currently specifies certain services allowable to persons with chronic mental illness (day treatment, psychosocial rehabilitation, clinic services, etc.), but this provision could be widened to include other populations (such as frequent users of health systems).

States could be given the flexibility to make these programmatic changes in a way that is budget-neutral, similar to other Medicaid waiver options.

### **Supportive Housing**

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

### **Care Coordination for Chronic Conditions**

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

recent Milliman Research Report notes that failing to coordinate care for Medicaid recipients with mental illnesses and addiction disorders alone may cost the system \$300 billion annually.

The Partnership for Medicaid supports expanding care coordination for all patients, especially those with chronic conditions, and strengthening linkages among preventive, primary, acute, and long-term care services and supports. These efforts can include: enrolling beneficiaries with chronic conditions in programs that coordinate care through the provision of services including drugs and care management, as well as ongoing monitoring of health conditions; state initiatives under the new Medicaid Health Homes option; new Medicaid ACO models including a pediatric ACO model; innovative managed care arrangements; shared savings models involving state Medicaid agencies, hospitals and health plans to reduce ED utilization; and other models of care integration.

At the same time, any care coordination requirement must be accompanied by risk adjustment and payment mechanisms to counter adverse risk selection and assure adequate provider and plan reimbursement; these mechanisms may take the form of new statutory provisions or rigorous implementation of existing BBA '97 requirements.

### **Care Coordination for Pregnant Women**

Pregnancy medical homes hold great promise for achieving cost-savings and improved outcomes. The North Carolina Department of Medicaid's pregnancy medical home program is expected to save the state \$10 million in the second year of implementation, with increased savings as the program expands to cover all Medicaid eligible pregnancies. Program quality markers will ensure against elective deliveries before 39 weeks gestation, decrease the rate of cesarean sections among this patient population, facilitate provider use of interventions to prevent premature deliveries, and guarantee patients risk screening and local care and case management. This innovative program has been embraced by the medical community and by patients. The Partnership supports programs like this that benefit patients, while reducing costs.

### **Simplify and Align Enrollment Periods for Health Coverage to Improve Quality**

Typical private coverage and other public programs such as Medicare have an annual or 12-month enrollment period that allows for continuous, stable coverage for enrollees. In contrast, after their initial application and enrollment, Medicaid enrollees must periodically prove that they are eligible for Medicaid. Because of the complex administrative processes, families often do not know when their Medicaid certification periods expire, may be dropped without knowing it, and do not know why they lost coverage. Those who have been disenrolled typically say they wanted to retain their insurance coverage, but did not know how to do so. This leads to what is commonly known as "churning." Churning happens when people enroll in Medicaid, only to subsequently lose their coverage, despite still being eligible, because of inefficient and cumbersome paperwork requirements. The interruptions in coverage affect the continuity and effectiveness of health care received, particularly for patients with chronic conditions. Medicaid enrollees would be especially likely to benefit from an annual enrollment period. Currently the average Medicaid beneficiary is enrolled for only three-quarters of a year. This

number is even smaller for adults – the most significant population of new Medicaid beneficiaries that will soon be covered under the Medicaid expansion.

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

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

The Partnership for Medicaid supports giving states the option to establish a 12-month continuous eligibility period for all Medicaid enrollees, and potentially a longer eligibility period for some categories of enrollees, such as seniors and dual eligibles. This is consistent with a draft document compiled by the National Governors Association's Health Care Task Force which called for a similar policy to allow states to increase the time period for eligibility redeterminations to *no more frequently than 12 months* for certain Medicaid enrollees, including elderly beneficiaries and people with disabilities. The governors' document states that it is expensive to annually re-determine eligibility for individuals whose eligibility status does not often fluctuate. In fact, many states have already implemented an annual enrollment period for their state's Children's Health Insurance Program.

### **Develop Comparable Data about the Quality of Medicaid Services**

There are many powerful tools that policymakers and providers have to ensure the highest quality of care is provided to Medicaid enrollees. These tools could be further strengthened through the collection of comparable data on the quality of care that is provided to enrollees, regardless of whether they are enrolled in a Medicaid fee-for-service program, Primary Care Case Management (PCCM), or managed care organizations.

Federal law already requires that there be procedures for quality monitoring and improvement for capitated managed care organizations. This has allowed enrollees and Medicaid officials at the state and federal level to evaluate the value and quality of care provided. Since a substantial number of Medicaid enrollees are still served under fee-for-service or PCCM arrangements, information about the quality of care provided under Medicaid is available for a minority of those enrolled, and it is not possible to get an overall perspective of the quality of care in Medicaid.

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

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

### **Pharmacy Savings**

Prescription drugs reduce total Medicaid spending by helping patients control chronic conditions and helping avoid more costly interventions, including surgery and hospitalizations. Advances in pharmaceuticals have improved life expectancy and quality of life for many. However, it's important that Medicaid pharmacy benefits are optimally managed to reduce costs for states and taxpayers.

The Partnership supports greater use of generic substitution when available and clinically appropriate.

Currently the 340B Drug Discount Program offers discounted outpatient pharmaceuticals to safety net providers that serve a disproportionate volume of uninsured and low-income patients. A full extension of the 340B program to the inpatient setting, i.e. allowing safety net providers, including mental health and substance abuse providers, to receive the same discounts for inpatient drugs as they do for outpatients drugs, will not only save safety net providers significant time and resources but will also save the federal government \$1.2 billion over ten years through lower prices for Medicaid and Medicare drugs. We urge Congress to extend 340B drug discounts to the inpatient setting of safety net hospitals and other safety net providers.

American Academy of Family Physicians  
American Congress of Obstetricians and Gynecologists  
American Health Care Association  
Association for Community Affiliated Plans  
Association of Clinicians for the Underserved  
Medicaid Health Plans of America  
National Association of Children's Hospitals  
National Association of Community Health Centers  
National Association of Counties  
National Association of Public Hospitals and Health Systems  
National Council for Community Behavioral Healthcare  
National Health Care for the Homeless Council  
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