



Issue Brief:

Redesigning Medicaid Using the Deficit Reduction Act

National Association of State Budget Officers

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Background

President Bush signed the Deficit Reduction Act (DRA) into law on February 8, 2006. Among other things, the DRA seeks federal Medicaid spending reductions of \$4.8 billion over the 2006 to 2010 period and \$26.1 billion over the 2006-2015 period. One of the most critical parts of the DRA for states is a provision allowing states flexibility to redesign their Medicaid plans through the streamlined State Plan Amendment (SPA) process. Since the DRA was signed into law, several states have received SPA approval and have begun the implementation process, and many more are preparing SPAs for submission. This brief reviews the major provisions of the DRA that affect states' ability to redesign Medicaid coverage and looks at three cases of state Medicaid reforms that have relied heavily on the flexibilities offered by the DRA.

The Use of the DRA in Reforming State Medicaid Plans

Many states have either submitted or are developing State Plan Amendments (SPAs) to amend their state Medicaid plans. This is due to the flexibility offered under the Deficit Reduction Act (DRA) as well as the recognition in most states that their current Medicaid spending patterns are not sustainable over the long-run. One reason for this lack of sustainability is that, nationally, about 70 percent of Medicaid expenditures are used to care for just 25 percent of the Medicaid population. These are typically disabled persons of all ages and elderly people. Non-elderly adults and children without severe health problems, however make up 75 percent of the country's 67 million Medicaid enrollees, but account for only 30 percent of Medicaid spending, which is expected to total \$305 billion in 2007¹. States realize that redesigning benefit programs and focusing benefits and services for different Medicaid population cohorts can be a source of substantial Medicaid savings and improved health care by eliminating the one-size-fits all version of Medicaid.

Medicaid Waivers

Since the inception of the Medicaid program, Section 1115 waivers have been used by states in order to waive regulatory and statutory provisions of Medicaid without a statutory change. In 2001, the administration introduced a new Section 1115 waiver initiative known as the Health Insurance Flexibility and Accountability (HIFA) initiative, which encourages states to seek Section 1115 waivers to expand coverage within existing resources. One of the drawbacks to using waivers to make changes to Medicaid is that all waivers must be revenue neutral for the federal government, meaning that federal costs under a

¹ Vern Smith, Health Management Associates

waiver cannot be more than projected federal Medicaid costs in the absence of the waiver². Therefore, states have often used waivers in periods of fiscal pressure to reduce program spending by restructuring benefits, rather than using the waivers to expand coverage. Another issue with waivers is that the Secretary of the Department of Health and Human Services (HHS) has broad discretion in deciding whether to grant a waiver and on what terms. In contrast, to amend a Medicaid program under DRA authority, states can submit SPAs detailing proposed changes in benefit plans and cost-sharing schemes. Also unlike waivers, SPAs carry no budget neutrality requirement, meaning that states can receive federal matching funds for programs introduced in their SPAs³. Additionally, the Center for Medicare and Medicaid Services (CMS) must act on the SPA within 90 days and generally is required to approve any SPA that meets federal statutory requirements, regardless of the fiscal impact on the federal government. These features of the DRA have given states the flexibility to restructure their Medicaid programs in ways that contain costs. States that have begun to implement their approved SPAs are hopeful that they will be able to improve health outcomes for beneficiaries while simultaneously reigning in growing Medicaid expenses.

While the DRA does offer great flexibility to states, SPAs can only be used to make changes that are consistent with federal requirements for state Medicaid plans. Waivers must still be used for changes that are not consistent with one or more federal requirements and require CMS to excuse the state from compliance with federal regulations. Therefore, the approval process for waivers is generally more strenuous than that of SPAs. Using DRA authority, states can expedite approval of Medicaid policy changes that are within the bounds of current federal Medicaid law by utilizing the SPA process rather than having to use waivers. Some states combine SPAs with waivers such as the Section 1115 waiver, the Section 1915(b) (the freedom of choice waiver), and the section 1915(c) (the home and community-based services waiver) to provide wrap-around coverage for special populations that require changes outside of the realm of current federal Medicaid law, particularly those needing long-term care services.

According to the Kaiser Commission on Medicaid and the Uninsured's report, *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey, State Fiscal Year 2006 and 2007*, 12 states planned to implement new section 1115 waivers or waiver amendments in fiscal 2007, down from 25 states in fiscal 2006. Additionally, nine states indicated that they had previous plans to use a section 1115 waiver to make program changes but decided instead to submit SPAs to make these changes.

Based on data collected by NASBO and presented in the spring 2007 edition of the *Fiscal Survey of States*, a handful of states are planning to use DRA provisions as a vehicle to implement Governors' fiscal 2008 budget proposals to reduce the number of the uninsured. For example, in Wisconsin, legislators convened on July 25, 2007 in a conference committee session to iron out the details of a plan to use the DRA without a waiver to expand health care to over 180,000 residents. In Missouri, Governor Matt Blunt's proposal calls for expansion of coverage by combining the DRA with waivers, and Connecticut is considering the use of a waiver/DRA combination. In Connecticut, a study for the Governor's Charter Oak Plan to expand coverage has been approved by the legislature. Although still in the beginning planning stages, policymakers in that state are considering using a DRA and/or waiver to implement the plan.⁴

Major Provisions of the DRA

The provisions of the DRA pertaining directly to states' flexibility in designing Medicaid coverage relate to cost-sharing, benefit design, spending provisions including the Family Opportunity Act (which relates to health services for children) and the establishment of Health Opportunity Accounts, a new waiver authority allowing states to receive more federal Medicaid matching funds.

² Mann, Cindy and Samantha Artiga, "New Developments in Medicaid Coverage: Who Bears Financial Risk and Responsibility?", Kaiser Commission on Medicaid and the Uninsured, June 2006.

³ Rudowitz, Robin and Andy Schneider, "The Nuts and Bolts of Making Medicaid Policy Changes: An Overview and a Look at the Deficit Reduction Act", Kaiser Commission on Medicaid and the Uninsured, August 2006.

⁴ *Spring 2007 Fiscal Survey of States*, National Association of State Budget Officers

Cost-Sharing Changes. Prior to passage of the DRA, states were not permitted to charge most Medicaid beneficiaries premiums or enrollment fees, and could only impose nominal cost-sharing requirements (up to \$3) on certain populations for medical services. Under the DRA, states submit SPA proposals to allow them to impose premiums and cost-sharing following specific guidelines:

- For individuals and families with incomes between 100 and 150 percent of the federal poverty level (FPL), premiums are not permitted; cost-sharing is allowed, but is capped at 5 percent of family income and cannot exceed 10 percent of the cost of the medical service or item.
- For individuals and families with incomes above 150 percent FPL, premiums and cost-sharing are allowed, but both are capped at 5 percent of family income, and the cost-sharing burden cannot exceed 20 percent of the cost of the medical service or item.
- As under Medicaid law prior to the DRA, children under the age of 18, pregnant women, and other special populations are exempt from premiums and cost-sharing.

States are also given additional options to impose cost-sharing on non-preferred prescription drugs and inappropriate emergency room use, two very costly items for states. Also new under the DRA is the ability of states to make cost-sharing and premium payment enforceable.

The Congressional Budget Office (CBO) estimates that the DRA provisions related to cost-sharing and premiums will reduce federal Medicaid spending by \$1.9 billion over the next five years and \$9.9 billion over the next ten years, with about 70 percent of these savings coming from increased cost-sharing and 30 percent coming from enforcing premiums.

Benefit Design. Prior to the adoption of the DRA, states were required to provide certain mandatory services to mandatory populations and could receive federal matching funds for the costs of covering people and services not mandated by federal statute. Once a state decided to cover a particular service, it generally had to provide that service to all Medicaid beneficiaries, regardless of eligibility groups. Under the DRA, states are permitted to replace these one-size-fits-all benefit packages with ‘benchmark coverage’ for healthy adults and children who were eligible for all services prior to passage of the DRA. This benchmark coverage includes the standard Blue Cross/Blue Shield plan offered under the Federal Employees Health Benefit Plan (FEHBP), health coverage offered by the largest commercial HMO in the state, or Secretary-approved coverage. Essentially, this provision of the DRA allows states, through SPAs, to separate Medicaid beneficiaries into groups and offer tiered benefits, which is expected to be more efficient and cost-effective than a one-size-fits-all approach. In general, states have broad flexibility in designing these benchmark plans and to offer different plans to different groups of people, although benchmark plans are limited mostly to low-income parents and children who are in generally good health and may not be used for people with disabilities or elderly people who require more extensive services. CBO estimates that changes in benefits packages under the DRA will save the federal government \$1.3 billion over the next five years and \$6.1 billion over the next ten years.

Spending Provisions. In addition to allowing states to change benefits and institute cost-sharing in Medicaid through the submission of SPAs, the DRA also includes legislation called the Family Opportunity Act and establishes Health Opportunity Accounts (HOAs). The Family Opportunity Act allows states the option to permit parents with disabled children and incomes up to 300 percent of the federal poverty level (FPL) to buy-in to Medicaid. CBO estimates that an additional 115,000 children will receive Medicaid as a result of this provision. Although in some states these children are covered by SCHIP, this affords states the opportunity to enroll children in Medicaid who otherwise may not receive coverage either due to eligibility requirements or shortfalls in federal SCHIP funding. The DRA also requires the Secretary of HHS to establish a demonstration program for HOAs in which ten states can participate during the first five years (2006-2010). HOAs are defined contribution accounts similar to Health Savings Accounts. States have the opportunity to fund and enroll some Medicaid beneficiaries into HOAs. Demonstration states will contribute funds to an individual’s HOA (up to \$2,500 per adult and \$1,000 per child) and receive federal matching funds. So far, only three states (New Hampshire,

Oklahoma and South Carolina) have indicated that they wish to apply to participate in the HOA demonstration project.

Case Studies: Kentucky, Idaho, West Virginia

During 2006, Kentucky, Idaho, West Virginia, among other states, received approval for the SPAs under DRA authority. All three of these states have used the benefit redesign and cost-sharing flexibility provisions in their plans. While waivers are still used post-DRA, SPAs are generally easier administratively than waivers and Kentucky and Idaho were both able to accomplish the vast majority of their Medicaid reform goals using DRA provisions. All of these states initially considered using waivers to achieve their reform goals but decided on submitting SPAs.

Kentucky. In May 2006, Kentucky's SPA was approved by CMS, allowing the state to introduce the KYHealth Choices program, with the goals of improving health for Kentuckians and reducing costs. The state expects the plan to save about \$120 million in the first year and \$1 billion over the next seven years. This program features tiered benefit packages, new cost-sharing requirements, and consumer empowerment initiatives. The programs four targeted benefit plans are as follows:

- Global Choices (235,000 members) covers the general Medicaid population (pregnant women, adults up to 68 percent FPL, foster children and medically fragile children, Supplemental Security Income-related groups, and women with breast or cervical cancer). This plan covers basic medical services, excluding long-term care, but prescription coverage is limited to four prescriptions a month and occupational and physical therapy visits are limited to 15 per year. Therefore, for individuals with more acute health issues, another plan is probably preferable.
- Family Choices (263,000 members) covers most children, including Kentucky Children's Health Insurance Program (KCHIP) children. This plan offers the same benefits as Global Choices, but there are no prescription drug limits and there is a higher vision care maximum benefit.
- Optimum Choices (3,500 members) covers individuals with developmental disabilities and mental retardation in need of long-term care services. This plan offers the same benefits as Global Choices and also offers three levels of long-term care services.
- Comprehensive Choices (27,900 members) covers the elderly and individuals with disabilities in need of nursing facility level care. This plan offers the same benefits of Global Choices plus two levels of long-term care, including services offered through the state's current home and community-based (HCB) waivers.

Using targeted benefit plans allows the state to serve Medicaid beneficiaries with only the services they need and is more cost-effective for the state. In addition to these redesigned benefits, KYHealth Choices also includes a new cost-sharing requirement which went into effect on June 1, 2006. While there are no co-pays for preventative services and pregnant women and mandatory children are exempt from cost sharing, most beneficiaries will be required to share in the cost of medical care. Under the basic Global Choices plan, for example, there is a \$50 co-pay for inpatient services; a \$3-6 co-pay for physician services; a \$1 co-pay for generic drugs, \$2 for preferred drugs, and 5 percent coinsurance for non-preferred drugs; and a \$225 annual out-of-pocket maximums for both prescription coverage and medical services. For many beneficiaries, this will be the first time they have been required to make co-payments in Medicaid, and although the maximum amount of cost-sharing must be 5 percent or less of family income, cost-sharing will have a great impact on both individual beneficiaries and state Medicaid spending.

The KYHealth Choices program also emphasized consumer choice and individual responsibility through Self-Directed Services and Get Healthy Benefits. Self-Directed Services allows Kentucky residents who qualify for either the Comprehensive Choices or Optimum Choices plan the option to control and direct Medicaid long-term care funds through an individual budget. Get Healthy Benefits are earned by beneficiaries after one year of compliance with a disease management program offered by the state in the areas of diabetes, asthma, pediatric obesity, and cardiac or heart failure. These benefits can be used for additional dental or vision services (up to \$50) or nutritional or smoking cessation counseling. Overall, the KYHealth Choices program aims to reduce state Medicaid expenditures through the tailoring of

benefits packages and introduction of cost sharing, and also to improve health outcomes by instilling personal responsibility and directing services to those who need them the most.

Idaho. Several forces led to Medicaid reform in Idaho, including the recognition that the spending levels in the program were not sustainable and that a one-size-fits-all approach was not effectively serving all Medicaid beneficiaries. Additionally, Idaho wanted to transform their Medicaid system into one that balanced access, quality, and cost-containment. In April 2006, Idaho submitted a Section 1115 waiver to CMS, but was advised by the agency to utilize the SPA process under DRA instead. In May 2006, CMS approved most of Idaho's SPA proposals. One of the main elements of Idaho's Medicaid reform is the introduction of three targeted benefit plans.

- The Basic Plan serves low-income children and working age adults with average health care needs. It covers most medical services, preventative dental care, basic mental health services, and vision care. It does not cover services such as case management, hospice, or institutional or home and community based care services.
- The Enhanced Plan serves individuals with disabilities or special health needs. It offers Basic Plan benefits plus extensive mental health care, developmental disability services, long-term care, and targeted case management. (This was essentially the standard Medicaid plan offered to all beneficiaries prior to reform.)
- The Medicaid/Medicare Coordinated Plan supplements Medicare and serves dual eligibles, who can choose to participate in a Coordinated Plan through a Medicare Advantage Plan. Medicaid pays for any premiums or services not covered under the Advantage Plan.

Beginning in July 2006, Medicaid and SCHIP enrollees were placed into either the Enhanced or Basic Plan at their re-enrollment. The Medicaid/Medicare Coordinated Plan was implemented on April 1, 2007. There are three triggers that automatically place an individual into the Enhanced Plan or move them from the Basic to the Enhanced Plan:

- Physician diagnosis of special needs;
- Utilization of mental health services up to the limit of the Basic Plan;
- Receiving other forms of assistance from the Idaho Department of Health and Welfare or other public services, including disability payments.

The Idaho plan also features other elements such as cost-sharing requirements, a modified enrollment process, and preventative health assistance. The cost-sharing system features tiered premiums for individuals enrolled in the Basic Plan who earn above 133 percent FPL. Those earning between 133 and 150 percent FPL face \$10 monthly premiums, while those earning between 151 and 185 percent FPL must pay \$15 monthly premiums. Additionally, there are small co-pays for particular services. To increase efficiency and cut costs, Idaho has modified the Medicaid enrollment process by introducing an interactive online application that is able to use beneficiaries' answers to direct them to the proper benefit plan while allowing users to bypass questions that do not apply to them. Finally, Idaho's Medicaid reform program includes preventative health assistance. Beneficiaries earn points for weight loss, tobacco cessation, well child exams and immunizations, and can use their point for weight management programs, nicotine patches or gums, bicycle helmets, and premium payment assistance, among other things.

West Virginia. In May 2006, West Virginia became one of the first states to utilize the new provisions of the DRA when they received CMS approval for an SPA to change their Medicaid program. The four year phased-in implementation of these changes began with three counties on July 1, 2006. The approved SPA focuses on changes in benefits packages and promoting personal responsibility. Although there are currently no cost-sharing requirements, the state may institute such changes by submitting an additional SPA. Under the new program, children and parents are being moved from the standard Medicaid plan to one of two Secretary-approved plans: the Basic Plan or the Enhanced Plan. The Basic Plan includes all mandatory and some optional services but is more limited than the state's previous Medicaid benefits. The Enhanced Plan covers all services included in the Basic Plan plus mental health services, diabetes care, and unlike the Basic Plan, prescription drug coverage is not limited to four prescriptions per month.

Coverage under the Enhanced Plan is very similar to coverage offered under the previous Medicaid program. The most unique aspect of West Virginia's new plan is the member agreement, which adults must sign in order to have themselves or their children moved from the Basic Plan to the Enhanced Plan. The member agreement, or personal responsibility contract, includes broad responsibilities for individuals as well as beneficiary rights. Physicians are responsible for reporting to the state on the beneficiaries' adherence to the member agreement via Physician Status Reports. For individuals who sign the member agreement in the Enhanced Plan, the state uses physician status reports to determine compliance with:

- Screenings as directed by the provider;
- Adherence to health improvement programs;
- Missed appointments, and;
- Medication compliance.

If the state determines an individual has not met his or her responsibilities after one year of enrollment, the individual or the child will be moved to the Basic Plan and must wait 12 months to qualify for re-enrollment in the Enhanced Plan.

Conclusion

In addition to the three states discussed above, Kansas, Virginia, South Carolina and Washington have also received approval for SPAs that offer specialized benchmark benefit plans. As stated previously, several other states have included use of DRA flexibilities as a vehicle for implementing Governors' health care expansion programs proposed in their fiscal 2008 budgets.

The experiences of Kentucky, Idaho and West Virginia illustrate the variety of changes to Medicaid programs that have been made thus far using State Amendment Plans under DRA authority. Although it is still too early since the implementation of these new programs to evaluate the precise effect in terms of cost savings or health outcomes, state Medicaid Directors and other officials are hopeful that these changes aimed at targeting benefits, implementing cost-sharing, and increasing patient responsibility for health outcomes will have positive impacts on beneficiary health as well as state Medicaid costs. Please contact Jordan Head at 202.624.5949 or jhead@nasbo.org with questions or comments.