SHORT-RUN

MEDICAID REFORM

from the

NATIONAL GOVERNORS ASSOCIATION

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Preface

On June 15, 2005, NGA released a preliminary policy paper that outlined recommendations for Medicaid Reform. This paper has a narrower focus in that it includes only those policies that could become part of the revenue and spending reconciliation bills that will be debated in September as part of the 2006 federal budget. The paper does provide more detail on the Governors' recommended proposals for the spending reconciliation bill, but is consistent with the policy recommendations in the June 15, 2005 paper.

The recommendations included in this paper were adopted by the Governors because they are good public policy not to satisfy any spending reduction target. It is also true that Medicaid will continue to grow in the high single digit rate even if these policies are enacted. Alternatively, from a state budget perspective Medicaid is still unsustainable. It is therefore critical that these recommendations be considered at the beginning, not the end, of the reform process. For Medicaid to be sustainable in the long-run, broader program and health care reforms must be considered.

The Governors appreciate the fact that the Medicaid Commission has come to many of the same policy conclusions that are recommended in this paper and they look forward to working with them over the next 16 months as they focus on the long-run restructuring of Medicaid.

I. Prescription Drugs

Increased transparency. Reforms are needed to bring greater transparency to pharmaceutical pricing methods for Medicaid. Currently, many states negotiate prices on prescription drugs according to the published average wholesale price (AWP). There is widespread acceptance that AWP is inflated and does not reflect a valid benchmark for pricing. A different reference price should be established and made available to the states that more accurately reflects the actual price for drugs.

The Average Manufacturer Price (AMP) should be used for this purpose; however, reforms need to be made before AMP can be used as the new benchmark for drug pricing in Medicaid. Reforms should include: 1) CMS issuing clear guidance on manufacturer price determination methods and the definition of AMP; 2) manufacturer-reported prices should be easily auditable so that systematic oversight of the price determination can be done by HHS; 3) manufacturer-reported prices and rebates should be provided to states monthly rather than the current quarterly reporting; and 4) new penalties should be implemented to discourage manufacturers from reporting inaccurate pricing information.[1] The AMP should be used to establish a federal ceiling for pharmaceutical reimbursement. States would still retain the ability to negotiate lower prices.

[1] Recent reports by the General Accounting Office (GAO) and the Office of Inspector General (OIG) identified problems with AMP, particularly in manufacturer price determination methods and reporting, and oversight by CMS. Improvements in these areas are essential to ensure that AMP is a reliable and accurate reference price for states.

Option for Closed Formulary. States should have the option of adopting closed formularies, just like the federal government does in the VA system and with the new Medicare PDPs. Adoption of a closed formulary would mean that the state would not be guaranteed a rebate or the "best price"; however, some states, with enough negotiating power and leverage, could negotiate lower overall drug prices than in the current system, even with supplemental rebates. [2]

Dispensing Fees. With the introduction of a new price methodology (AMP), states should have flexibility to determine appropriate dispensing fees for drugs. Dispensing fees should not be linked to the price of drugs, as was proposed by the President, nor should they be capped. Flexibility to determine dispensing fees is important to ensure that pharmacies are appropriately compensated and that pharmacists are encouraged to dispense the most cost-effective drugs for beneficiaries.

Increased Minimum Rebates for Brand Name Drugs. The minimum rebates that states collect on brand name drugs should be increased to 20 percent (from 15.1 percent) to ensure lower total costs that would not solely impact pharmacists. Medicaid's "Best Price" provision should not be eliminated in exchange for this.

"Authorized Generics." For those states that continue to rely on the Medicaid drug rebate and "best price" provisions, reforms should be made to ensure that <u>all</u> drugs be included in these calculations. "Authorized generics" should be included in calculations of best price for the brand name drug. In addition, an "authorized generic" should qualify a particular drug for having a CMS set FUL. Currently, if at least three versions of the drug are rated as therapeutically equivalent by the FDA and the drug has at least three suppliers listed in current editions of national compendia, an FUL should be set by CMS.

Medicaid Managed Care. As more and more states utilize managed care to help administer their program, managed care companies should be able to directly access rebates for prescription drugs purchased for their Medicaid population. States should have the option of collecting these rebates directly or allowing plans to access them in exchange for lower capitation payments.

Purchasing Pools. States should be given greater ability both within their state and between states in establishing purchasing pools. For those states that choose to forgo the "best price" and rebate in order to close their formulary for the Medicaid program, they should be automatically able to combine their Medicaid population in with other state populations (e.g. state employees) in order to negotiate greater savings. Amend OBRA '90 to require drug companies to give Medicaid level prices to state funded drug programs, including Medicaid managed care plans, SPAPs, stand-alone SCHIP programs, state employees, prison programs, and other programs such as drug discount programs for low income residents of a state.

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[2] No other entity in the health care system is required by law to maintain an open formulary. Medicaid law (OBRA 90) was written so that this open-ended requirement was to be balanced by guaranteed minimum rebates from manufacturers. Many states feel that this trade-off does not allow them the flexibility to manage their programs effectively or the ability to truly negotiate deep enough discounts. Currently, states do not have the option of withdrawing from the Drug Rebate Program without sacrificing federal financial participation for prescription drugs.

Federal Upper Limit. To ensure that states do not pay too much for prescription drugs, a new federal reimbursement ceiling for payment for all drug products should be established based on the AMP. In addition, the current practice of applying a Federal Upper Limit (FUL) to classes of drugs with three therapeutically equivalent products should be maintained; however, the current FUL in this instance is based on 150 percent of the AWP of the least costly therapeutically equivalent product, and should be revised to reflect 150 percent of the AMP of the least costly therapeutically equivalent product. [3]

Tiered Copay for Prescription Drugs. *(See this section under cost-sharing.)*

Allow Mail Order for Maintenance Drugs. States should be given the option to require Medicaid recipients to use mail order pharmacies to obtain their maintenance drugs. Under such an option, the Medicaid statute would need to be changed to allow "freedom of choice" to be waive-able in this case at a states request.

II. Long Term Care

Asset Transfer. States should have increased ability to prevent inappropriate transfer of assets by seniors to qualify for Medicaid. To that end, 1) the look-back period should be increased from 3 to 5 years; 2) penalty periods should begin at the time of application; and 3) the sheltering of excess resources in annuities, trusts or promissory notes must be prevented.

Accordingly, if at any time during the applicable five year look-back period an applicant, the applicant's spouse, or a fiduciary or person acting for the applicant, the applicant's spouse, or both, transfers or sequesters resources or the right to receive resources, income, or both, from any source, and as a result of the transfer or sequestration the funds available to pay for medical assistance are diminished, the applicant shall be ineligible for medical assistance for the period of time that would cause the transferred or sequestered resources, income, or both, to be fully expended at the weighted average nursing facility rate in effect when the transfer or sequestration occurred (either the monthly rate or the daily per diem multiplied by 30.42 and rounded to the nearest dollar). The disqualification period will begin with the date of application for Medicaid long term care services or if the individual is a recipient of Medicaid long term care services at the time of the transfer, the disqualification period shall begin with the month following the month of the transfer.

[3] Currently CMS sets FUL for drugs with generic equivalents, when there are three therapeutically equivalent drug products. The FUL is set at 150 percent of the published AWP price for the least costly therapeutically equivalent product. A recent OIG report found that Medicaid could save hundreds of millions of dollars per year by basing FUL amounts on reported AMPs. According to the report, if Medicaid based FUL amounts on 150 percent of the lowest reported AMP rather than 150 percent of the lowest published price (AWP), the program may have saved up to $300 million in just one quarter of 2004; an estimated $650 million per year of savings. Previous reports by the OIG in 2004 found that CMS does not effectively add qualified drugs to the FUL list (e.g. OIG found that 90 drug products were not included on the FUL list in 2001 that met the criteria and had they been they could have saved $123 million in 2001). CMS should ensure that a FUL is set for qualifying drugs in a timely manner.

If the transfer is between spouses this rule does not apply to the extent that the transfer does not cause the transferees' resources and rights to receive income, resources, or both, to exceed the maximum community spouse resource allowance in effect at the time of the transfer. This same exemption also applies to dependent disabled children. Furthermore, if a dependent disabled child is living in their parent(s) home at a time such parent is applying for Medicaid, that child has the right to stay in the home. In the event of death of the dependent disabled child or the spouse, the state then has the right to recover the asset of the home.

In the case of Community Care Retirement and "Life Care" Facilities (CCRCs), entrance deposits should be considered an available resource for purposes of determining Medicaid eligibility, as CMS guidance currently dictates.

Reverse Mortgages. Current law precludes the state to include certain assets as "countable" in determining Medicaid eligibility, including homes. This leads to the current "pay and chase" in estate recovery where states are left to recover funds after beneficiaries die. Reforms should be made to avoid trying to recover funds after the fact and instead have individuals be responsible upfront for their health care costs.

Home equity should be considered a countable asset in order to require individuals to use home equity to off-set long-term and other medical expenses that would otherwise be paid by Medicaid. Reverse mortgage loans are available to allow seniors (age 62 or older) to convert home equity into cash. To facilitate the use of reverse mortgages, however, reforms should be made to relieve seniors of the upfront costs of applying for such loans. For those seniors that are applying for Medicaid, reforms should be made to allow such costs be assumed into the annual payout of the mortgage.

Protections for seniors and their families should be put in place to allow a person who obtained a reverse mortgage to afford long-term care and medical expenses to shelter a certain portion of their home equity. The amount that would be sheltered would be 10percent of the market value of the home or $50,000 (whichever is lower). States that can demonstrate that their current estate recovery programs are operating effectively, they should be able to opt-out of this provision.

Long-Term Care Insurance Partnership. To help the aging population plan for future long-term care needs all states should be allowed to participate in the Long-Term Care Partnership program. Federal law should be reformed to no longer prohibit the expansion of these partnerships.[4]

[4] Currently four states have been operating such partnerships that provide an incentive to individuals to purchase long-term care insurance. Individuals who purchase insurance through such partnerships are able to shelter a portion of their assets. The Medicaid program saves money under such partnerships because Medicaid becomes the payer after the policy benefits are exhausted; making Medicaid the payer of last resort, not the first. However, it is critical that those LTC payments must be used to pay for LTC services.

Protections, such as suitability, rating standards, non-forfeiture clauses, and inflation protection are important for individuals and states as well as to the success and potential cost-savings of the Partnership program. As more states are given the ability to operate Partnership programs, flexibility to be innovative in such policies is important. New Partnership policies should not be prescriptively mandated into a single model that may become obsolete over time. Reciprocity between states that operate Partnership programs is an important goal. A nationwide standard of assets should be considered as models to implement expansion of the program are developed in order to ensure that the value of asset protection purchased in one state is comparable in value in another state.

III. Cost Sharing

Cost-Sharing Responsibility. States should be given the ability to implement common-sense, enforceable cost-sharing throughout the Medicaid program both to increase responsibility of Medicaid beneficiaries for the cost of their health care, and encourage cost-effective care in the most appropriate setting.[5] This new flexibility would be completely at state option, and states could choose to further restrict the types of cost-sharing in the program by income level, beneficiary category, or service type.

- **At or Below 100 percent FPL.** Existing cost-sharing limits would remain for beneficiaries at or below the federal poverty level (*with the exception of tiered copays for prescription drugs as described below*); however, states would be given the authority to make cost-sharing enforceable. No beneficiaries in this group could be charged a premium (*see premium section below).*

- **Above 100 percent FPL.** States would be able to increase cost-sharing beyond nominal levels for all beneficiaries above the federal poverty level and be given the authority to make cost-sharing enforceable. For these beneficiaries, premiums may be appropriate as a cost-sharing option for states and states should be given flexibility to experiment with mechanisms to collect these premiums (*see premium section below).* Beneficiaries will be protected by a 5 percent cap on the total amount of cost-sharing they could be responsible for (5 percent of total family income). This could increase to 7.5 percent for those higher income households (defined as above 150 percent FPL).

Premiums. Although premiums may not be appropriate for some beneficiaries; if designed appropriately they are a worthwhile cost-sharing tool. States should be given flexibility to experiment with mechanisms to collect premiums in the Medicaid program. Using premiums, rather than a copays would prevent beneficiaries from being denied care that they need for failure to pay when they can least afford it. It also introduces an insurance principle into the Medicaid program. Nothing in this proposal would preclude states from continuing existing waivers that include premiums as a coverage mechanism or preclude other states from entering into such waivers with CMS.

[5] Currently states are prohibited from implementing cost-sharing above nominal levels [deductible is $2 per family per month; co-payment from $.50 to $3; co-insurance is 5 percent of the state's payment rate for the item or services) and are prohibited from requiring cost-sharing for certain categories of beneficiaries and certain services.

Cost-sharing would not be implemented on the following categories of beneficiaries or services, as under current law:

- Infants and children under age 18 that are provided "mandatory" coverage (0-5 133 percent FPL and 6-18 100 percent FPL)
- Preventive services for all children (well baby, well child care and immunizations);
- Pregnant women with respect to any services related to pregnancy or any other medical condition which may complicate pregnancy;
- Terminally ill individuals receiving hospice care with respect to any service;
- Inpatients in hospitals, nursing facilities, or ICFs/MR who as a condition of eligibility are required to apply most of their income to the cost of care;
- Emergency services, as defined by CMS; and
- Family planning services and supplies

Tiered Co-pays for Rx. Additionally, states should be given the ability to develop effective tiered co-pay structures to encourage cost-effective drug utilization where appropriate for all beneficiaries, regardless of income. Although states may currently operate tiered co-pays, Medicaid's current cost sharing rules, with an unenforceable maximum co-pay of $3 per drug is not conducive to encouraging cost-effective utilization. States should be able to increase co pays on non preferred drugs beyond nominal amounts when a preferred drug is available, to encourage beneficiaries to fill the least costly effective prescription for treatment. Such co pays must be enforceable to be meaningful.

For beneficiaries at or below the federal poverty level, co-pays for preferred drugs would remain nominal, although they would be enforceable. For this population, states would be able to increase these enforceable copays beyond nominal amounts for a non preferred drug. States should be given broad authority to waive these co-pays in unique circumstances and cases of true hardship.

IV. Benefits

Increased Flexibility to Tailor Benefits to Beneficiary Health Care Needs. The Medicaid population is very diverse and includes medically frail individuals as well as relatively healthy individuals that Medicaid serves as a traditional health insurance program. Currently "comparability" requirements limit states' ability to tailor benefit packages to meet different health care needs of beneficiaries. Reforms are necessary to allow states to design programs to support the health care needs of the diverse Medicaid population in their state. For medically frail populations, chronic care management provided in a managed care model holds promise for improving the health care of these individuals. (*see discussion of comparability and state wideness in waiver reform section).*

For relatively healthy individuals, flexibility as is afforded states in the SCHIP program would allow states to design an appropriate benefit package for these beneficiaries. This flexibility includes the ability to choose *to provide the set Medicaid benefit package* or to provide a tailored benefit package with four options for coverage:

1. *Benchmark coverage*: This is a coverage package that is substantially equal to either the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan; or a health benefits plan that the state offers and makes generally available to its own employees; or a plan offered by a Health Maintenance Organization that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state.
2. *Benchmark equivalent coverage*: In this instance, the state must provide coverage with an aggregate actuarial value at least equal to one of the benchmark plans. States must cover inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, include age-appropriate immunizations.
3. *Existing state-based comprehensive coverage*: In the states where existing state-based comprehensive coverage exists (e.g. state-only funded programs; or waiver populations), the existing health benefits package is deemed to be meeting the coverage requirements.
4. *Secretary approved coverage*: This may include coverage that is the same as the state's Medicaid program; coverage provided in a Medicaid demonstration project approved by the Secretary; or coverage purchased by the state that is substantially equal to coverage under one of the benchmark plans through the use of benefit-by-benefit comparison.

SCHIP benefits flexibility is not being proposed for the following categories of beneficiaries:

- Pregnant women, infants and children under age 18 that are provided "mandatory" coverage (up to age 6 133 percent FPL and 6-18 100 percent FPL);
- SSI recipients;
- Dual eligibles;
- Terminally ill individuals receiving hospice care; and
- Medically frail and special needs populations

V. Waiver Reform

Increased Ease of Waiver Approvals. Waiver applications are time consuming and costly for states that seek waivers to better manage their Medicaid program and meet the needs of beneficiaries. Increased ease for states to bypass some federal Medicaid requirements without having to go through a lengthy waiver approval process would facilitate innovation in the program.

States believe they and their federal partners would benefit from states' increased flexibility to create programs that target special populations or limited geographic areas before expansion to entire states. In many situations, smaller pilots or experiments could iron out problems and keep research investment to a minimum before decisions on whether or not a program works are

made. With freedom to create smaller experiments states could test new care delivery and other concepts as well as assess demand and beneficiary/provider satisfaction before committing to an expensive and potentially risky new program.

For commonly waived portions of the Medicaid statute, states should be allowed to use the state plan amendment process. The state plan amendment process would include check boxes for typical waived items, such as those requiring that beneficiaries have "freedom of choice" of provider, and that services be comparable, statewide, and consistent with respect to amount, duration, and scope. States would realize cost savings because services would be implemented sooner and States would reduce administrative costs associated with waiver development and the waiver amendment/renewal process. The revised state plan amendment would also include a checkbox indicating limited geographic service area or other limitations. Similarly, 1915(b), 1915(c) and PACE waivers should also be administered through the state plan process. Certain protections in the waiver process should be maintained through this reform effort, such as the ability to control costs and utilization common to the 1915(c) waivers.

To ease the administrative burden for those states that have an existing waiver; it should automatically become a part of the state plan after it has been renewed once.[6]

States should be given more flexibility within waivers in provider contracting. Although states now may contract selectively for some services without waivers, there are many more services where the ability to contract with, say preferred providers, might enable states to cut costs while improving quality. Contracting flexibility will be important in pay-for-performance (P4P) approaches. Additional at-risk contracts that share savings with provider groups are valuable to stretch increasingly scarce resources as they can lower care costs while improving quality. State purchasing pools have been successfully utilized for pharmaceutical products, but the same concepts might be applied to other services and products if requirements can be adequately addressed under current regulations or waivers.

Requirements for waivers to be cost-neutral can be an unrealistic burden on new or experimental programs. States should be given a greater period of time for waiver programs to be budget neutral (e.g. ten years vs. the current five year requirement). These reforms would allow states to implement programs such as disease management and quality improvement that are expected to result in savings in later years, but have significant upfront costs. The statute should also allow for states to consider savings to Medicare and other federal programs when considering the impact of Medicaid changes. There are many promising innovations in Medicare/Medicaid integration or care coordination that are never implemented because of outdated notions of siloed budget neutrality requirements.

[6] Through this mechanism, states would be able to expeditiously replicate waivers that have been implemented and sustained in other states. Some waivers are so commonplace and have been in existence for so long that they have become the standard of practice. Yet currently any new state that wanted to implement a similar program would be forced to submit and defend a lengthy waiver application and wait for a time consuming review. This process is lengthy and tends to discourage innovation by forcing states to make a substantial investment in any new programs without much benefit to anyone.

Current waivers should be grandfathered into the program in order to not undermine existing agreements between a state and CMS. However, states should be given the opportunity to revisit current waivers following implementation of new Medicaid laws at a state's request.

VI. Judicial Reform

The right of states to locally manage the optional Medicaid categories is clearly defined in both policy and law, and the federal government should remove legal barriers that impede this fundamental management tool. Also, U.S. Department of Health and Human Services officials should have to stand by states when one of their waivers or state plans is questioned in the judicial system and should work with states to define for the judiciary system that any state has a fundamental right to make basic operating decisions about optional categories of the program.

VII. Medicare Rx "Clawback"

Congress and the Administration should partner with the states to make regulatory changes and enact legislative fixes to the law to ensure that the congressional intent of the program is realized and all states gain some form of relief from passage of the MMA.

VIII. Reinvestment Options:

As Congress considers reforms to the Medicaid program, certain reinvestments of federal dollars should also be considered. However, Congress should not increase the Medicaid gross cut in the reconciliation bill to accommodate these or any other reinvestments. The following are some potential areas for reinvestment that need further discussion by the Governors.

Territories. The federal Medicaid partnership with U.S. commonwealths and territories has become increasingly unbalanced over a period of years, to the extent that some of the jurisdictions are financing over 80 percent of their Medicaid costs, and many of the Medicaid expansions such as transitional medical assistance are not available. The imbalance affects access, quality of care, and creates increased financial stress. Medicaid reform needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing of this partnership.

Quality and Technology Improvements. Grants to the states and/or an increased matching rate should be provided for quality improvement efforts in Medicaid, such as those being considered for Medicare. Such efforts include adoption of health information technology; improved patient safety; reduction of medical errors; chronic care management; and pay-for-performance.

Tax Credits and Deductions for Long Term Care Insurance. Some combination of a significant tax credits, e.g., $2,000, and deductions, e.g., $200, to provide an incentive for individuals to purchase long term care insurance.

Tax Credits and Purchasing Pools to Increase Access to Health Insurance. A combination of individual health care tax credits and tax credits for small employers combined with funding to create purchasing pools should provide assistance to low-income working individuals to enable them to obtain health insurance and avoid reliance on Medicaid.

Fraud and Abuse. Medicaid Directors have long asked for three items to help fraud and abuse efforts

1) Permit states the same opportunities as are currently afforded the federal government to limit, restrict, or suspend the eligibility of beneficiaries and providers, subject to due process, who have been determined in state proceedings to have engaged in fraud or abuse involving the Medicaid program, even if they have not been convicted in federal court of the listed federal crimes.

2) Amend Section 1903(a)(6) of the Social Security Act to provide the same federal match for all costs associated with fraud and abuse and Surveillance and Utilization Review Services (SURS) activities conducted by the state Medicaid agency as currently received by the Medicaid fraud control units (75 percent). This enhanced funding would apply to direct fraud and abuse and SURS functions that include, but are not limited to, identification, investigation, and administrative actions (e.g. recoveries and provider exclusions).

3) Provide that when a state discovers an overpayment and determines it to be attributable to fraud or abuse, the state should refund the federal overpayment in the quarter in which the recovery is made, regardless of when the overpayment is discovered.