Medicaid Acute Care Delivery System

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Medicaid Commission Meeting

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Preview of Presentation

- Medicaid-covered benefits
- Rules governing delivery of benefits
- Beneficiary cost-sharing
- Waivers that affect acute care benefits
- Delivery systems
- Preview of some key questions for the March 2006 session

Medicaid-Covered Benefits

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As with eligibility, the federal Medicaid Act distinguishes between "mandatory" and "optional" . . .

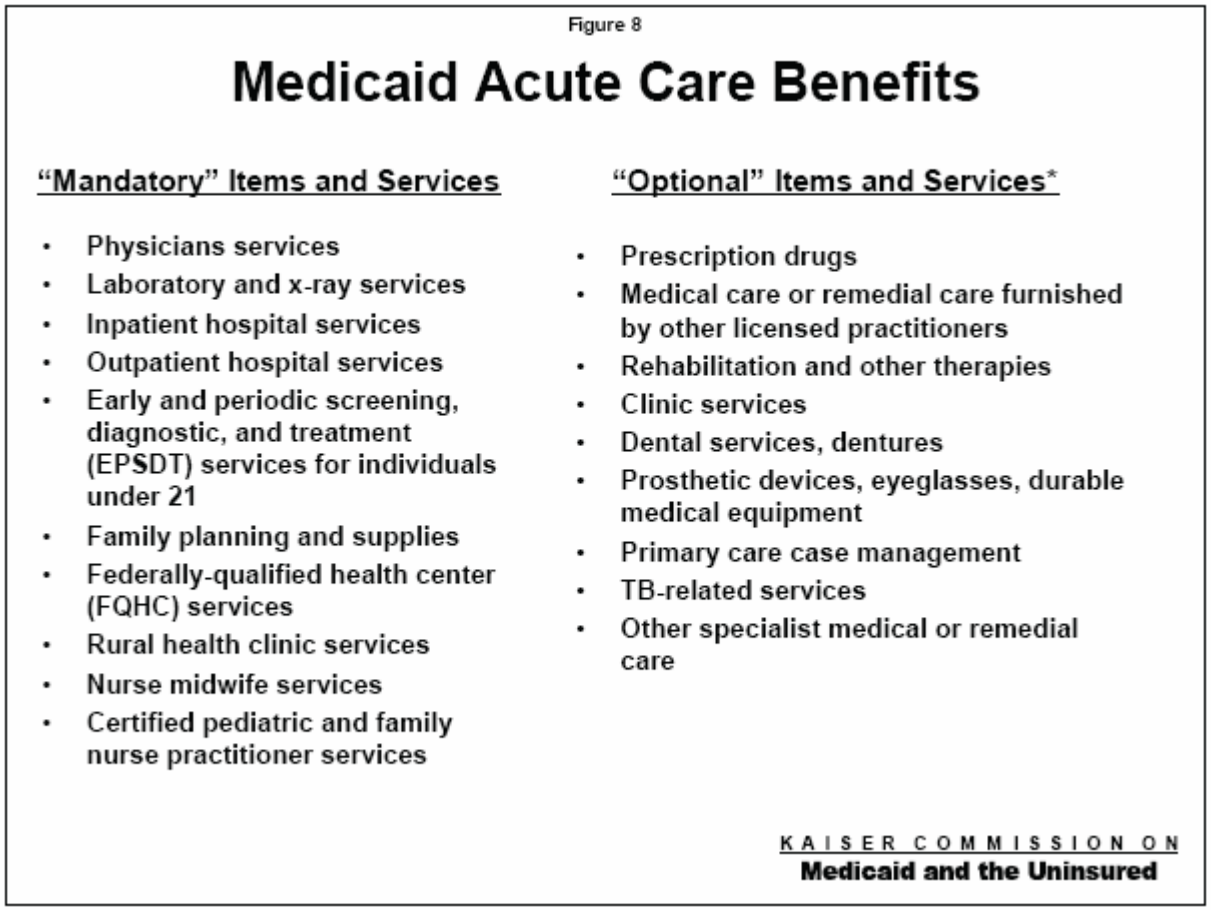

Figure 8

Medicaid Acute Care Benefits

"Mandatory" Items and Services

- Physicians services
- Laboratory and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Family planning and supplies
- Federally-qualified health center (FQHC) services
- Rural health clinic services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services

"Optional" Items and Services*

- Prescription drugs
- Medical care or remedial care furnished by other licensed practitioners
- Rehabilitation and other therapies
- Clinic services
- Dental services, dentures
- Prosthetic devices, eyeglasses, durable medical equipment
- Primary care case management
- TB-related services
- Other specialist medical or remedial care

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. . . but it is a little more complex than that . . .

- Under EPSDT, otherwise optional benefits become mandated for children if necessary to correct or ameliorate a condition
- Many “optional” benefits are offered in all or virtually all states (e.g., Rx; optometry; nursing facility under age 21; ICF/MR)

. . . including the issue of Medicaid's "Cadillac" benefits . . .

- One reason for "Cadillac" benefits is that current federal Medicaid law mandates that states offer certain services beyond what's available through private insurance.
  - E.g., EPSDT; long-term custodial nursing facility care.
- Another reason is that the poverty and disability status of many Medicaid beneficiaries requires services that are not needed by a generally healthier and wealthier population in a private insurance plan.
  - E.g., behavioral health; non-emergency transportation; long-term custodial nursing facility care; ICF/MR

. . . especially when compared to the S-CHIP law.

- S-CHIP (Title XXI), passed in 1997, allows states to select a benchmark. E.g.:
  - Medicaid
  - State employees
  - Federal employees
  - Largest plan in the state
- This has fewer mandates than Medicaid, such as no EPSDT requirement.
- It also targets a slightly higher income group whose needs may be different.

Rules Governing Delivery of Benefits

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In delivering the covered benefits, states must follow four guidelines . . .

- *First, a benefit must be sufficient in "amount, duration, and scope"* to reasonably achieve its purpose
  - Cannot offer inpatient hospital, and then only cover one day a year
    - Many states contain Medicaid costs by limiting benefits while complying with this requirement (e.g., Rx/month, inpatient hospital days/year)
  - E.g., Viagra may be limited to a certain number of doses per month
  - The "scope" of a benefit may be subject to "medical necessity" and utilization control tests
    - E.g., states can limit Viagra coverage to particular diagnoses
    - Also, states may develop preferred drug lists

. . . the second guideline is "comparability" . . .

- In general, "comparability" means that the benefits must be comparable for all Medicaid eligibility groups
- Yet, children's benefits may vary from adults due to EPSDT
- "Comparability" complicates the transition of the Rx benefit to Medicare. States still are required to offer drugs to dual eligibles, when they offer these drugs to other Medicaid beneficiaries. E.g.:
  - Over the counter
  - Non-Medicare covered classes.

. . . the third guideline is "statewideness" . . .

- In general, "statewideness" means that the benefit package must be identical in all parts of the state

. . . and the fourth guideline is "freedom of choice" . . .

- In general, "freedom of choice" means that Medicaid beneficiaries must have the right to access the benefits from any Medicaid-participating provider.

Beneficiary Cost-Sharing

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Federal law exempts some groups from cost-sharing . . .

- Children under age 18
- Pregnant women (for pregnancy-related services)
- Beneficiaries receiving hospice care
- Most beneficiaries in an institution (e.g., nursing facility)

. . . and prohibits cost-sharing for certain services . . .

- Emergency services
- Family planning services and supplies

. . . for certain populations . . .

- Native Americans
- Children
- Pregnant women

. . . and requires that any permissible cost-sharing imposed be "nominal"

- "Nominal" was defined by then-HCFA in a regulation in 1982 to be these levels:
  - $2 per month deductible per family
  - $.50 to $3 co-pay per service
  - 5% co-insurance per service
  - Maximum $19 family premium per month (based on family size)

- One exception to these amounts: non-emergency care provided in a hospital emergency room may be subjected to a higher cost sharing level, provided other sources of outpatient care were available

Cost-sharing is another example of a difference between Medicaid and S-CHIP.

- S-CHIP permits slightly higher cost-sharing:
  - For children in households between 100%-150% FPL, the maximum cost-sharing in S-CHIP is higher than Medicaid:
    - $5 office visit co-pays
    - $10 co-pays for non-emergency services furnished in an emergency room
  - For children in households above 150% FPL, no specific limits are set, although total cost-sharing may not exceed 5% of the household's income
- But S-CHIP regulations bar cost-sharing for well-child services, and for services utilized by Native Americans

Waivers that Affect Acute Care Benefits

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States have pursued benefit-specific Section 1115 waivers

- Section 1115 waivers must be “budget neutral.”
- Examples of specific waivers:
  - Utah’s Primary Care Network
  - Pharmacy Plus waivers
  - Family planning waivers
  - AIDS/HIV waivers

. . . home and community-based waivers permit non-medical benefits . . .

- Known as 1915(c) waivers, HCBS waivers allow states to offer non-medical services to avoid institutionalization

- These waivers generally are limited to a certain number of approved “slots”

. . . and freedom of choice waivers allow states to place benefits inside a managed care system.

- Known as 1915(b) waivers, it is necessary to restrict freedom of choice to operate a managed care program with a medical home and a provider network.

- Two versions:
  - Primary care case management
  - Capitation

Delivery Systems

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A roadmap for delivery systems

- Fee-for-service
- Primary care case management
- Capitated managed care

Fee-for-service

- Medicaid beneficiary visits any Medicaid provider at any time…and the state pays the provider a fee for that service

- States determine the fee schedules, and, as such, they vary widely across the country

State flexibility in setting private physician fees leads to great variation around the country.

Table 1 - Fees for High-Volume Evaluation and Management Procedures

CPT Code	CPT Procedure Description	DC	DE	PA[a]	VA	W VA	MD	Medicare[b]
99201	Office/outpatient visit; new Minimal	$25	$35	$25	$25	$26	$29	$38
99202	Office/outpatient visit; new Moderate	$33	$63	$25	$44	$47	$51	$68
99203	Office/outpatient visit; new Extended	$49	$93	$25	$65	$70	$77	$101
99204	Office/outpatient visit; new Comprehensive	$69	$132	$25	$92	$100	$109	$143
99205	Office/outpatient visit; new Complicated	$88	$167	$30	$117	$127	$139	$181
99211	Office/outpatient visit; established Minimal	$15	$21	$25	$15	$15	$17	$23
99212	Office/outpatient visit; established Moderate	$19	$37	$25	$26	$27	$30	$41
99213	Office/outpatient visit; established Extended	$27	$51	$25	$36	$37	$42	$55
99214	Office/outpatient visit; establ. Comprehensive	$42	$79	$30	$56	$59	$66	$86
99215	Office/outpatient visit; established Complicated	$62	$115	$45	$81	$87	$97	$125
99241	Office consultation Minimal	$32	$48	$30	$34	$36	$39	$53
99242	Office consultation Moderate	$46	$88	$30	$62	$67	$73	$96
99243	Office consultation Extended	$61	$118	$30	$83	$90	$97	$128
99244	Office consultation Comprehensive	$87	$166	$49	$116	$126	$137	$180
99245	Office consultation Complex	$113	$215	$49	$151	$164	$178	$232

[a] - Pennsylvania's fees correspond to 2004. All other states' and Washington, DC's fees correspond to 2005.
[b] - Medicare Fee schedule for 2005.

Primary Care Case Management

- Each beneficiary is assigned to a primary care provider (PCP)
- The PCP generally receives a monthly fee for managing the beneficiary's care
- PCP does not assume financial risk; generally receives payment for medical care services rendered on a fee-for-service basis

Full Managed Care (Risk Model)

- Each beneficiary is assigned to a managed care organization (MCO)
- MCO develops a network of providers to offer a comprehensive set of benefits
- MCO receives a monthly capitation fee from the state…and assumes the financial risk for providing covered services

State's objectives in pursuing managed care include improving quality, access and cost containment . . .

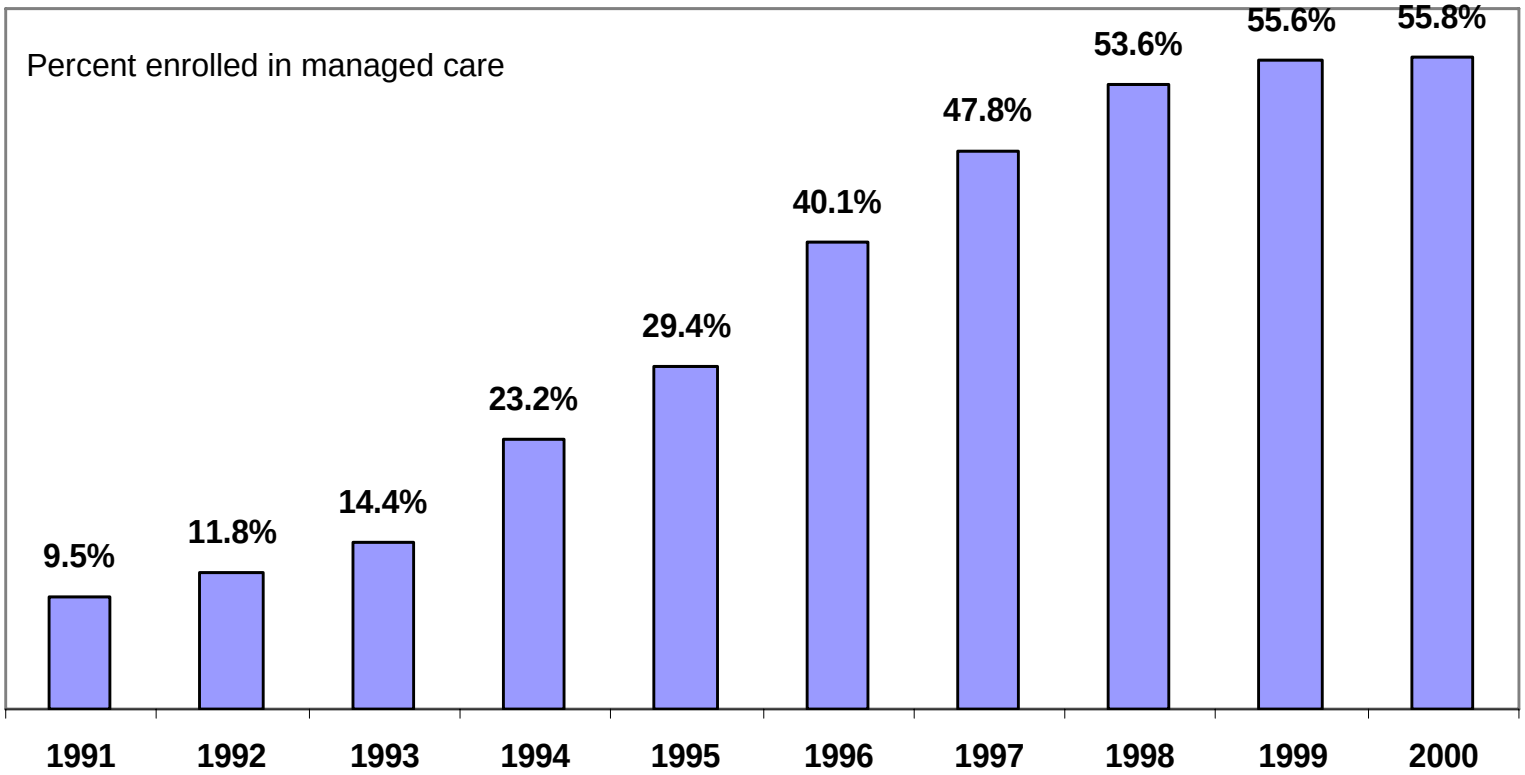
- Managed care has opened up provider networks to reach specialists who reject Medicaid's low FFS payments
- HEDIS and other quality standards are not available in FFS
- MCOs are expected to reduce the use of unnecessary services

. . . and capitated managed care is not constrained by certain requirements in Medicaid fee-for-service.

- MCOs may cover non-medical benefits, with the goal of prevention:
  - Bike helmets
  - Car seats
  - Smoking cessation and weight management programs
  - After-school care
- MCOs also may hire family members and friends to provide supports

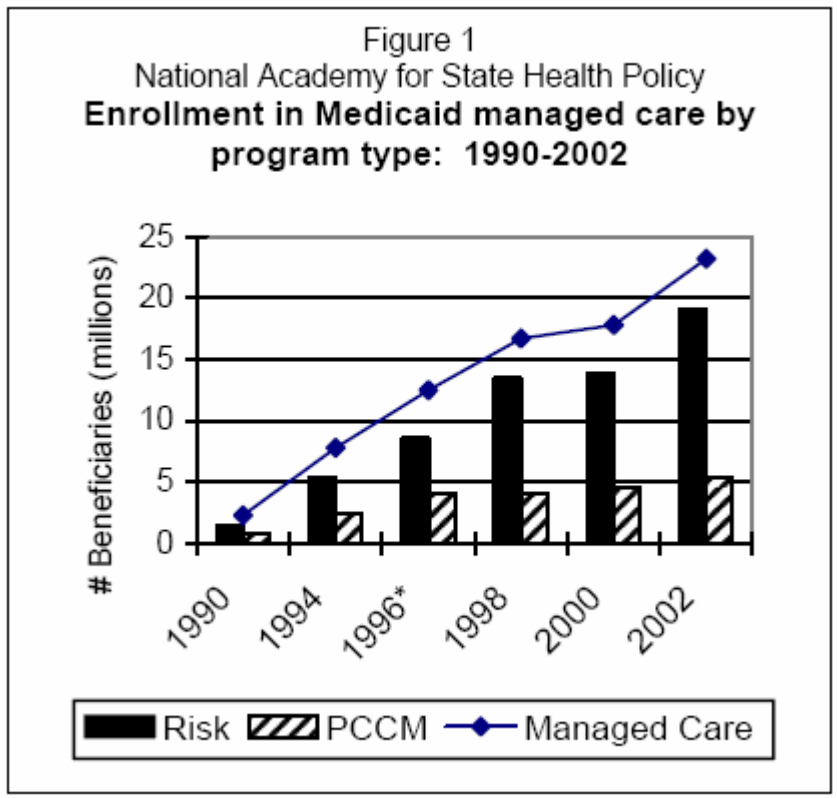
Medicaid managed care saw rapid growth in the 1990s . . .

Growth in the Share of Medicaid Beneficiaries Enrolled in Managed Care, 1991-2000



Adapted from Kaiser Commission on Medicaid and Uninsured, Medicaid and Managed Care Fact Sheet, December 2001

. . . and most of that growth was in the form of capitated programs

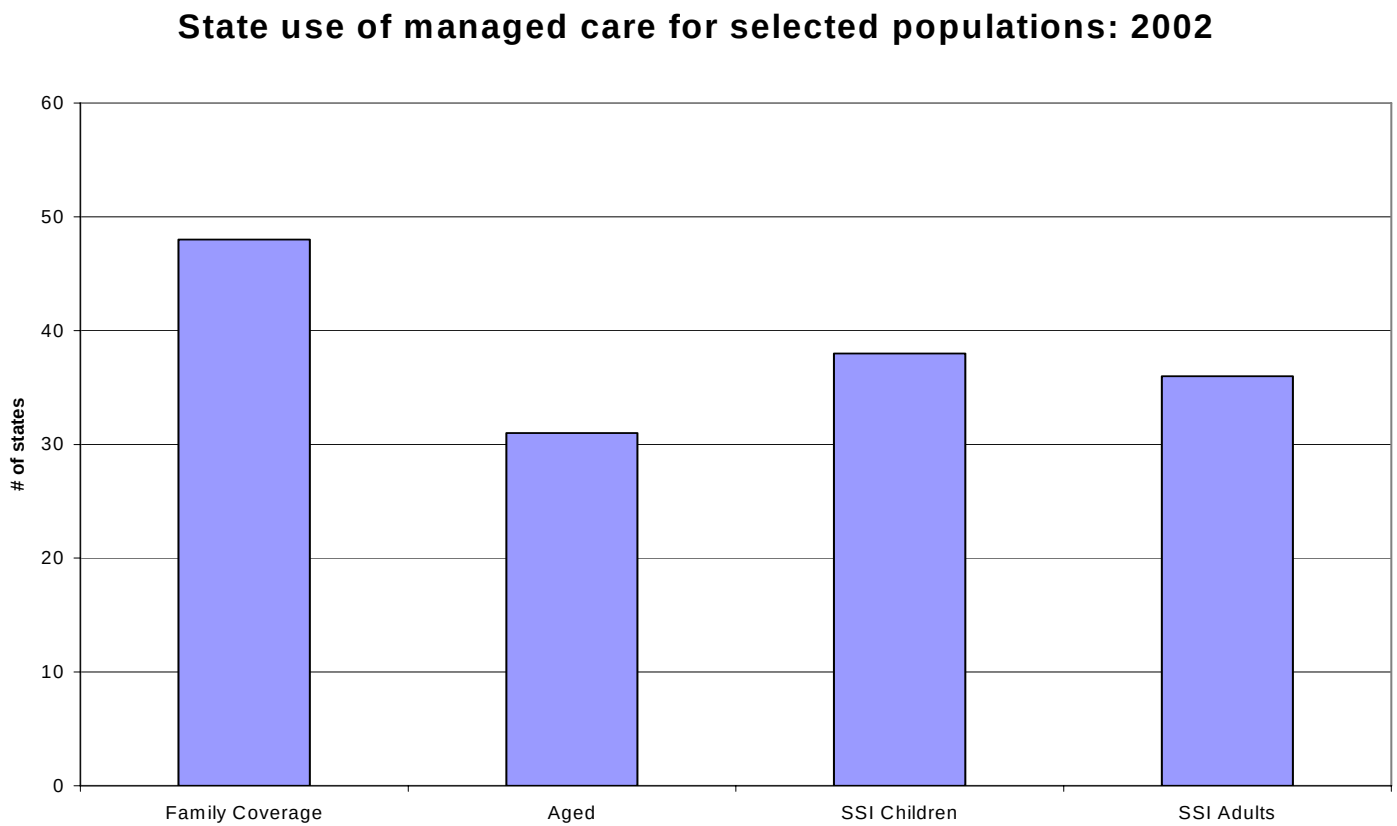


Managed care has become a widespread tool in the states

- 40 states have more than 50% of their Medicaid population enrolled in some form of managed care

- Only 3 states have no beneficiaries enrolled in any form of managed care (AK, NH, WY)

Families and children are the most likely eligibility groups to be enrolled in managed care programs



Adapted from National Academy for State Health Policy
Medicaid Managed Care: Looking Forward, Looking Back June 2005

The most basic forms of managed care no longer require a freedom of choice waiver

- Balanced Budget Act (BBA) of 1997 allows states to mandate managed care enrollment without obtaining a federal waiver

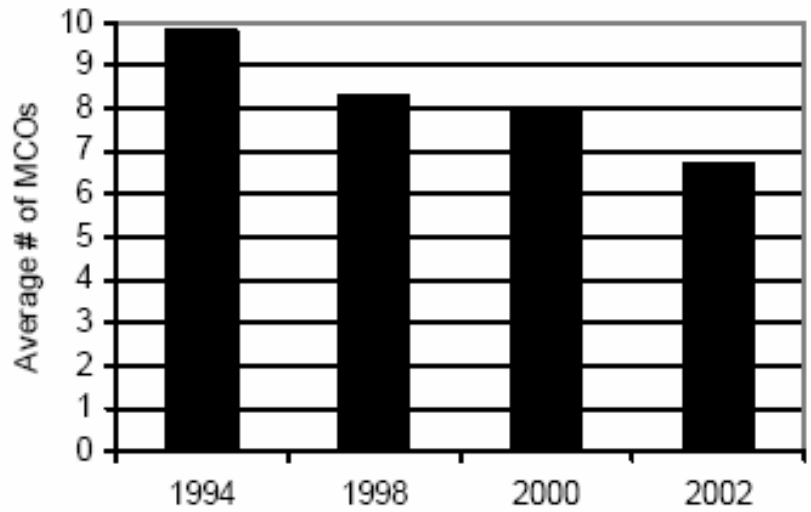
Excepted from this are special needs children, Medicare beneficiaries, and Native Americans

The BBA of 1997 also facilitated more widespread MCO participation

- Eliminated the requirement that participating MCOs have at least 25% of their business in commercial insurance
- Allowed states to lock-in a beneficiary's choice of a managed care organization for 12 months, instead of 6 months

Despite the growth in managed care, fewer MCOs are participating.

Figure 9
National Academy for State Health Policy
Average number of participating MCOs in states that contract with MCOs: 1994-2002



Preview of Some Key Questions for the March 2006 Session

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Key recommendations in "acute care delivery system" from the Commission will include:

- Should minimum national "benefits" standards be set?
- If so, should the minimum national standards be altered?
- Should other national coverage rules be set?
- Should maximum national "cost sharing" standards be set?
- If so, should the maximum national standards be altered?
- Should some rules be set about policies that are within a state's discretion vs. policies that require express federal approval (like the current waiver model)?
  - Managed care and other delivery system models
  - Tiered benefit and cost-sharing arrangements, ala S-CHIP
- If so, where is that line drawn?

Questions

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