April 14, 1997

HHS RECOMMENDED POSITIONS
on the
NGA MEDICAID TASK FORCE
WORKING DRAFT (FEBRUARY 24, 1997)

Cost Saving Alternatives.

1. *Managed care for the dually eligible.*

The Task Force urges greater reliance on managed care for this group, with the goals of reducing costs while serving beneficiaries in a more coordinated, effective manner. Specifics as to how this would be achieved are absent.

Position:

HCFA is working extensively with States on a number of demonstrations in this area. We welcome this discussion on how to structure programs to meet this goal. This Administration strongly supports maintaining beneficiaries' rights under Medicare and any proposal should include beneficiaries right to freedom of choice.

2. *QMBs and SLMBs.*

The Task Force urges Federalization of what is now a State mandate to pay for Medicare cost-sharing for low-income Medicare beneficiaries through the Medicaid program.

Position:

In the past, we supported in principle the Federalization of Medicare cost-sharing within the context of the overall budget. We would be interested exploring these issues with NGA in the context of the balanced budget discussions.

3. *Reimbursement rates for QMBs and the dually eligible.*

States want statutory clarification that, if they must pay Medicare deductibles and coinsurance, they should be allowed to pay based on the Medicaid rate and not based on the Medicare rate. Under recent judicial interpretations, many States have been forced to pay based on the Medicare rate, which is typically higher and which therefore increases State costs for this population.

Position: We believe it would not be appropriate to legislatively over-rule the prevailing court decisions on this issue.

4. Boren repeal.

States believe that reimbursement rates for institutional care will be significantly moderated when the Boren Amendment is repealed. The NGA cites the American Public Welfare Association model, which projects federal savings between $6 and $8 billion over four years for nursing facilities, and an additional savings between $4 to $10 billion in hospital costs due to the repeal of Boren.

Position: The President's FY98 Budget includes this provision.

5. Cost Based Reimbursement.

Policies that require States to reimburse providers, such as federally qualified health centers (FQHCs) at rates that do not reflect States' positions as dominant purchasers in the health care market place should be repealed. Similarly, Boren-like language that has exposed States to lawsuits driving up rates for services, including outpatient and home health care should be repealed. Ohio currently faces a cost-based reimbursement lawsuit for home health services that could cost the State between $100 and $130 million, essentially doubling home health reimbursement rates.

Position:

The President's FY98 Budget includes a proposal to phase-out cost-based reimbursement for FQHCs in 1999. In addition, a funding pool is created for supplemental payments to health centers during the transition away from cost-based reimbursement.

6. *Private sector insurance coverage.*

The NGA Task Force urges stronger reporting requirements on employers regarding provision of health insurance coverage for workers and their families. No specifics are provided as to the nature of the requirement, who would impose, implement, and enforce it, or which employers the mandate would apply to.

Position:

Although we support State efforts to expand enrollment of Medicaid beneficiaries in employer-sponsored insurance plans, we have serious reservations about the usefulness of new reporting mandates. In light of HCFA's own experience with the Medicare employer data bank and the ongoing work of administrative simplification under health insurance reform, this is premature. This would be addressed under implementation of administrative simplification provisions under health insurance reform.

7. *Managed Care*

Repeal of the waiver requirement for mandatory managed care will facilitate further development of the Medicaid managed care market. As the Medicaid markets mature, competition between managed care entities will enable States to negotiate even more favorable rates. States have already achieved significant savings through Medicaid managed care. For example, Michigan will save $120 million in Medicaid costs through managed care in 1998, about 2.5% of the state's total program budget. Between 1990 and 1996, Wisconsin has saved $100 million as a result of managed care.

With the development of models to accommodate special population needs, Medicaid managed care will increasingly penetrate the more complicated and costly segments of the caseload - the elderly and disabled.

Position:

The President's FY98 Budget provides for the elimination of waiver requirements for the initiation and renewal of mandatory managed care programs. This would facilitate further development of Medicaid managed care markets. Quality protections are important (as discussed below), however, particularly as special needs populations (e.g., special needs children, the disabled and the elderly) move into managed care plans. The Federal government and the States will need to work together to make sure that the special needs of these populations are addressed.

8. *Provider Selectivity.*

To clarify that there is no defacto entitlement for providers to participate in the Medicaid program in the fee for service environment, HCFA should support states in their efforts to contract with a limited number of facilities so they can negotiate better rates. For example, Medicaid recipients could be directed to two out of four hospitals in a city for services, or to a particular source to have prescriptions filled.

Position:

States have sufficient flexibility under current law (section 1915(b)(4)) to implement provider selectivity.

9. *Cost sharing:*

The NGA Task Force believes substantial savings could be achieved if all Medicaid beneficiaries were required to pay a small premium every month. Alternatively, premiums could be considered

for certain subgroups within Medicaid. Two examples: disabled children who receive Medicaid even though their parents are not poor and expansion populations.

Position:

HCFA opposes imposing more cost-sharing obligations on current beneficiaries than are permitted under current law, especially when the purpose is merely to reduce program spending. These are the poorest of the poor and even a $5 per month payment could be a hardship. A premium would discourage people from enrolling when they are healthy, which in turn would reduce the use of preventive services, and increase the incidence and cost of treatment for more serious conditions later.

In limited circumstances, HCFA does not oppose the imposition of additional cost-sharing that would give States the flexibility to impose nominal copayments on HMO enrollees to the same extent as they do on non-HMO beneficiaries. This provision is in the President's FY98 Budget. Also, under 1115 waiver programs, we have agreed that States may impose premiums on people who are eligible for Medicaid without these waivers.

10. *EPSDT.*

Governors, congress and the Administration should work together to assess the difference in cost between EPSDT and an actuarially based package of benefits comparable to those offered through a private sector managed care plan.

Position:

To date, States have not demonstrated that the EPSDT benefit package has created a significant financial burden on States. Preventive services for children result in better health outcomes and cost-effectiveness. Childhood immunizations, for example, are one of the most cost effective prevention interventions. Data from a 1995 CDC report indicate that DPT vaccinations save $29 for every $1 spent and MMR vaccinations save $21 for every $1 spent. Given the research on the significant value of preventive services for children related to both health care outcomes and cost effectiveness, we support maintaining the EPSDT program requirements under current law.

11. *Fraud and abuse:*

The Task Force urges expansions of aggressive new State-based strategies to combat fraud and abuse. Specifics are absent.

Position:

HCFA and the Inspector General will continue to work with States to aggressively combat fraud and abuse in the Medicaid program. In fact, the Administration currently is developing a series of

proposals to reduce fraud and abuse. This package will help the Federal government and State governments save money.

Managed Care and Quality

The staff of the Medicaid task force suggest that the States proactively pursue a quality agenda focused on monitoring quality and evaluating improvement.

States would provide HCFA with quality assurance plans which could include a number of elements, such as a grievance process; a comparative report card of health plan performance; deeming of NCQA accreditation standards; and HEDIS reporting requirements. In its quality assurance plan, a state would establish benchmarks tied to measuring future quality performance. A number of indicators could be monitored and assessed annually by States, such as consumer satisfaction, numbers of low birth weight babies, cesarean section rates and immunization rates, to name a few of the dozens of possibilities. States would set quantifiable goals for providers to meet, and providers would have their performance in meeting these goals considered as decisions are made whether to continue the contractual relationship between the health plan and the Medicaid program.

Position:

This proposal appears to be consistent with quality-related provisions in the President's Budget for FY98. We are working with NGA staff to further discuss the roles of the States and HCFA in establishing standards, thresholds and other quality requirements.

Children and Outreach

The task force work group recommends that as a first step HCFA provide the States with any available demographic information on the children, including a state-by-state breakdown of where they live, so States may better understand the situation that they are being asked to address.

The vast majority of children eligible for Medicaid are already enrolled in the program. Once States have a better understanding of those who have not yet received available coverage, new targeted outreach plans can be implemented, calling on the knowledge gained by studying the best practices currently in place.

Position:

HCFA agrees with the Governors that identification of the unenrolled population is essential in order to expand outreach efforts. HCFA will work with States to identify the unenrolled population, the barriers to enrollment and best practices of states regarding outreach activities in order to successfully enroll eligible children currently not participating in Medicaid.