

**KANSAS HEALTH POLICY AUTHORITY
LEGISLATIVE COORDINATING COUNCIL STUDY #9
Medicaid Reforms Allowed by Federal Law
Deficit Reduction Act of 2005¹**

Background

On July 9, 2008, the Legislative Coordinating Council (LCC) approved a number of studies to be conducted during the Interim by the Kansas Health Policy Authority (KHPA). Identification of these studies was in response to a May 2008 request made by the Conference Committee on H. Sub. For SB 81. Reporting on the flexibility in Medicaid design allowed under federal law was one of the studies identified.

Introduction

The Deficit Reduction Act of 2005 (DRA) is the result of a budget resolution passed in 2005. The resolution called for several committees in Congress to recommend legislation that would reduce federal spending by \$35 billion from 2006 – 2010. CBO estimates are that the DRA will reduce federal spending by \$39 billion over five years. About one third of that amount will come from changes in Medicare or Medicaid programs. Listed below are brief summaries of the key components of the DRA.

Federal Upper Payment Limit for Multiple Source Drugs

The federal upper payment limit (FUL) which applies to multiple source drugs for which the Food and Drug Administration has rated two or more products to be therapeutically and pharmaceutically equivalent, will be calculated as equal to 250% of the average manufacturer wholesalers. CMS previously calculated the FUL to be equal to 150% of the published price for the least costly therapeutic equivalent.

Reform of Asset Transfer Rules

Assets transferred for less than fair market value during the “look-back period” before an individual applies for Medicaid are added to the applicant’s countable resources. The individual’s eligibility for Medicaid for long-term care will be delayed for a penalty period; the length of the penalty period is calculated by dividing the uncompensated value of the transferred assets by the monthly cost of private nursing care in the state. The look-back period for most transfers is mandatory and was increased from 36 months to 60 months.

Expansion of State Long-Term Care Partnership Program

The state long-term care partnership consists of two elements: (1) provisions in the state Medicaid plan to disregard assets to the extent of payments made under a long-term care policy; and (2) insurance policies meeting certain requirements. The policy must:

- be a qualified long-term care insurance policy as defined by Internal Revenue Code
- have been issued on or after the effective date of the state plan amendment
- cover an insured who was a resident of the state when coverage became effective
- meet the model regulations and requirements of the model Act

¹ Deficit Reduction Act of 2005, Public Law 109-107, CCH Law and Explanation, Wolters Kluwer

- contain inflation protections based on the age at which the beneficiary purchased the policy.

A certificate under a group insurance contract may be a long-term care insurance policy. If the insured has exchanged one policy for another, the requirement of the state residence applies to the first policy issued. If, when the policy is sold, the insured is under the age of 61, it must provide compound annual inflation protection. If the purchaser is between 61 and 76 years old, it must have some level of inflation protection. If the purchaser is 76 years or older, inflation protection is optional. The Medicaid agency must assist the state department of insurance to assure that the individuals who sell long-term care partnership policies are trained and demonstrate an understanding of the policies and their relationship to other public and private coverage of long-term care.

The policies must meet the requirements of the Long-Term Care Insurance Model Act and Long-Term Care Model Insurance Regulations published by the National Association of Insurance Commissioners for consumer protection. The policies must be portable; therefore, by January 1, 2007, the Secretary must develop standards for uniform reciprocal recognition of long-term care partnership policies among the states with qualified partnerships so that benefits paid under the policies will be treated the same way by all states. Kansas implemented a Long-Term Care Partnership Program in April 2007.

Eliminating Fraud, Waste and Abuse in Medicaid

Beginning January 2007, the Federal Medical Assistance Percentage (FMAP) for amounts recovered under state false claims actions will be decreased by 10 percentage points to encourage states to establish and maintain laws and standards for the prosecution of false or fraudulent Medicaid claims. Generally, states must repay the federal share of any provider overpayment within 60 days of discovering the overpayment whether or not the state has recovered the overpayment. The amount of repayment is determined by the FMAP. The provision established a reduction in the FMAP for those states whose false claims legislation meets the requirements of the Inspector General of HHS (OIG). Kansas implemented a policy to ensure these federal requirements are met.

Flexibility in Cost Sharing and Benefits

States, through Medicaid state plan amendments, may impose premiums and cost sharing for any group of individuals for any type of services, except for prescribed drugs which are treated separately, and may vary such premiums and cost sharing among such groups of individuals or types of service. The existing Social Security Administration (SSA) provisions on premiums and cost sharing for workers with disabilities are not affected by the amendment. The income eligibility limits for Medicaid are extremely low in Kansas. Cost sharing for this very low income population is formidable. See Legislative Coordinating Council Study 4 for a review of potential cost sharing and buy in options for Medicaid eligible families.

Special Rules for Cost Sharing for Prescription Drugs

States may impose higher cost sharing amounts for state-identified non-preferred drugs within a class, and waive or reduce the cost sharing otherwise applicable for preferred drugs within a class of drugs. States may not apply such cost sharing otherwise applicable for preferred drugs for individuals exempt from cost sharing. Preferred drugs are those identified by the state as the least costly effective prescription within a class of drugs. In Kansas, the standard

prescription co-payment for Medicaid beneficiaries is \$3.00 regardless of class of drug, or whether it is a brand name or generic drug.

Emergency Room Copayments for Non-Emergency Care

State plans may be amended to permit a hospital to impose cost sharing on individuals, within state-specified groups, for non-emergency services furnished to an individual in the hospital emergency department, if certain criteria are met. Kansas does not impose a co-pay in this instance.

Use of Benchmark Benefit Packages

A state has the option to amend its state plan to provide for Medicaid assistance to state-specified groups through enrollment in: (1) benchmark or benchmark equivalent coverage, and (2) wrap-around benefits to the benchmark coverage or benchmark equivalent coverage, consisting of early and periodic screening, diagnostic, and treatment services, for any child under the age of 19 under a state plan. Kansas proposed the use of benchmark plans by establishing a Premium Assistance program, Healthy Choices, which was repealed.

Reforms of State Financing Under Medicaid

Managed Care Organization Provider Tax Reform

Medicaid managed care organization (MCO) provider classes will expand to include all MCO's, which includes both Medicaid and non-Medicaid MCO's. States desiring to qualify for federal reimbursement should apply to both MCO's. KHPA has analyzed this approach and does not propose to pursue it at this time.

Reforms of Case Management and Targeted Case Management

The definitions of case management and targeted case management services have been modified. Case management services are defined as those services that will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services. Such services include:

- Assessment of an eligible individual to determine needed services
- Development of a specific plan of care based on information collected
- Referrals and related activated to help an individual obtain needed services
- Monitoring to ensure that an individual's care plan is effectively implemented and adequately addresses the individual's need

Activities that are not reimbursable as case management services include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual is referred. Kansas meets federal regulation through CMS approval of its State Plan Amendment in December, 2007.

Miscellaneous Medicaid Provisions

Family Opportunity Act

A new optional Medicaid eligibility group has been created for children with disabilities under the age of 19 who meet the severity of disability requirement under the Supplemental Security Income (SSI) program, without regard to any income or asset eligibility requirements applicable under SSI for children, and whose family income does not exceed 300% of the federal poverty level (FPL).

Demonstration Projects Regarding Home and Community Based Alternatives to Psychiatric Residential Treatment Facilities for Children

The Secretary is authorized to award grants on a competitive basis to conduct demonstration projects in up to 10 states during fiscal years 2007-2011. The project will test the effectiveness of improving or maintaining a child's functional level and the cost-effectiveness of providing coverage for alternative home and community based services (HCBS) to psychiatric residential treatment (PRTF) for children enrolled in Medicaid.

Money Follows the Person Rebalancing Demonstration

To increase state use of home and community based care, the Secretary of HHS will award grants to states to conduct demonstration projects that will (1) expand the state's capacity to provide home and community based long term care services for individuals who choose to transition into the community, and (2) ensure that procedures are in place to provide quality assurance and continuous quality improvement that is comparable to other Medicaid home and community based services. The project will also help relocate individuals from institutions into the community. Kansas was awarded a Money Follows the Person (MFP) demonstration grant in May 2007, in the amount of \$37 million over 5 years.

Medicaid Transformation Grants

The Secretary will provide for payments to states for the adoption of innovative methods to improve the effectiveness and efficiency of providing medical assistance for a two year period beginning in FFY 2007. Kansas was awarded a CMS Medicaid Transformation Grant in October of 2006 for \$906,664.

Health Opportunity Accounts

The Secretary is required to establish no more than 10 demonstration programs with Medicaid for health opportunity accounts (HOAs). After a five year initial period, if the programs are determined to be successful based on quality of care and cost effectiveness, the program may be extended or made permanent in the state and other states may implement the demonstration programs. The Kansas Healthy Choices program, a Premium Assistance model was proposed by KHPA, and repealed. It included a pilot on consumer driven health care including Health Opportunity Accounts (HOA's) which allow incentives to be provided to beneficiaries seeking preventive care services.

State Option to Establish Non-Emergency Medical Transportation Program

A state may establish a non-emergency medical transportation brokerage program for beneficiaries who need access to medical care and have no other means of transportation. The program may include a wheelchair van, taxi, stretcher car, bus tickets and any other transportation that the Secretary finds appropriate. KHPA proposes to establish a transportation brokerage program.

Home and Community-Based Services as an Optional Benefit for Elderly and Disabled Beneficiaries

States may provide medical assistance for home-and community-based services in their state plan amendments. The services would be for beneficiaries whose income does not exceed 150% of the FPL who are eligible for medical assistance under the state plan. The state may provide this option with determining that, but for the provision of such services, the beneficiaries would require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICFMR).

Optional Choice of Self-Directed Personal Assistance Services

A state may cover payment for part or all of the cost of self-directed personal assistance activities based on a written plan of care to individuals for whom there had been a determination that, but for the provisions of such services, the individuals would require and receive personal care services under the plan or home – and community – based services provided pursuant to a waiver under the SSA. Self-directed personal assistance services may not be provided to beneficiaries who reside in a home or property that is owned or operated by a provider not related by blood marriage. Kansas offers self directed Personal Assistance Services through the Demonstration to Maintain Independence and Employment grant.

Notice of Proposed Rulemaking under Moratorium

In an attempt to address what it perceived as violations in Medicaid policy, the Bush administration cited Government Accountability Office (GAO) and Office of Inspector General (OIG) reports to justify the formulation new of regulations that would restrict payment for certain Medicaid expenses. In response to the newly released CMS notice of proposed regulations, Sen. Henry Waxman surveyed all State Medicaid Directors to assess the impact of the proposed rules. In March, 2008, KHPA wrote to the Kansas Congressional delegation citing the regulations as potentially onerous, fiscally and programmatically burdensome. In June, 2008 the Iraq War Funding bill was signed which included suspension of the six regulatory actions proposed by CMS. These six proposed rules have direct impact on the Medicaid program and are under Moratorium until April 1, 2009. The impact to Kansas reflects the fiscal impact for one year.

1. **Public Provider Reimbursement**
A change in the definition of a unit of government which limits the types of entities authorized to provide non-federal share funding, and determines which health care providers would be subject to the new cost limit. Governmental hospitals would be negatively impacted due to change in cost based UPL calculation. Courts ruled the regulation was not legally adopted, it could be republished by CMS after April 1, 2009.
Impact to KS: \$18.7 M
2. **Graduate Medical Education Payments**
Costs and payments associated with direct GME programs are not eligible for FFP under state Medicaid programs. CMS contends the current methodology does not provide for clear accountability, payments are difficult to track, and there is little assurance they are supporting GME programs that benefit Medicaid beneficiaries. CMS never adopted this proposed rule issued on May 23, 2007; no action may be taken before April 1, 2009
Impact to KS: \$1.178 M
3. **Rehabilitation Services**
CMS is prohibiting payment for services through the Medicaid rehabilitation option if such services could be funded through other federal, state or local programs. Prohibits imposition of any restrictions relating to the coverage of or payment for these services that were more restrictive than those in place as of July 1, 2007.
Impact to KS: Undetermined
4. **School Based Administration and Transportation Services**
CMS published a final rule on Dec. 28, 2007 which eliminated payment for school based administration and severely curtailed payment for school based transportation. Sec 206 of PL 110-173 postponed the effective date to June 30, 2008, the War Funding bill extends the date to April 1, 2009
Impact to KS: \$3.3M

5. Targeted Case Management
The funding bill suspends CMS' interim final rule, published Dec. 4, 2007 until April 1, 2009, except for the portion that adopts the DRA definitions of case management services and targeted case management services, only to the extent those definitions are not more restrictive than the policies set forth in a State Medicaid Director (SMD) letter on Jan 19, 2001 or the SMD letter of July 25, 2000.
Impact to KS: Undetermined
6. Provider Taxes
Suspends until April 1, 2009 the effect of the final rule on provider taxes published on Feb. 22, 2008, except the portions that implement the Congressionally-mandated change in the hold harmless safe harbor percentage from 6 percent to 5.5 percent (until Sept. 30, 2011) and a new definition of the Medicaid managed care service class of providers that can be taxed.
Impact to KS: Undetermined

Other Flexibilities

States may use the DRA in combination with other options under titles XIX and XXI of the Social Security Act, and other programs to create meaningful reform in their state. The table below lists waiver options along with state plan options available under Federal law that offer flexibility to help states manage their Medicaid programs.

1915(c) Waivers	Home and Community Based Services waivers. This section of the law allows the Secretary of HHS to waive Medicaid provisions in order to allow long term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long term services in institutional setting.
1915 (b) Waivers	Managed Care/Freedom of Choice waivers. This section allows the Secretary to grant waivers that allows states to implement managed care delivery systems, or otherwise limit individual's choice of provider under Medicaid.
1115 Research and Demonstration Projects	This section provides the Secretary of HHS broad authority to approve state projects that test policy innovations likely to further the objectives of the Medicaid program
Combined 1915(b)/(c) Waivers	States use 1915(b) to limit freedom of choice and 1915(c) to target eligibility for the program and provide HCBS. This option allows states to provide long term care services in a managed care environment.
1115 Demonstration HIFA Waivers	The HIFA option under 1115 is specifically designed to help states extend coverage to uninsured individuals.
1915(i) Waiver	States have the option to amend their State plans to provide Home and Community Based services without regard to statewideness or certain other Medicaid requirements, and may establish needs based criteria for eligibility. These services may include case management, homemaker/home health aide, personal care services, adult day health services, habilitation services and respite care.
1915(i)(1)	This section of the Act gives states the option of providing HCBS under their state plan to individuals eligible for Medicaid under an eligibility group covered in the state plan, and who have income that does not exceed 150% of the FPL.
1915 (i)(3) HCBS Program	Under this section of the Act, States may exercise the option not to

Eligibility	apply 1902(a) (10) of the Act which pertains to income and resource eligibility rules for the medically needy living in the community. This election allows States to treat medically needy individuals as if they are living in an institution by not deeming income and resources from an ineligible spouse to an applicant, or from a parent or child.
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Source: Centers for Medicare and Medicaid Services, www.cms.hhs.gov, downloaded November 4, 2008