

Encouraging Healthy Behavior and Proper Utilization of Services

Introduction

The 2006 Joint Chairmen's Report stated that "the design of Maryland's Medicaid program fails to encourage healthy behavior and discourage inappropriate utilization of care," and the committees noted that "other states are exploring the use of health savings accounts and higher beneficiary cost-sharing to change behavior and generate program savings." The committees encouraged DHMH to explore potential innovations aimed at changing enrollee behavior and directed the Department to:

- Study methods for rewarding Medicaid enrollees who engage in healthy behaviors
- Study the feasibility of establishing a health savings account through which enrollees can access rewards earned
- Study the potential impact of additional cost-sharing on enrollee health
- Include an analysis of the fiscal implications of the options examined

Background

In recent years, states and the federal government have focused on the need for extensive Medicaid reform. At the same time, the country has faced an increasing number of uninsured individuals. The federal government has attempted to mitigate the burden of the growing number of uninsured and rising Medicaid costs by allowing additional program flexibility for states. One of the most recent examples of this newly granted flexibility came with the passing of the Deficit Reduction Act of 2005 (DRA). The DRA introduced multiple options for states to encourage responsible behavior among participants and to implement changes which would ultimately result in savings to the Medicaid program. One of the primary goals of the DRA was to standardize options for states to change their benefit structure and provision of care. Prior to the DRA, states' only option for implementing changes to the traditional Medicaid system of care was through Demonstration programs or waivers, most often § 1115 waivers. These waivers would allow states to waive certain provisions of the Social Security Act which authorizes the Medicaid program. However, the waivers also require extensive monitoring and that programs be "budget neutral" (meaning they can't cost more than the traditional Medicaid program). In short, the DRA affords states the opportunity to implement program changes without the additional administrative burden required under waiver programs.

Encouraging healthy behaviors among Medicaid recipients is viewed by many as important to promoting the health of the Medicaid population and possibly reducing Medicaid expenditures. Although state Medicaid agencies have not undertaken efforts to influence the health-related behaviors of program recipients, the Centers for Medicare and Medicaid Services (CMS) is allowing states to integrate incentives and penalties into its programs that promote healthy behaviors. One such approach is to create financial incentives that would encourage Medicaid recipients to take greater care of their own health. Through such an approach, money would be deposited in individual health care accounts established for Medicaid recipients. The recipients would accrue funds in the accounts when they engage in behaviors designated by the state as health promoting. Such services might include receiving preventive care services or participating in disease management programs. The funds deposited in the accounts could be

used by the recipients to pay for out of pocket health related costs, such as over-the-counter drugs.

In addition to the new leeway sought by states in establishing individual health care accounts, States have also sought to implement reforms with greater benefit flexibility and greater recipient cost-sharing. Programs in Florida, Kentucky, West Virginia, and South Carolina are undertaking reforms that promote healthy behaviors and accrue savings by enrolling individuals in managed care. HealthChoice, Maryland's risk-adjusted capitated managed care program, is almost 10 years old and has slowed the growth of costs considerably. Given that approximately 80 percent of Maryland's Medicaid enrollees are already enrolled in managed care, any additional savings in the families and children populations would be difficult to achieve. In addition, HealthChoice has had a demonstrable effect on improving healthy behavior among the Maryland Medicaid population. The most recent evaluation of HealthChoice showed that between 2001 and 2004 there were increases in:

- The percentage of enrollees receiving ambulatory care visits from 60% to 70%;
- The percentage of well child visits from 38% to 46%;
- Children receiving a dental visit from 34% to 44%, and;
- One-year olds receiving lead screening from 43% to 49%.

Since its inception, HealthChoice data have also shown lower levels of hospital admissions for individuals with asthma and diabetes, which indicates improved access to preventive care.¹

Maryland charges recipients a nominal co-pay for prescription drugs, e.g., \$1 for generics and drugs on the state's preferred drug list and \$3 for brand-name drugs and drugs not on the state's preferred drug list. Children, pregnant women, and individuals residing in institutions are excluded from co-pay requirements. Prescriptions currently cannot be denied to enrollees for failure to pay, which forces pharmacists to absorb the co-pay.

The new benefit flexibility and recipient cost-sharing allotted by the DRA could be used to promote healthy behaviors and appropriate health care utilization, although the impact would vary depending on what a state may be doing under existing federal waivers. Among the new flexibility offered by the DRA, states can impose co-pays on the use of an emergency room for non-emergent care. In doing so, states could discourage inappropriate and costly emergency room care while promoting efficient preventive care that is available in a physician's office.

Rewarding Healthy Behaviors

Rewards for healthy behaviors are a common thread among states championing Medicaid reform via consumer-directed health care. The effort to promote and reward healthy behaviors is premised on the belief that it is less expensive to care for healthier beneficiaries such as a patient who actively manages his diabetes.² Florida is one of the most high-profile state programs promoting healthy behaviors via Medicaid Reform. Owing to the scope and development of the Florida program, an in-depth examination of the state's reforms is presented.

Florida Medicaid Reform – In Depth

One of the most high-profile state programs promoting healthy behaviors is the Enhanced Benefits Account pilot project, which is part of Florida's Medicaid Reform. This program is

¹ HealthChoice Evaluation. 2006. http://www.dhmf.state.md.us/mma/healthchoice/pdf/FINAL_HCEval2006.pdf

² Patients key to latest Medicaid reforms. Daniel C. Vock, Stateline.org. Tuesday, October 03, 2006
<http://www.stateline.org/live/details/story?contentId=146088>

designed to reward Medicaid recipients who engage in activities that can improve their health such as showing up for doctor's appointments, undergoing routine screenings, losing weight or quitting smoking. Participation in such activities will earn credits that recipients can use to buy health-related items at a pharmacy.

All individuals enrolled in Florida Medicaid Reform are eligible to earn and use credits in the Enhanced Benefits Account program. Enrollees earn credits by taking part in a healthy behavior. Each type of healthy behavior and the corresponding credit amount are defined and approved by the state. Individuals may earn up to \$125 in credits during the first year of the pilot program (September 1, 2006-June 30, 2007), but Florida has not announced the earning limit for subsequent years. Healthy Benefits Accounts became available November 1, 2006. Enhanced Benefits Accounts are to be funded through savings incurred by the Medicaid program under the state's new •1115 waiver, although there is no special fund designated for this purpose.

Groups eligible for Florida Medicaid Reform—and therefore the Healthy Benefits Accounts—are parents and pregnant women, children, and children and adults with disabilities. All Medicaid Reform participants must enroll in a managed care plan, which had not been previously mandatory. During the two-year pilot program operating in Duval and Broward Counties, the state expects 200,000 individuals to enroll in both Medicaid Reform and Enhanced Benefits Accounts, comprising about 9 percent of Florida's Medicaid beneficiaries.

Healthy behavior programs may be offered by health plans participating in Medicaid Reform, as well as community centers and other not-for-profit organizations. The list of approved healthy behaviors was developed by Florida's Enhanced Benefits Panel. This seven-member panel is charged with designating healthy behaviors, assigning credit values, approving items that may be purchased with credits, and evaluating program participation and costs. Panel members include the Deputy Secretary for Medicaid or his/her designee (chair of the panel), three members of the Division of Medicaid, a patient advocate, a health plan representative, and an Agency Fraud and Abuse representative. The 2006-07 list of approved healthy behaviors can be found in the Appendix of this report.

The individual's health plan must verify and record an enrollee's participation in a healthy behavior (either a behavior offered by the plan or another organization). This is done through either a claim (if the service has a CPT code) or an Enhanced Benefit Universal Form (included in the Appendix), which is first completed by the enrollee and then signed off by the plan. If the enrollee participates in a healthy behavior offered by another organization, s/he must complete an Enhanced Benefit Universal Form and have it approved by his/her health plan. Plans are required to file monthly reports to the state on designated healthy behavior activities completed by enrollees. The state then assigns credits to enrollees' Enhanced Benefits Accounts and provides account balance information by mail. Initially, the state administered Healthy Benefits Accounts, but has recently hired a vendor to handle program administration.

The state stipulates that healthy behaviors must be provided by "structured" programs, defined as "any program with defined goals and/or milestones that is located in a facility that is accessible to the public that provides information, guidance, and/or assistance with specific behaviors." This means that individuals can participate in a wide variety of healthy behavior programs, as long as the recipient submits a signed Benefit Universal Form. Florida intends on developing a website that lists available programs, although programs do not have to be certified by the state.

Credits in Enhanced Benefits Accounts may be used by enrollees to purchase approved items at Medicaid-approved pharmacies. Enrollees must make their purchases at the pharmacy

counter, using their Medicaid cards and presenting a photo ID. The state hopes to eventually offer debit cards that may be used for approved items at locations other than Medicaid-approved pharmacies, but this involves some technological challenges. Pharmacies can access beneficiaries' records to see what credits are available and what has been spent. Approved items for "purchase" from Enhanced Benefits Accounts include first aid supplies, cough and cold medication, dental supplies, and many other over-the-counter items. A list of approved items is included in the Appendix of this report.

An Enhanced Benefits Call Center handles consumer calls about the plans. The state expects the health plans to assist enrollees as best they can. The state provides health plan administrators with training materials and expects plans to assist enrollees as much as possible. Enrollees may carry unspent credits in their Enhanced Benefits Account forward into the next year. Enrollees who lose Medicaid eligibility may also retain credits in their accounts for spending on approved items. The credits will remain available for up to three years after the individual loses Medicaid eligibility, as long as the individual's income remains below 200% of poverty. Florida's 1115 waiver application states that credits may be used toward the purchase of health insurance, although this option is not currently available.

Healthy Behavior Promotion in Other States

Rewards for healthy behaviors, such as those proposed in Florida, are being offered or considered by several states championing Medicaid reform. In one new approach, West Virginia requires Medicaid recipients in three counties to sign a Medicaid Member agreement, called a "personal responsibility contract," that outlines recipient rights and responsibilities.³ Enrollees are enrolled in managed care plans either upon gaining eligibility or upon renewal. The members are then automatically enrolled in a basic health plan which is based on the current Medicaid benefit package. By signing the personal responsibility contract, recipients agree to accept responsibility for promoting personal health and to avoid "using drugs illegally, drinking too much alcohol, and being overweight." They also agree not to use an emergency room for non-emergent care. If the member signs the agreement and follow its tenets, they earn extra benefits, including access to tobacco cessation and nutritional education programs; diabetes care; chemical dependency/mental health care; adult cardiac rehabilitation; chiropractic services; emergency dental services; skilled nursing care; and orthotics/prosthetics for children. Enrollees who do not wish to join the enhanced plan or who decide to disenroll will receive the standard Medicaid benefit package. Failure to honor the agreement could also result in exclusion from the special benefit and incentive programs.

Similar to West Virginia, Kentucky intends on offering additional benefits, such as dental and vision care, to recipients who adhere to disease management programs. Kentucky was the first state to receive federal approval under the DRA to make significant changes to its Medicaid program through a state plan amendment. Under a program called KyHealth Choices, Medicaid benefits will be tailored to different recipient categories. Global Choices is the standard benefit package offered to all enrollees. Comprehensive Choices provides additional benefits for members who need long-term care and covers nursing facility level of care. The Optimum Choices benefit covers (1) disabled adults in need of ICF/MR level of care, (2) those who are at risk of institutionalization, and/or (3) those currently served in the Supports for Community Living waiver. The fourth option, Family Choices, is designed for children and will serve those

³ West Virginia Medicaid Member Agreement
<http://www.wvdhhr.org/medRed/handouts/WVMedicaidMemberAgrmnt.pdf>

currently covered by the KCHIP program and some children served under the traditional Medicaid Program.

KyHealth Choices will also encourage Medicaid members to be personally responsible for their own health care. Kentucky is developing a web-based resource directory of public and private, traditional and non-traditional long term care services for enrollees with nursing home level of care needs. They are also implementing disease management programs and a series of educational programs as part of the KyHealth Choices' Get Healthy Benefits, which allows individuals with targeted diseases to access additional benefits if they participate in healthy practices.

In Idaho, Medicaid recipients who engage in healthy behaviors can accrue money to a medical savings account that can be used to pay program premiums or to purchase additional health promotion services, such as a smoking cessation program. Idaho's reform plan allows Medicaid beneficiaries to select one of three benefit plans: a basic plan designed for healthy children and adults; an enhanced plan for those with more complex health care needs; and a coordinated plan for dual eligible populations. Enrollees can opt out of these packages at any time and return to standard Medicaid. All three packages will include new benefits, including preventive and nutrition services to help obese individuals, smokers, and others adopt healthier habits. The working disabled will also be able to purchase Idaho's basic Medicaid benefits package – an approach similar to recent Medicaid reforms in Maryland. Detailed descriptions of the Florida, Idaho, Kentucky, and West Virginia reforms can be found in Appendix Two of this document.

Promoting Healthy Behaviors – Implications for Maryland

If Maryland were to implement an Enhanced Benefits Account similar to that in Florida, it would be difficult to estimate the potential costs or savings to Medicaid. Given that Florida's program is new, there is little that can be learned about besides potential program design. Florida Medicaid recipients participating in the Enhanced Benefits Account demonstration project will accrue dollar credits for engaging in approved healthy behaviors and will be permitted to spend those dollars at approved outlets to purchase designated items such as vitamins or pain and cold medication (see Appendix One). Recipients will use their Medicaid card to purchase the items.

It is possible to estimate the potential costs associated with rewarding healthy behaviors such as those approved under the Florida demonstration. The data presented in Table 1 estimates Maryland expenditures to provide credits for health behaviors (as approved by Florida) based on actual utilization data from HealthChoice enrollees. Based on estimates derived from available data, the non-administrative costs associated with rewarding only a partial selection of behaviors designated under a Florida-style Enhanced Benefits Account would require approximately \$12 million in enrollee credits for the HealthChoice population (based on CY 2005 dollars and utilization). It is important to note that this is an estimate of only the partial costs for a single year. Utilization data were not available for many of the approved health behaviors presented in Appendix One, therefore the costs of rewarding those behaviors are not included in the estimate. Additionally, the availability of the credits may induce demand for such services resulting in increased credit payments in subsequent years. It is also important to note that the estimates in Table 1 do not include administrative costs associated with operating the incentive payments, or costs for FFS Medicaid, since the majority of enrollees are in managed care.

Table 1: Estimated Beneficiary Qualification and Maryland Expenditures for Enhanced Benefits Accounts

Approved Health Behavior	Credit Amount per Occurrence	Enrollees Qualifying for Credit	Total Credits Paid for Healthy Behaviors
Childhood Dental Exam	\$ 25.00	104,188	\$ 2,604,700
Childhood Preventive Care Visit	\$ 25.00	238,415	\$ 5,960,375
Childhood Wellness Visit	\$ 25.00	48,663	\$ 1,216,575
Mammogram	\$ 25.00	32,428	\$ 810,700
Cervical Cancer Screen	\$ 25.00	27,059	\$ 676,475
Adult Dental	\$ 15.00	14,447	\$ 216,705
Adult Vision Exam	\$ 25.00	43,572	\$ 1,089,300
Total Expenditures for Health Behaviors			\$ 12,574,830

Among the reasons for the high cost estimate presented in Table 1 is that the use of preventive services, such as those being promoted in Florida, is already quite high among enrollees in Maryland’s HealthChoice program. According to the 2005 Value-Based Purchasing Report, roughly 60 percent of HealthChoice women are receiving cervical cancer screenings, and approximately three-quarters of HealthChoice children received their immunizations as well as recommended well care visits.⁴ Preventive service utilization by HealthChoice enrollees has been found to rival national commercial utilization.⁵

HealthChoice MCOs have successfully implemented programs which promote healthy behavior among participants. Most participating MCOs have numerous activities that promote healthy behavior by providing incentives and collaborating with community programs. Some programs are also specific to a geographic area or demographic characteristic, as MCOs recognize the need for multiple methods of reaching their diverse populations. Many programs focus on children’s health issues such as proper dental care, well-child visits and immunizations. The MCOs have also emphasized the importance of prenatal health by devoting resources to efforts that promote prenatal education.

One MCO offers all members ‘gifts’ (e.g., baby bibs, diabetic nutrition boards, puzzle rulers, measuring cups & spoons, mirrors) for responding to outreach. The same MCO offers incentives to pregnant mothers to encourage them to keep prenatal appointments, go to classes, and participate in other healthy activities such as breastfeeding and smoking cessation. By earning points, the mother can purchase items at the “Stork’s Nest”, including infant and toddler clothing, diapers, car seats, boosters and baby carriers. The Stork’s Nest program is a national program that links with local partners to promote prenatal health and education. It also represents collaboration between the MCO and other community entities that support prenatal health.

Another HealthChoice MCO offers health promotion activities that include events ranging from a “Healthy Smiles Poster Contest” in Baltimore and Prince George’s Counties to community-based outreach in Montgomery County. In conjunction with the Women, Infants, and Children (WIC) Program, this MCO also offers a Baby Safety Shower Education Program which is part of the Department of Health and Human Services’ efforts to increase prenatal education among parents-to-be. The showers include information on injury prevention and immunization, and provide referrals to community resources and gifts for participants.

⁴ Maryland Medicaid Managed Care Organizations. Value Based Purchasing Activities Report. Final Report. Calendar Year 2005.

⁵ The Health Plan Employer Data and Information Set. <http://www.ncqa.org/Programs/HEDIS/index.htm>

One particular MCO offers financial incentives for enrollees engaging in healthy behaviors. For prenatal patients who comply with certain treatment protocols, one participating MCO provides gift certificates to selected retailers. Mothers will earn rewards for attending each prenatal visit, post partum visit, dental visit, first pediatrician visit, and education class during and after pregnancy. This MCO also worked to increase treatment compliance among patients with diabetes by offering gift certificates to both patients and providers.

Since MCOs are currently engaged in health promotion activities, creating a new mechanism for doing so could be problematic. Currently, the MCOs are able to offer certain incentives and rewards through the existing capitation payments. The State does not want to duplicate what is already in place with the contracted MCOs. There is also no guarantee that there would be a substantial increase in healthy behavior practices, given that there are already some incentives in place.

Florida's Enhanced Benefits Accounts is just one option for encouraging healthy behaviors. There are additional provisions in the Deficit Reduction Act of 2005 that allow states to make benefit and cost sharing changes that are aimed at encouraging healthy behaviors through benefit and cost sharing changes. These provisions are discussed below.

Implications of the DRA for Maryland Medicaid: Benefit Flexibility, Cost-Sharing, and Premiums

The DRA includes projected spending reductions of \$26 billion for the Medicaid program over the next ten years.⁶ The Congressional Budget Office estimates that some of the savings would result from states shifting costs to beneficiaries and imposing newly permitted limits on health benefits. Specific changes in the DRA would permit states to impose premiums on certain recipients, increase cost-sharing (in the form of co-pays), and introduce benefit flexibility.

Benefit Flexibility

Prior to the DRA, states were generally required to offer the same set of benefits to all Medicaid enrollees, regardless of income or eligibility category. Starting on March 31, 2006, the Act allowed states to scale back Medicaid benefits provided to a limited group of enrollees, mainly adults who are not disabled or pregnant and have income that exceeds the eligibility standard for the old Aid to Families with Dependent Children program. States could offer reduced benefit packages only to enrollees who are in eligibility categories the state established before the date of the DRA enactment, not to new categories of enrollees. Additionally, states cannot reduce benefits for mandatory children, pregnant women that the federal government requires state Medicaid programs to cover, certain poor parents, individuals with disabilities, individuals eligible for both Medicare and Medicaid, and certain other enrollees who are elderly or have disabilities and are receiving long-term care services, are medically frail, or have special medical needs.

The provision would require that states choosing to restrict benefits offer packages of benefits that meet certain minimum standards. The package of benefits would have to include certain basic services, such as physician and hospital coverage, and with some exceptions, would be required to be actuarially equivalent to coverage provided via one of the specified "benchmark" benefit packages. The benchmark benefit packages would be the standard Blue Cross/Blue Shield preferred-provider option in the Federal Employees Health Benefit program,

⁶ Congressional Budget Office Cost Estimate: S. 1932, Deficit Reduction Act of 2005.
<http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf>

which is a health benefit plan offered and generally available to state employees and includes the benefits offered by the health maintenance organization with the largest commercial enrollment in the state.

The Act would allow states to offer less than actuarially equivalent benefits for certain services, such as prescription drugs and mental health services, and would permit states to offer wrap-around coverage for other health insurance. States would be permitted to enroll children in a benchmark benefit plan but would be required to provide supplemental coverage for all other Medicaid benefits, including early and periodic screening, diagnostic, and treatment services (EPSDT). Table 2 shows that more than half of all Maryland Medicaid recipients would be exempt from benefit flexibility. This estimate greatly overstates the potential impact of such flexibility; however, as most of the eligible recipients are Medicaid expansion population children and the EPSDT requirement of the DRA would exempt nearly all children below the age of 19. The EPSDT requirement would limit the true effect of the benefit flexibility provisions to children aged 19-21 and a very small handful of adults. In the end, savings from benefit flexibility would be derived from approximately 6,200 children.

Table 2: Maryland Medicaid Population Eligible for Benefit Flexibility⁷

Coverage Group	All Medicaid	Less Specifically Exempt Populations	Likely Eligible Population after Excluding Children Under 19 Due to EPSDT
Family and Children/SOBRA	392,378	203,804	-
MCHP	102,448	102,444	6,200
SSI	190,981	474	474
Other	1263	212	212
Total	687,070	306,934	6,886

Potential Fiscal Impact of Benefit Flexibility

Given that so few recipients would be subject to benefit flexibility, there is little potential for significant savings. Some states, such as Kentucky, are offering enhanced benefit packages to reward healthy behaviors and to encourage enrollment in managed care organizations. (The enhanced benefit packages are mostly funded through the expected savings in the increased managed care enrollment.) Maryland, however, already provides a comprehensive benefit package to all Medicaid recipients and requires managed care enrollment for 80 percent of its enrollees. Creating new benefit packages would mean a reduction in benefits for certain populations. As previously outlined, benefit flexibility would be largely confined to a small population of young adults aged 19 to 21.

⁷ The EPSDT requirement would limit the true effect of the benefit flexibility provisions to children aged 19-21 and a very small handful of adults. In the end, savings derived from benefit flexibility would be derived from approximately 6,200 children.

Table 3: FY 2007 PMPM by Service Category for Children Eligible for Benefit Flexibility

Service Category	Total Dollars PMPM	Percent of Total PMPM	State Share PMPM
Hospital Inpatient	\$ 41.42	27.2%	\$ 14.50
Hospital Outpatient: Other than Emergency	\$ 9.30	6.1%	\$ 3.26
Hospital Outpatient: Emergency Dept.	\$ 11.83	7.8%	\$ 4.14
Primary Care	\$ 24.66	16.2%	\$ 8.63
Other Medical	\$ 9.07	6.0%	\$ 3.18
Pharmacy	\$ 9.65	6.3%	\$ 3.38
Dental	\$ 5.60	3.7%	\$ 1.96
Specialty Care	\$ 16.18	10.6%	\$ 5.66
Non-Cap (Mental Health, etc)**	\$ 24.71	16.2%	\$ 8.65
Total PMPM	\$ 152.42		\$ 53.35

The majority of the enrollees eligible for benefit flexibility are enrolled in managed care and the FY 2007 per member per month (PMPM) expenditure for these recipients is estimated to average \$152 (Table 3). Of that cost, \$127 represents the MCO capitation rate and \$25 represents FFS expenditures for mental health and other wrap around services. Medicaid will expend approximately \$11.4 million (6,200 * \$152 PMPM * 12) in FY 2007 for those eligible for benefit flexibility. As these are predominantly MCHP recipients the state share of those expenditures is approximately \$4 million.⁸ As indicated by Table 3, removing dental services could save \$148,000 per year (3.7 percent of \$4 million); removing costs associated with all specialty visits would generate \$268,000 (6.3 percent of \$4 million); and eliminating pharmacy would produce \$424,000 (10.6 percent of \$4 million). Precise savings are difficult to estimate as the State would likely define a benefit plan that contained a mix of changes and coverage reductions.

Premiums and Cost-sharing

Prior to the implementation of the DRA, states were permitted to impose only nominal cost-sharing requirements on services for certain beneficiaries, other than children and pregnant women, and states' ability to charge premiums were very limited. Cost-sharing had been limited to \$3 for most services and providers were not permitted to deny services to recipients unable/unwilling to pay.⁹

Although Maryland imposes premiums on higher-income enrollees in MCHP the majority of Medicaid and MCHP enrollees do not pay any cost-sharing. The DRA would allow Maryland and other states to subject a broader range of enrollees to premium and cost-sharing. Premiums could not be imposed on mandatory populations or individuals with income between 100 and 150 percent of the poverty level. The new cost-sharing allowances would apply to Medicaid beneficiaries with family income at or above the poverty level. The DRA exempts, however, mandatory children, pregnant women, and individuals residing in institutions.¹⁰ Cost-sharing also would be prohibited for preventive services for all children, all pregnancy-related services, and certain other services exempt from cost-sharing. States may require cost-sharing, even for those who are otherwise exempt, for non-emergency care received in a hospital when no

⁸ Assumes a federal match of 65%.

⁹ *Ibid*

¹⁰ The Deficit Reduction Act of 2005, S. 1932.

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s1932enr.txt.pdf

other cost-sharing is imposed for care in hospital outpatient departments or by other alternative providers. The recipient protections outlined in the federal legislation will make it difficult for any state to implement the new emergency care cost sharing levels, however. Before non-emergency care is provided, the recipient must be told (1) the hospital can require a higher copayment, (2) the name and location of an alternative non-emergency room provider, and (3) the hospital can provide a referral.

Cost-sharing under the DRA is limited to 10 percent of actual costs for individuals in families with income between 100 and 150 percent of the poverty level and to 20 percent for those with family income above 150 percent of the poverty level. Total cost-sharing and premiums cannot exceed 5 percent of family income – regardless of income level. Another significant change contained in the DRA is that states may now permit providers to deny services to Medicaid recipients based on failure to pay and states may also condition the receipt of Medicaid benefits on the prepayment of imposed premiums.¹¹

Beneficiary Cost-sharing

The use of cost-sharing to promote healthy behavior or to encourage appropriate utilization of health care services is not without significant controversy. A comprehensive study conducted by the RAND Corporation and funded by the federal government in the mid-1970's determined that the utilization of health care is greatly influenced by co-insurance or cost-sharing – as cost-sharing increases, care utilization declines.¹² Although such a finding may be expected, the study further determined that cost-sharing was just as likely to decrease the receipt of effective care (such as preventive services) as it was the receipt of ineffective care (non-emergent ER services). The study further determined that the decreased utilization of care resulting from increased cost-sharing had no discernibly negative health effect on an average (healthy and more financially well off) health care consumer, but had disproportionately negative health and financial effects on poor and less healthy individuals – a population similar to those receiving Medicaid. The RAND study found that low-income adults and children reduced their use of effective medical care services by nearly half when they were required to make co-payments.¹³

Impact on Maryland: Cost-sharing

Concern has been raised that the premium and cost-sharing provisions of the DRA will “shift costs to beneficiaries and have the effect of limiting health care coverage and access to services for low income beneficiaries.”¹⁴ An analysis of the impact of the DRA on Maryland Medicaid, however, suggests a somewhat muted impact. DRA cost-sharing allowances would impact far more recipients than would premiums, but there are still a considerable number of exemptions. The DRA exempts from cost-sharing, services provided to mandatory children under 18, all children in foster care, all preventive services for children under 18 (even for optional populations), pregnancy related services, services for the institutionalized or terminally

¹¹ *ibid*

¹² Jonathan Gruber. 2006. “The Role of Consumer Copayments for Health Care: Lessons From the RAND Health Insurance Experiment and Beyond.” Kaiser Family Foundation. <http://www.kff.org/insurance/upload/7566.pdf>

¹³ Leighton Ku. 2003. “Charging the Poor More for Health Care: Cost-Sharing in Medicaid.” Center for Budget and Policy Priorities. <http://www.cbpp.org/5-7-03health.pdf>

¹⁴ Deficit Reduction Act of 2005: Implications For Medicaid. February 2006. Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/medicaid/upload/7465.pdf>

ill, emergency services, family planning services, and services for women in breast or cervical cancer eligibility categories.

As shown in Table 4, nearly half of the state’s Medicaid recipients could be subject to cost-sharing. Of those eligible, over half would be individuals in the SSI/ABD eligibility category who have incomes below SSI thresholds and higher health care needs because of their status as aged, blind, or disabled. SSI/ABD enrollees in Maryland Medicaid have higher average per member per month costs than do enrollees in other coverage groups. Prior research conducted by the Department has found that SSI/ABD enrollees are less likely than other enrollees to use services, such as ER, inappropriately. Studies have shown that the health of low income and chronically ill individuals is more sensitive to cost-sharing, as compared to those who are healthier or better-off financially.¹⁵

Table 4: Medicaid Population Eligible for Cost-sharing under DRA after Exemptions

Coverage Group	All Medicaid	Less Children and Foster Care	Less Pregnant Women	Less Inpatient/ NF/ICF	Less Breast Cancer/ Family Planning	Likely Final Count
Family and Children/SOBRA	392,378	105,895	91,127	91,127	91,127	41,753
MCHP	102,448	102,448	102,448	102,448	102,448	102,448
SSI	190,981	172,820	172,820	155,592	155,592	155,592
Other	1263	1111	1111	1111	734	734
Total	687,070	382,274	367,506	350,278	349,901	300,527

Potential Fiscal Impact of Cost-sharing

As cost-sharing would generate service based savings, estimates of the fiscal impact of the DRA required an analysis of service utilization by the affected populations. As presented in Table 5, for the children potentially subject to cost-sharing, nearly 62 percent of the services that they receive are exempt (inpatient, ER and preventive primary care). After exemptions, there would be approximately 76,100 visits and 85,000 prescriptions potentially subject to cost-sharing. Among adults, approximately 49 percent of services would be exempt, but there would be approximately 114,000 eligible visits. The state already imposes cost-sharing on the 202,000 prescriptions received by adults. The new DRA provisions also allow states to increase pharmacy copays for non-preferred drugs beyond the nominal amounts for individuals with incomes above 150% of FPL (20% of the cost of the script). Given that Maryland already has a 90% compliance with our preferred drug list (PDL), however, any additional savings will be minimal. In addition, changes to ER cost-sharing rules may duplicate savings already estimated with the non-emergent use of the ER policy.

Based on year 2005 expenditures for services potentially subject to cost-sharing, it is estimated that the state could save approximately \$950,000, if cost sharing was imposed on all eligible services and populations. (This number could be slightly higher if the Maryland allowed the managed care organizations to charge pharmacy premiums to the eligible children under the DRA.) Estimated savings were derived by tallying the total number of services delivered through HealthChoice during CY 2005 that could be eligible for cost-sharing under the DRA. The average cost per service was then calculated using the HealthChoice Financial Monitoring Report (HFMR), assuming a 10% per service co-pay. An option under the DRA allows states to

¹⁵ Joseph Newhouse, *Free For All? Lessons from the Rand Health Insurance Experiment*, Cambridge: Harvard University Press, 1996.

deny services for failure to pay. It is worth noting, however, that this would likely result in decreased service utilization.

Table 5: Services Eligible for Cost Sharing and Potential Savings

Services Eligible for Cost Sharing and Potential Savings - Children

Service Category	Services Eligible for Cost Sharing	Average Cost per Service	Total Savings at average 10% Co-Pay	Total Savings State Share
Hospital Outpatient: Other than Emergency	13,964	\$ 251	\$ 350,793	\$ 122,778
Hospital Outpatient: Emergency Dept.	3,084	\$ 216	\$ 66,703	\$ 23,346
Specialty Care	48,418	\$ 82	\$ 396,584	\$ 138,804
Dental	8,891	\$ 172	\$ 153,275	\$ 53,646
Total	82,809		\$ 994,415	\$ 348,045

Services Eligible for Cost Sharing and Potential Savings - Adults

Service Category	Services Eligible for Cost Sharing	Average Cost per Service	Total Savings at average 7% Co-Pay	Total Savings State Share
Hospital Outpatient: Other than Emergency	28,030	\$ 492	\$ 1,380,211	\$ 690,106
Hospital Outpatient: Emergency Dept.	1,646	\$ 316	\$ 51,974	\$ 25,987
Primary Care	32,058	\$ 85	\$ 271,423	\$ 135,712
Specialty Care	79,013	\$ 111	\$ 875,017	\$ 437,509
Dental	1,280	\$ 165	\$ 21,067	\$ 10,534
Total	316,741		\$ 1,219,481	\$ 609,741

It is difficult to estimate the precise savings from cost-sharing. The Congressional Budget Office estimates that 80% of savings from cost-sharing would result from reduced use of services and prescriptions. The remaining 20% would come from decreased payments to providers (although states have the option to allow providers to deny services).¹⁶ The reduced use of preventive services by adults, however, could result in cost shifting to hospitals and emergency rooms where care is more expensive – potentially offsetting any savings. Existing research has shown that increased cost-sharing creates barriers for low-income individuals’ access to health services and may adversely affect their health.¹⁷ Cost-sharing has been found to cause low-income individuals to use fewer essential health services which can lead to significant health problems.

The projected savings of \$480,000 would represent less than 10 percent of the estimated cost of funding Enhanced Benefits Accounts (Table 1) and may be offset by other cost shifting resulting from decreased or delayed utilization.

The DRA provides an additional avenue for Maryland to consider that offers the potential of significant cost savings. The DRA would allow states greater flexibility in the imposition of premiums on Medicaid recipients. Although premiums are not associated with the promotion of healthy behavior and are beyond the scope of the JCR request they do provide an alternative method for generating cost offsets and would likely have a significant impact on enrollee health.

¹⁶ Congressional Budget Office Cost Estimate: S. 1932, Deficit Reduction Act of 2005. <http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf>

¹⁷ Julie Hudman and Molly O’Malley, Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations, Kaiser Commission on Medicaid and the Uninsured, April 2003.

Impact on Maryland: Premiums

Imposing premiums is not seen as a viable method for promoting healthy behavior, but may be considered as a means to generate program savings for the purpose of funding health promotion activities. Although Maryland, under the DRA, would have greater allowance for imposing premiums, much of the State’s Medicaid recipients would be exempt, specifically: mandatory children under 18; all children in foster care; pregnant women; the institutionalized; individuals with family earning below 150 percent FPL; and women in breast or cervical cancer eligibility categories. As shown in Table 6, the impact of these exemptions would be substantial. As detailed in Table 6, of the 687,000 Marylanders served by Medicaid, nearly all would be exempt from premiums. Approximately 61,000 recipients, less than 10 percent of all recipients, would be eligible for premiums. Nearly all of those subject to premiums would be children in MCHP and approximately 12,000 of the 61,000 eligible for premiums already pay them through MCHP Premium. The remaining population would consist of about 43,000 MCHP enrollees and about 7,000 adults (most in Medicaid spend down categories).

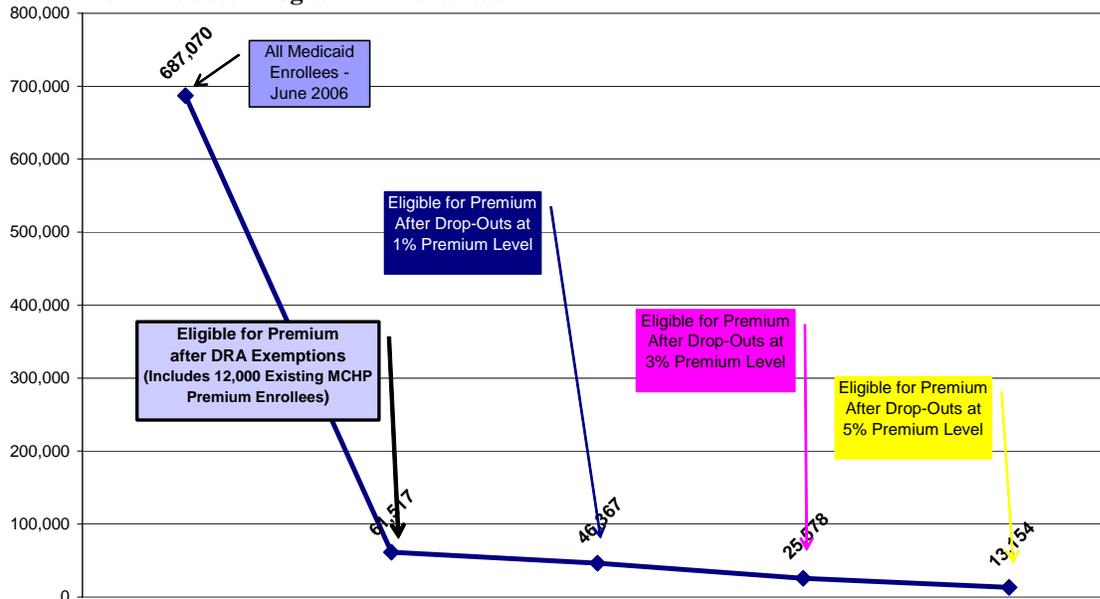
Table 6: Medicaid Population Eligible for Premiums under DRA after Exemptions

Coverage Group	All Medicaid Enrollees	Less Exempt Populations
Family and Children/SOBRA*	392,378	1,179
MCHP	102,448	54,484
SSI	190,981	5,289
Other	1263	565
Total	687,070	61,517

Premium imposition would not have a static impact on enrollment, however, and it is very likely that enrollment among the population subject to the premiums would decline considerably. Studies have shown that imposing premiums would cause existing enrollees to “drop out” rather than pay. Estimates of any premium impact on enrollment vary and precise drop-out projections are difficult to achieve but reasonable estimates (shown in Figure 1) suggest that of the 61,000 Maryland Medicaid recipients eligible for premiums under the DRA, 15,000 individuals would drop out at a premium level equal to 1 percent of family income; 36,000 at 3 percent premium level; and 49,000 at a 5 percent premium level (the maximum amount allowed under DRA).¹⁸

¹⁸ Estimates of enrollment declines from various premium levels are based upon methodology established by the Urban Institute in, "The Use of Sliding Scale Premiums in Subsidized Insurance Programs." <http://www.urban.org/publications/406892.html>

Figure 1: Maryland Medicaid Recipients Subject to Premiums under the DRA after Population Exemptions and Premium Induced Program Withdrawals



Even with 90 percent of state Medicaid recipients exempted, the imposition of premiums could yield significant cost savings for the State. The potential savings at three premium levels (1 percent of family income, 3 percent, and 5 percent) are shown in Tables 7 and 8. Children (Table 7) and adults (Table 8) are considered separately as the children are predominantly MCHP, receive a different federal match rate, and their enrollment would be differentially effected by premiums.

Table 7: MCHP Children – Savings from Combined Impact of Premium Collection and Enrollment Declines at Various Premium Levels

	5% Premium	3% Premium	1% Premium
Initial Enrollment	54,410	54,410	54,410
Total Estimated Enrollment Decline	42,804	31,842	12,945
Final Enrollment Tally	11,606	22,568	41,465
Estimated Enrollment Decline	78.7%	58.5%	23.8%
Total Savings from Enrollment Decline	\$ 78,289,525	\$ 58,240,348	\$ 23,677,200
Revenue from Premiums on Remaining Enrollees	\$ 10,163,799	\$ 11,857,766	\$ 4,861,693
Administrative Costs Associated with Premium	\$ (1,098,296)	\$ (2,135,575)	\$ (3,923,759)
Total Estimated Savings	\$ 87,355,029	\$ 67,962,539	\$ 24,615,134
Total Estimated State Share Savings	\$ 30,574,260	\$ 23,786,889	\$ 8,615,297
Savings Derived from Enrollment Decline	89.6%	85.7%	96.2%

Table 8: Adults – Savings from Combined Impact of Premium Collection and Enrollment Declines at Various Premium Levels

	5% Premium	3% Premium	1% Premium
Initial Enrollment	7,033	7,033	7,033
Total Estimated Enrollment Decline	5,485	4,023	2,131
Final Enrollment Tally	1,548	3,010	4,902
Estimated Enrollment Decline >150% FPL	78.0%	57.2%	30.3%
Total Savings from Enrollment Decline	\$ 59,238,723	\$ 43,449,807	\$ 23,017,091
Revenue from Premiums on Remaining Enrollees	\$ 832,888	\$ 971,702	\$ 527,496
Administrative Costs Associated with Premium	\$ (102,535)	\$ (199,374)	\$ (324,694)
Total Estimated Savings	\$ 59,969,076	\$ 44,222,135	\$ 23,219,892
Total Estimated State Share Savings	\$ 29,984,538	\$ 22,111,068	\$ 11,609,946
Savings Derived from Enrollment Decline	98.8%	98.3%	99.1%

Savings estimates presented in Tables 7 and 8 were derived by tallying the impact of enrollment declines multiplied by current per member per month (PMPM) Medicaid expenditures for the affected population, added were the premium revenue collected from remaining enrollees, and finally the administrative costs associated with maintaining a premium program were deducted. State share, General Fund, savings assumed a 50 percent federal match for adults and a 65 percent match for (MCHP) children. Although the number of recipients affected in the adult and child populations are considerably different, the potential cost savings are similar.

The state would save between \$8.6 and \$30.6 million by imposing a premium on eligible children and \$11.6 to \$30 million from eligible adults. Combined savings would range from \$20.2 to \$60.6 million. Across both populations and regardless of premium size, between 86 and 99 percent of the savings would result from recipients ending their Medicaid participation – not from the collection of new premium dollars. In fact, savings from the imposition of premiums is directly linked to Medicaid recipients discontinuing coverage. Drop-out rates would range from one-quarter at the lowest premium rate to three-quarters at the highest premium rate - the higher the drop-out rate, the greater the savings to the state.

Summary

Maryland has made significant strides in developing its managed care program. HealthChoice is in its tenth year of operation and has slowed cost growth considerably. For the past few years, rate increases have stabilized as the program has become more efficient. The State also continues to explore opportunities to achieve cost savings through the rate-setting process.

Through the savings from the HealthChoice program, the State has implemented numerous waivers, which ultimately result in cost savings. For example, the Primary Adult Care (PAC) program provides preventive care and pharmacy for low income individuals not eligible for full Medicaid benefits. Because PAC offers primary and preventive benefits, the State hopes to avoid costs these individuals would have incurred for chronic health conditions and hospital fees. In addition, HealthChoice MCOs have successfully implemented several programs which promote healthy behavior among participants such as offering ‘gifts’ (e.g., baby bibs, diabetic nutrition boards, puzzle rulers, measuring cups & spoons, mirrors) or other incentives. The MCOs continue to explore alternatives for encouraging healthy behaviors of recipients.

The Maryland Medicaid program has been a leader among state programs. While this report outlines some of the options for implementing changes, none will be achieved without

significant pushback from stakeholders and advocates. Advocates are opposed to making changes that will limit enrollee access or have negative impacts on enrollee benefits. A multitude of existing studies document the potential for negative health outcomes resulting from increased cost-sharing or the imposition of enrollee premiums.^{19,20&21}

Since there is little room for increases in managed care penetration for the majority of Maryland Medicaid recipients (the families and children population), new health behavior incentives would require new funding, which may or may not be offset by savings from cost sharing, premium imposition, or reductions in benefits. As mentioned earlier, the impact of cost-sharing may result in higher costs and worse health outcomes, because enrollees would not seek care that they consider to be costly.

The current benefit structure is quite rich. Potential savings from significant reductions to the benefit structure is limited by the EPSDT provisions of the DRA, which prohibit some benefit reductions. The 6,200 children that would be affected by changes in the benefit structure would accrue little savings for the program, but could prove costly if enrollees choose to forgo necessary services.

The final option of implementing premiums is possible, but the benefit of such a change could ultimately worsen health outcomes. Research on the MCHP Premium program has shown high levels of satisfaction with the program. Although the current MCHP premium program is experiencing enrollment growth, implementing additional premiums would remove significant numbers of enrollees. However, not all of these individuals would go without insurance coverage. In 2005, Maryland studied the impact of implementing premiums for children whose family income was between 185% FPL and 200% FPL and found that over half of the individuals surveyed found other insurance coverage. Since Maryland has an all-payer hospital system it is likely that many of these enrollees would end up in emergency rooms, which would result in increased uncompensated care costs for both the State and Federal governments and for all Marylanders with health insurance.

There are also numerous administrative costs that are not addressed in this report. The costs to implement any of the changes could be substantial. For instance, if multiple benefit structures are created, there is the potential that enrollees could switch between programs regularly. The Maryland MMIS would have to be updated to handle these types of changes. For instance, based on the findings earlier in this report, savings for implementing copays for approximately 300,000 people would result in approximately \$950,000 of general fund savings; this amounts to a savings of about \$3 per person. It is possible that administrative costs would greatly exceed any of the projected savings.

Conclusion

While this report provides a first look at the potential impact of changes, more in-depth analysis that outlines all the costs of changes would be necessary (e.g. administration, health outcomes). Maryland recognizes the importance of many of the innovations being made across

¹⁹Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, April 2003.

²⁰ Joseph Newhouse, *Free For All? Lessons from the Rand Health Insurance Experiment*, Cambridge: Harvard University Press, 1996.

²¹ Robyn Tamblyn, et al., "Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons," *Journal of the American Medical Association*, 285(4): 421-429, January 2001.

states to lower the costs of providing Medical Assistance to low income citizens. While we are committed to this effort, many of the options available to other states are not feasible in Maryland. The success of the HealthChoice program, along with many recent positive changes to Medicaid policy, makes it difficult to implement some changes. Because our State has achieved great savings from the mechanisms now being used (managed care, pharmaceutical management, etc.), we should explore other options for changing enrollee behavior. Any efforts to change enrollee behavior must be studied thoroughly before being decided upon because of the potential negative impact on the more than 700,000 Marylanders served through the Medicaid program.

Appendix One

Enhanced Benefits Approved Healthy Behaviors and Credits

Children: Behavior Name	Credit Amount Per Occurrence	Annual Occurrence Limit
Childhood dental exam	\$ 25.00	2
Childhood vision exam	\$ 25.00	1
Childhood preventive care (age-appropriate screenings and immunizations)	\$ 25.00	Any combination, up to 5
Childhood wellness visit	\$ 25.00	
Keeps all primary care appointments	\$ 25.00	

Adults: Behavior Name	Credit Amount Per Occurrence	Annual Occurrence Limit
Keeps all primary care appointments	\$ 15.00	2
Mammogram	\$ 25.00	1
PAP Smear	\$ 25.00	1
Colorectal Screening	\$ 25.00	1
Adult Vision Exam	\$ 25.00	1
Adult Dental Exam	\$ 15.00	2

ALL: Behavior Name	Credit Amount Per Occurrence	Annual Occurrence Limit
Disease management participation	\$ 25.00	1
Alcohol and/or drug treatment program participation	\$25.00	1
Alcohol and/or drug treatment program 6 month success	\$15.00	2
Smoking cessation program participation	\$25.00	1
Smoking cessation program 6 month success	\$15.00	2
Weight loss program participation	\$25.00	1
Weight loss program 6 month success	\$15.00	2
Exercise program participation	\$25.00	1
Exercise program 6 month success	\$15.00	2
Flu Shot when recommended by physician	\$25.00	1
Compliance with prescribed maintenance medications	\$7.50	4

Appendix One

Enhanced Benefits Approved Health Related Products and Supplies

Category	Examples
Analgesics/anti-inflammatory agents	Advil, Aspirin
Cough and Cold OTC	Cough and Cold Medications that do not require a prescription
Cough and Cold by Rx only	Cough and Cold Medications that require a prescription and are not covered by Medicaid
Ear	Debrox, Ear drops, Nurine ear drops
Eye	Visine, Refresh, Tears Naturale
First Aid Products	Bandages, braces, ointments
Gastrointestinal	Antacids, Pepto-Bismol, Prilosec OTC
Laxatives	Phillip's Milk of Magnesia, Metamucil Fiber Wafer
Nose	Simple Saline, Sinus Nasal Spray
Orthopedic aids	Arthritis Relief Gloves, Arch Supports, Heating Pad
Topical	Sunscreens, medicated shampoos, lotion
Topical Antifungal	Clotrimazole, Desenex, Lamisil
Topical Vaginal	Summers Eve Cream, Vagasil
Vitamin	Vitamin A, Vitamin B, Vitamin C, Multi-vitamin tablet(s), Stress B tablet(s)
Dental Supplies	Toothpaste, Tooth brushes, Mouthwash, Floss, etc.

Appendix Two

Florida Medicaid Reform

Component	FLORIDA - Description
Reform Authority	Section 1115(a)(1) Research and Demonstration Waiver
Reform Name	Florida Medicaid Reform
Time Frame	<ul style="list-style-type: none"> • Approved by CMS October 19, 2005. • 5-year period: July 1, 2006 – June 30 2011 • Phase I—July 1, 2006 Implementation in 2 Counties: Broward and Duvall. Within 1 year, expansion to 3 additional counties: Baker, Clay, and Nassau. • Phase II—If legislature approves, based on experience in Phase I, expansion to additional geographic areas. • Phase III—Expansion statewide by June 2010.
Goals	<ul style="list-style-type: none"> • Patient Responsibility and Empowerment • Marketplace Decisions • Bridging Public and Private Coverage • Sustainable Growth Rate
Main Program Elements	<ul style="list-style-type: none"> • Risk-Adjusted Premiums • Enhanced Benefit Accounts (EBA) • Employer-Sponsored Insurance (ESI) • Low-Income Pool (LIP)
Quick Summary	<ul style="list-style-type: none"> • The State will develop risk-adjusted premiums for Medicaid enrollees. This caps the amount the state will spend on a beneficiary for any given year. • Health Plans will offer all mandated benefits, but can tailor their scope to meet the needs of specific Medicaid groups. • Beneficiaries can choose the plan that best meets their needs. By participating in activities that promote healthy behavior, beneficiaries earn credits which can be used to purchase additional services, such as over-the-counter drugs. • Beneficiaries can also choose to enroll in their employers' plan with the State contributing toward the cost of that plan up to the Medicaid premium amount.
Populations Covered (Initially)	<p><u>Mandatory Participants:</u></p> <ul style="list-style-type: none"> • TANF and TANF-related group--1931 Eligibles <ul style="list-style-type: none"> ○ Families under 23% of FPL ○ Poverty-related children with income above TANF limit: <ul style="list-style-type: none"> ▪ Up to age 1, up to 200% FPL ▪ Up to age 6, up to 133% FPL ▪ Up to age 21, up to 100% FPL <p>(All are mandatory Medicaid eligibles except poverty level children up to age 1 with income between 185% and 200% of FPL)</p> • Aged and Disabled—SSI cash assistance (75% of FPL) and children eligible under SSI.

Appendix Two

Component	FLORIDA - Description
	<p><u>Voluntary Participants:</u> (Mandatory enrollment of these groups will be phased in)</p> <ul style="list-style-type: none"> • Foster children • Individuals with developmental disabilities • Children with special health care needs • Individuals residing in institutions • Individuals in hospice-related group • Pregnant women above 1931 poverty level • Dual eligible individuals <p><u>Enhanced Benefit Account</u></p> <ul style="list-style-type: none"> • Individuals under 200% of FPL can continue to access EBA benefits after losing Medicaid eligibility.
Enrollment	<ul style="list-style-type: none"> • Newly Medicaid eligible will be enrolled upon becoming eligible • Current enrollees will enroll in reform plan at the time of eligibility re-determination or open enrollment period.
Service Providers	<ul style="list-style-type: none"> • The Health Plans can be Managed Care Organizations, Provider Service Networks, or Employer-Sponsored Plans.
Benefit Packages	<ul style="list-style-type: none"> • Benefits received determined by the group an individual is in, and by the Plan chosen. • Health Plans must cover all mandatory State Plan services. • For children under 21, pregnant women, and emergency services, service limits cannot be more restrictive than State Plan limits. • For other populations and services, plans can change the amount, duration and scope of State Plan services to tailor it to particular population, but revised benefit package must be actuarially equivalent to the current State Plan package and State must certify that it meets a benefit sufficiency standard. • Benefits divided into comprehensive and catastrophic benefit packages <p><u>Comprehensive Benefits</u></p> <ul style="list-style-type: none"> • Services which most people need. Represents dollar amount equivalent to 90% of historical Medicaid expenditures. • The premium covers 100% of the cost of care up to established comprehensive care threshold, and then the catastrophic benefit premium covers additional care. <p><u>Catastrophic Benefits</u></p> <ul style="list-style-type: none"> • For unusually high costs incurred by an enrollee during a given year. Expected to represent less than 10% of the aggregate premium. • Catastrophic benefit threshold is triggered by either a pre-determined dollar threshold or an inpatient day threshold. • If MCO accepts financial risk, it receives catastrophic premium and pays for catastrophic care up to annual limit. If MCO does not accept risk, State becomes a re-insurer and pays MCO Medicaid fees for catastrophic level care. <p><u>Enhanced Benefits Account (EBA)</u></p> <ul style="list-style-type: none"> • For clients that participate in State-defined activities that promote healthy behavior, State deposits funds into an EBA account which can be used for additional services such as over the counter drugs or vitamins. <p><u>Employee Sponsored Insurance</u></p> <ul style="list-style-type: none"> • Medicaid clients can voluntarily opt out of Medicaid coverage and enroll in their

Appendix Two

Component	FLORIDA - Description
	<p>employer's health insurance plan.</p> <ul style="list-style-type: none"> • State pays up to the amount it would have paid to cover recipient under Medicaid. (If ESI premium is higher, client pays the difference.) • State does not provide any wrap-around. (State does not pay difference between ESI cost sharing and nominal Medicaid cost sharing, nor does it cover services not covered under the ESI plan.)
Premiums	<ul style="list-style-type: none"> • State develops aggregate, risk-adjusted premiums based on individuals' age, sex health status. The Aggregate premium is divided into Comprehensive and Catastrophic Care components, based on pre-determined dollar amounts. The annual maximum benefit limit will be applied to all recipients with the exception of children under 21 and pregnant women. (Recipients are responsible for making arrangements for care which exceeds the annual benefit limit.)
Payment to Plans	<ul style="list-style-type: none"> • Risk-adjusted premiums are divided into comprehensive and catastrophic components. • All plans are at risk for comprehensive component and receive a premium for comprehensive care. Plans can choose whether to cover (be at risk for) catastrophic component. If plan chooses not to cover catastrophic component, the State becomes the re-insurer and plan remits claims to the State for services rendered under this component. • State has built-in safeguards to minimize cost shifting and maximize enrollee care.
Cost Sharing	<ul style="list-style-type: none"> • ESI participants will have to pay any cost sharing imposed by their employers' plans. All other enrollees will be subject to the same cost sharing restrictions and protections provided for all Medicaid recipients under federal law.
Other	<ul style="list-style-type: none"> • A Low Income Pool was established to ensure continued government support for provision of health care services to Medicaid, underinsured and uninsured populations. The Pool is a capped annual allotment of \$1 billion per year for five years. •
Waivers Requested	<ul style="list-style-type: none"> • Statewide-ness/Uniformity—(Different delivery systems in certain areas) • Amount, Duration, and Scope and Comparability—(Different intensity of services for mandatory services, and different benefits for those in ESI or EBA groups) • Income and Resource Test—(Greater income/resource limits for EBA group) • Cost Sharing—(Greater cost sharing limits for ESI group) • Freedom of Choice—(Of providers) • Provider Agreements—(Allows non-enrolled providers to provide benefits to EBA group) • Retroactive Eligibility—(Waives 3-month retroactive eligibility) • Eligibility—(Provide only emergency care and nursing home care for up to 30 days from eligibility date until enrollment into MCO. Also allows for ESI group to receive less than State Plan benefits). • Payment Review—(To extent that prepayment review may not be available by individual beneficiaries to their providers.)

Idaho Medicaid Reform

Component	IDAHO - Description
Reform Authority	<ul style="list-style-type: none"> • State Plan Amendment (SPA)
Reform Name	<ul style="list-style-type: none"> • Modernizing Idaho Medicaid
Time Frame	<ul style="list-style-type: none"> • Approved by CMS on May 25, 2006 • Implementation date: October, 2006 • The SPA will be implemented statewide
Goals	<ul style="list-style-type: none"> • Encourage prevention and wellness to improve individuals' health and reduce future healthcare expenditures • Promote responsible use of the healthcare system to reduce unnecessary services that are often expensive • Use limited resources wisely and invest carefully in targeted services to achieve long-term savings
Main Program Elements	<ul style="list-style-type: none"> • Divide Medicaid beneficiaries into three groups based on health needs • Tailor benefit packages aimed at these three groups • Manage delivery of services more efficiently (provider pay for performance, selective contracting with vendors, use of health information technology)
Quick Summary	<ul style="list-style-type: none"> • Medicaid beneficiaries will be divided into three groups according to their identified health needs (pregnant women and children, children and adults with disabilities or special needs, and people who are elderly who also may have disabilities) • A health risk assessment will be part of the eligibility determination process and beneficiaries will be placed in the plan that best meets their needs • There are three health benefit packages: the Basic Plan, the Enhanced Plan, and the Medicare/Medicaid Plan. • Personal Health Accounts to reward healthy behaviors. Credits for weight loss and tobacco cessation, current immunization and well-child checks. Credits can be used for fitness memberships, nicotine patches, weight loss memberships, bicycle helmets, premium payments.
Populations Covered	<ul style="list-style-type: none"> • The entire Medicaid population will be covered, but it will be phased in starting with new enrollees and annual eligibility re-determinations.
Enrollment	<ul style="list-style-type: none"> • Newly eligible Medicaid beneficiaries will be enrolled in Basic Plan or Enhanced Plan. Existing Medicaid beneficiaries will be transitioned to new plans as part of their annual eligibility re-determination. • Enrollment for disabled in the Enhanced Plan, and for the elderly in the Medicare/Medicaid plan is voluntary

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Component	IDAHO - Description
Service Providers	<ul style="list-style-type: none"> • The Basic and Enhanced Plans will be furnished through either a primary care case management system (fee-for-service basis). Individuals with selected chronic diseases may enroll with a PCCM provider who receives an enhanced PCCM fee for measured clinical best practices. Enhanced fees are performance-based incentive payments for individuals with the following chronic diseases: diabetes, asthma, cardiovascular disease, or depression. • Individuals selecting the Medicare/Medicaid Plan will select and enroll in a Medicare Advantage Plan.
Benefit Packages	<p><u>Basic Plan</u></p> <ul style="list-style-type: none"> • For low income children and working age adults of average health and average health care needs (73% of the Medicaid population, or 130,000 individuals). • Designed to look similar to commercial health plans. • Specific Benefits/Limits: <ul style="list-style-type: none"> □ Wellness benefits for children and adults □ 26 outpatient mental health visits, 10 inpatient days □ No psycho-social rehabilitation or partial care □ Dental, PT, OT, ST, DME are covered □ No LTC or personal care □ EPSDT for those under 21 □ Case management only under EPSDT. Must be pre-authorized. • Will attempt to encourage individuals to make good health decisions and provide disincentives to discourage inappropriate services. Idaho's goals are to: <ul style="list-style-type: none"> □ Emphasize preventive care and wellness by implementing personal health accounts that encourage healthy behavior, promoting wellness for children in non-clinical settings such as schools, and restructuring provider payments to offer pay-for-performance incentives for delivery of key prevention services such as immunizations. □ Increase participant ability to make good health choices by implementing common-sense, enforceable cost-sharing to increase the responsibility of Medicaid beneficiaries. □ Strengthen the employer-based health insurance system by expanding the option of premium assistance to all children and working-age adults who would prefer to enroll in commercial insurance over Medicaid. <p><u>Enhanced Plan</u></p> <ul style="list-style-type: none"> • For children and adults with disabilities or special needs from birth to 64 years of age. All individuals with disabilities, regardless of age, may elect to be covered under this plan (20% of the Medicaid population, or 20,000 individuals). • This plan will mirror existing Medicaid benefits. The goal is to deliver cost-effective individualized care by providing more individual choice and control. <ul style="list-style-type: none"> □ Will provide community supports modeled after the National Cash and Counseling Demonstration. Will transform mental health system to address goals in the president's New Freedom Commission on Mental Health. □ Will provide increased opportunities for employment for persons with disabilities. • Includes pay-for-performance incentives for providers for preventive care, key outcomes and chronic disease management.

Appendix Two

Component	IDAHO - Description
	<p><u>Medicare/Medicaid Plan</u></p> <ul style="list-style-type: none"> • Medicaid benefits for adults over age 65 who are covered under Medicare. (7% of the Medicaid population, or 12,800 individuals.) • The plan will be implemented in selected counties and will be expanded to additional counties as Medicare Advantage Plans become available in those counties. • Younger adults with disabilities may choose this plan if they are covered under Medicare. • The goal is to deliver more cost-effective care integrated with Medicare coverage: <ul style="list-style-type: none"> □ Will improve coordination between Medicaid and Medicare, e.g. by contracting with vendors to provide prescription drugs for “dual-eligibles”. □ Will increase non-public financing options for long-term care, e.g. by participating in the Long-Term Care Partnership Program. □ Will use strategies such as expanding home and community-based services waivers and the use of respite care to help individuals live independently as long as possible.
Cost Sharing	Premiums and co-pays will be implemented depending on a family’s ability to pay under the Basic Plan.

Appendix Two

Kentucky Medicaid Reform

Component	KENTUCKY - Description
Reform Authority	<ul style="list-style-type: none"> • State Plan Amendment
Reform name	<ul style="list-style-type: none"> • <i>KyHealth Choices</i>
Time Frame	<ul style="list-style-type: none"> • The <i>KyHealth Choices</i> Waiver was approved by CMS on January 18, 2006. • Kentucky began implementing the waiver in May 15, 2006. • On May 3, 2006, CMS approved Kentucky's state plan amendment to restructure its benefits package.
Goals	<ul style="list-style-type: none"> • Stretch resources to most appropriately meet the needs of members • Encourage personal responsibility for health care • Provide a continuum of care options • Expand individual choice and engagement • Ensure future solvency of the Medicaid program
Main Program Elements	<ul style="list-style-type: none"> • Targeted benefits • Cost-Sharing • Employer-Sponsored Health Insurance • Integrated Care • Disease Management • Get Healthy Accounts
Quick Summary	<ul style="list-style-type: none"> • <i>KyHealth Choices</i> is the name of Kentucky's revised Medicaid program. The program will provide tailored benefit packages to four categories of beneficiaries, including the general Medicaid population, children, elderly and beneficiaries with disabilities or mental retardation. • Most Medicaid beneficiaries will receive a standard benefit package, known as Global Choices, which will provide basic medical services for most members, including mental health services. Other packages will target services to the needs of children and individuals requiring long-term care. Benefits may vary in amount, duration, and scope. Benefits may include dollar amount limits and limits on the number of office visits. • <i>KyHealth Choices</i> will require beneficiaries to enroll in employer-sponsored private health insurance if it is available and if it is more cost-effective. • The program will draw on the private sector's experiences and use best practices to coordinate mental health, physical health and mental retardation, and developmental disabilities. • <i>KyHealth Choices</i> will implement disease management programs for chronic conditions such as cardiovascular disease, pulmonary disease, and pediatric obesity and diabetes. • The program will provide incentives to beneficiaries who engage in healthy behaviors. Funds will be deposited into accounts to offset health care-related costs, such as co-payments, smoking cessation, and weight loss programs. Initially, disease conditions for participation will be limited to pulmonary disease,

Appendix Two

Component	KENTUCKY - Description
	diabetes, and cardiac conditions; however, conditions will be added later.
Populations Covered	<ul style="list-style-type: none"> • <i>KyHealth Choices</i> applies to all Medicaid enrollees throughout Kentucky except those in the counties surrounding the Louisville area, where an existing Medicaid managed care demonstration waiver (Kentucky Passport) operates. • The state enrolls members in one of the following four plans: <ul style="list-style-type: none"> ○ <u>Global Choices</u> covers the general Medicaid population ○ <u>Family Choices</u> covers must children and the KCHIP population ○ <u>Optimum Choices</u> covers individuals with mental retardation in need of long-term care. ○ <u>Comprehensive Choices</u> covers individuals who are elderly and in need of a nursing facility level of care and individuals with acquired brain injuries.
Service Providers	<ul style="list-style-type: none"> • Approved Kentucky Medicaid providers are required to provide all services included in a member’s benefit package. • Providers providing services to members receiving benefits for one of four new packages will be reimbursed on a fee-for-services basis using fee schedules approved by Kentucky. • Claims will be submitted and reimbursed by the State’s Fiscal Intermediary in accordance with requirements and fee schedules in effect for the program.
Benefit Packages	<ul style="list-style-type: none"> • Coverage is based upon financial and categorical eligibility. Many disabled and long-term unemployed individuals will continue to receive care on a fee-for-service basis. In addition, special packages will be developed to ensure appropriate care for those who need long-term care. All of the benefit packages will cover mandatory Medicaid services. • <u>Global Choices</u> is the standard package provided for most Medicaid members and is the benchmark to which the other plans are compared. This plan provides basic medical services, including mental health services in inpatient and outpatient settings. Hearing and vision services are limited to those 18 and under unless the service is EPSDT related. • The <u>Comprehensive Choices</u> plan will include all benefits in Global Choices and it will cover individuals who need a nursing facility (NF) level of care, are at risk of institutionalization and/or have been previously covered under the home and community based (HCB) Waiver, Model II (ventilator services), or the acquired brain injury (ABI) Waiver. The plan includes NF level of care services and all services currently available under the current ABI, Model II and HCB waivers as well as nursing facility services. • <u>Optimum Choices</u> covers disabled adults in need of ICF/MR level of care, are at risk of institutionalization and/or are currently being served in the supports for community living waiver (SCL) waiver. The plan will include all benefits in Global Choices and it will include ICF/MR level of care services such as all services under the current SCL waiver and the ICF/MR services. Optimum Choices also includes a new lower level of services aimed at keeping people in their homes longer. • The <u>Family Choices</u> package is designed for children and will serve those currently by the KCHIP program and some children currently served under the traditional Medicaid program.

Appendix Two

Component	KENTUCKY - Description
	<ul style="list-style-type: none"> • To provide additional or special services to the target populations, the <i>KyHealth Choices</i> benefit packages may vary the amount, duration, and/or scope of certain services and may contain service-specific coverage limits, such as the number of visits or dollar cost. These limits are “soft” rather than “hard” and additional visits or services beyond the stated limit may be approved if medically necessary.
Cost Sharing	<ul style="list-style-type: none"> • <i>KyHealth Choices</i> will require some members to pay certain pharmacy and non-pharmacy related services; co-pays are based on income levels. • Co-pays are due to the provider at the time of service. <i>KyHealth Choices</i> members will not have to pay co-pay for any covered service if the member is: <ul style="list-style-type: none"> ○ A child under the age of 18 covered by Medicaid; ○ Pregnant ○ Receiving a Medicare-covered drug at a pharmacy that is a certified provider for Medicare; ○ Receiving inpatient services in a nursing facility chronic disease or rehabilitation hospital or intermediate-care facility for the mentally retarded, or is admitted to a hospital from such a facility; ○ Receiving hospice care; ○ Has reached the co-pay cap for the year. The co-pay cap for all plans is \$225 per individual for pharmacy services and \$225 per individual for all other medical services.
Get Healthy Benefits Accounts	<ul style="list-style-type: none"> • Program promotes wellness, self-care, and health management by providing a direct incentive to enrollees to take an active role in their health. • All members who have one of several targeted conditions will be eligible. • Initially, disease conditions for participation will be limited to pulmonary disease, diabetes, and cardiac conditions; however, additions may be added later. • Get Healthy Benefits will include additional dental and vision services or obtaining nutritional or smoking cessation counseling.

Appendix Two

West Virginia Medicaid Reform

Component	WEST VIRGINIA - Description
Reform Authority	<ul style="list-style-type: none"> • State Plan Amendment (SPA)
Reform Name	<ul style="list-style-type: none"> • NA
Time Frame	<ul style="list-style-type: none"> • Approved by CMS on May 3, 2006 • Implementation: November, 2006 • Initially, the SPA will be implemented in three counties (Clay, Upshur, and Lincoln) and will be implemented statewide over four years.
Goals	<ul style="list-style-type: none"> • Streamline administration • Tailor benefits to population needs • Coordinate care, especially for members with chronic conditions • Provide members with the opportunity and incentives to maintain and improve their health
Main Program Elements	<ul style="list-style-type: none"> • Simplify Eligibility Categories • Basic and Enhanced Benefit Packages • Member Agreements • Healthy Rewards Accounts
Quick Summary	<ul style="list-style-type: none"> • Reduces 29 eligibility categories to 4 (children, adults 65 and over, adults with children, special needs groups) • Offer enrollees a choice between a Basic Medicaid benefit package and an Enhanced Medicaid package for those who sign member agreements indicating that they will comply with all prescribed mental treatments and wellness behaviors. • The Basic Medicaid Plan decreases some of benefits currently offered under the Medicaid State Plan. The enhanced plan provides current Medicaid benefits with some additional services. • Uses medical homes (PCPs) to provide enrollees with health care and care management services. Medical homes maintain centralized comprehensive records. • Healthy Rewards Accounts that provide enrollees with incentives to make healthy decisions and use health care services appropriately. Allot enrollees credits quarterly that they can use for co-pays and non-covered services. • Uses electronic health information to gather health information on enrollees needed to provide quality health outcomes. • Will use four indicators to monitor enrollees' compliance with the member agreement: receiving recommended screenings, adherence to health improvement programs, attending scheduled appointments, and taking medication as directed. Enrollees who fail to comply will be moved to the Basic package.
Populations Covered	<ul style="list-style-type: none"> • Healthy children and parents on Medicaid. • When implemented statewide, program will apply to about 180,000 children and 60,000 adults (about half the States' Medicaid population).

Appendix Two

Component	WEST VIRGINIA - Description
Enrollment	<ul style="list-style-type: none"> Enrollment will occur when individuals sign member agreements during their Medicaid enrollment or re-determination processes.
Service Providers	<ul style="list-style-type: none"> Enhanced benefit package will be furnished through either a primary care case management system (fee-for-service basis) or a managed care entity.
Benefit Packages	<p><u>Children – Basic Plan</u></p> <ul style="list-style-type: none"> Will have fewer benefits than current Medicaid plan. Limited to four prescriptions per month; new limits on dental, hearing, vision. No coverage of skilled nursing, orthotics, prosthetics, tobacco cessation programs, nutrition education, diabetes care, or chemical dependency and mental health services. <p><u>Children – Enhanced Plan</u></p> <ul style="list-style-type: none"> No limits on dental, hearing, vision services; prescription drugs; or medically necessary transportation. Includes skilled nursing care, orthotics/prosthetics, tobacco cessation, nutritional education, diabetes care, chemical dependency/mental health services <p><u>Adults – Basic Plan</u></p> <ul style="list-style-type: none"> Will have fewer benefits than current Medicaid plan. Limits on home health, DME, non-emergency transportation, and 4 prescriptions per month. Emergency dental services, diabetes care, physical and occupational therapy, and mental health services are not covered. <p><u>Adults – Enhanced Plan</u></p> <ul style="list-style-type: none"> No limits on medically necessary prescription drugs, home health, DME, or transportation. Also includes Cardiac Rehabilitation, Chiropractic Services, Emergency Dental Services, Tobacco Cessation, Chemical Dependency/Mental Health Services, Diabetes Care, and Nutritional Education.
Cost Sharing	<ul style="list-style-type: none"> Higher co-pays for non-emergency use of the emergency room. Other measures may be taken, but details are still being worked out.