

The Medicaid Commission

Report to the Honorable Secretary Michael O. Leavitt,
Department of Health and Human Service
and
The United States Congress
September 1, 2005

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Letter of Transmittal

September 1, 2005

To The Honorable Secretary Michael O. Leavitt:

On behalf of the Medicaid Commission, we are pleased to transmit to you the Commission's September 1, 2005 report reflecting our recommendations for achieving \$11 billion in savings over the next 5 years. This report fulfills the Commission Charter's mandate to report to you for submission to Congress our recommendations for \$10 billion in savings no later than September 1, 2005.

We look forward to beginning the next phase of our mandate, during which we will work collaboratively for the purpose of making longer-term recommendations on the future of the Medicaid program that ensure long-term sustainability.

We would like to take this opportunity to thank our fellow Commissioners for their dedication to participating in the effort to improve the Medicaid program.

Sincerely,



The Honorable Don Sundquist
Former Governor of Tennessee
Founding Partner, Sundquist Anthony LLC



The Honorable Angus S. King, Jr.
Former Governor of Maine
Partner, Bernstein, Shur, Sawyer & Nelson

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Introduction

Purpose of the Commission

The Medicaid Commission was established by charter by the Honorable Michael O. Leavitt, Secretary of the United States Department of Health and Human Services, in May 2005. The commission charge is defined as follows:

- a) The Commission shall report to the Secretary, for his consideration and submission to Congress, by September 1, 2005, their recommendations on options to achieve \$10 billion in scorable Medicaid savings over 5 years while at the same time make progress toward meaningful longer-term program changes to better serve beneficiaries.
- b) By December 31, 2006, the Commission shall submit to the Secretary a report making longer-term recommendations on the future of the Medicaid program that ensure the long-term sustainability of the program. They shall develop proposals that address the following issues:
 - 1) Eligibility, benefits design, and delivery;
 - 2) Expanding the number of people covered with quality care while recognizing budget constraints;
 - 3) Long term care;
 - 4) Quality of care, choice and beneficiary satisfaction;
 - 5) Program administration; and
 - 6) Other topics that the Secretary may submit to the Commission.

The Medicaid Program Today

Medicaid is a program that pays for medical assistance for certain individuals and families with low incomes and resources. The program became law in 1965 and is jointly funded by the Federal and state governments (including the District of Columbia and the Territories) to assist states in providing medical acute and long-term care assistance to people who meet certain eligibility criteria. Medicaid is the largest source of funding for medical and health-related services for people with limited income.

The portion of the Medicaid program that is paid by the Federal government, known as the Federal Medical Assistance Percentage (FMAP), is determined annually for each state by a formula that compares the state's average per capita income level with the national average. By law, the FMAP cannot be lower than 50 percent or greater than 83 percent. The wealthier states, as measured by per capita income, have a smaller share of their costs reimbursed. The Federal government also shares in the state's expenditures for administration of the Medicaid program at generally 50 percent. Due to the entitlement nature of Medicaid, the amount of total federal outlays for Medicaid has no statutory limit.

Program Enrollment

The Medicaid program, as the safety net for much of the nation's low-income uninsured population, has taken on an increasing responsibility for providing health coverage for this segment of the nation's population. For the five-year period from 1998 to 2003, total enrollment in the program increased by 30 percent.

Enrollment growth in the Medicaid program will play a large part in determining future spending. According to figures presented by the Centers for Medicare and Medicaid Services Office of the Actuary (CMS OACT) in the President's FY 2006 Budget, Medicaid enrollment is expected to increase from 54 million enrollees in 2003 to 65 million in 2015, a 21 percent increase. The growth in enrollment will vary by eligibility category, affecting the share of total enrollees in each of the four general categories of children, adults with dependent children, aged and disabled.

Program Expenditures

Consistent with the rapid rise in enrollment, Medicaid expenditures increased at a faster rate than other insurance coverage types between 1998 and 2003. Overall Medicaid expenditures increased by 62 percent from \$153 billion to \$248 billion, with spending on adults increasing by 77 percent, the greatest increase among all enrollment categories. These increases compare to increases of 51 percent for private insurance expenditures and 36 percent for Medicare over the same time period.

Beginning in 2004 it is projected that the rate of increase in Medicaid spending will exceed the rate of increase in overall health care spending. Projections by OACT indicate that total health care spending will continue to increase at over seven percent per year for the next ten years while Medicaid spending is expected to increase at a rate of nearly eight percent per year.

Additional estimates from OACT indicate that total Medicaid spending will increase from \$275 billion in 2003 to \$685 billion in 2015, an overall increase of almost 145 percent over the 12-year period (7.9 percent per year). Federal spending will have increased from \$161 billion to \$390 billion and state spending from \$114 billion to \$295 billion, increases of approximately 7.6 percent per year and 8.2 percent per year respectively.

Recommendations for Savings

The Medicaid Commission received over 100 submissions for consideration for the September 1, 2005 report. The Medicaid Commission charter directs the Commission to “report to the Secretary, for his consideration and submission to Congress, by September 1, 2005, their recommendations on options to achieve \$10 billion in scorable Medicaid savings over 5 years while at the same time make progress toward meaningful longer-term program changes to better serve beneficiaries.” Based on this requirement for scorable savings, only options that have been previously scored by either the Congressional Budget Office (CBO) or OACT, or that contained sufficient detail upon submission to allow OACT to provide a score prior to the subsequent Commission meeting, *and* that demonstrate savings in the 5-year period could be included as options to be presented to the Commission for consideration.

At a public meeting convened August 17-18, 2005, the Commission deliberated and voted on proposed options for savings that were submitted according to the guidelines established by the Commission at its July 27, 2005 meeting. Following presentations of all scored options, Chairman Governor Sundquist and Vice-chair Governor King prepared a “Chairman’s Mark”. This Mark was their suggestion of a package of options which would achieve \$11 billion in Medicaid savings over 5 years, and served as a starting point for the Committee deliberations. The Mark consisted of six of the options presented during the first day of the meeting, and reflected the Chairs’ recommendations to the Commission.

All Commission members were provided an opportunity to discuss the individual options on the Mark, ask clarifying questions of the subject matter experts present, and move to amend the recommended package by suggesting omissions and substitutions of other options. Three motions were made for amendments. None of the amendments had a sufficient number of votes to pass, and the Chairman’s Mark was not modified. The Commission then voted unanimously to adopt the Chairman’s Mark without amendment.

The Commission recommends the following reforms:

Prescription Drug Reimbursement Formula Reform

Current Law

Currently many states establish pharmaceutical prices based on the Average Wholesale Price (AWP). The AWP is the published suggested wholesaler price to retailers of a drug compiled by third party compendia and is typically significantly higher than the price actually paid by purchasers of the drug (e.g., pharmacies, etc). It is commonly used by state Medicaid agencies as a basis for determining Estimated Acquisition Cost (EAC) for pharmacy reimbursement purposes.

The EAC is the Medicaid agency’s best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer in the package size most frequently purchased by providers. It is used to determine the Medicaid’s agency’s pharmacy provider payment and is typically set at a product’s AWP minus a percentage, but varies from state to state.

Proposal

The Commission recommends allowing states to establish pharmaceutical prices based on the Average Manufacturer Price (AMP) rather than the published Average Wholesale Price (AWP). Additionally, reforms should be implemented to ensure that manufacturers are appropriately reporting data. Such improvements should include reforms to ensure: 1) clear guidance from CMS on manufacturer price determination methods and the definition of AMP; 2) manufacturer-reported prices are easily auditable so that systematic oversight of the price determination can be done by HHS; 3) manufacturer-reported prices and rebates are provided to states monthly rather than the current quarterly reporting; and 4) new penalties are implemented to discourage manufacturers from reporting inaccurate pricing information.

Estimated Savings

\$4.3 Billion over 5 years (CMS Office of the Actuary)¹

Extension of the Medicaid Drug Rebate Program to Medicaid Managed Care

Current Law

Section 1927 of the Social Security Act, effective January 1, 1991 sets forth the requirements of the Medicaid Drug Rebate Program. In order for Federal Medicaid matching funds to be available to States for covered outpatient drugs of a manufacturer, the manufacturer must enter into and have in effect a rebate agreement with the Federal government. Without an agreement in place, States cannot generally receive Federal funding for outpatient drugs dispensed to Medicaid recipients. Rebate amounts received by states are considered a reduction in the amount expended by States for medical assistance for purposes of Federal matching funds under the Medicaid program.

The basic rebate for brand name drugs is the greater of 15.1 percent of the Average Manufacturer Price (AMP) or AMP minus Best Price (BP). Best Price is the lowest price at which the manufacturer sells the covered outpatient drug to any purchaser, with certain statutory exceptions, in the United States in any pricing structure, in the same quarter for which the AMP is computed.

The rebate for generic drugs is 11 percent of AMP.

Under current law Medicaid states cannot collect rebates from managed care organizations in the Medicaid Drug Rebate Program.

¹ These estimates for the recommended proposals from the Office of the Actuary were based on available details and specifications. When specific legislation is developed, these estimates may change. There is the possibility that some or all of these proposals will interact with one another and that this could change the estimated savings of the total package. A preliminary estimate of the effect of such interactions is \$200 million in reduced savings over 5 years.

Proposal

The Commission recommends providing Medicaid managed care health plans access to the existing pharmaceutical manufacturer rebate program currently available to other Medicaid health plans. States should have the option of collecting these rebates directly or allowing plans to access them in exchange for lower capitation payments.

Estimated Savings

\$2 Billion over 5 years (CMS Office of the Actuary)²

Change the Start Date of Penalty Period for Persons Transferring Assets for Medicaid Eligibility.

Current Law

States determine financial eligibility for Medicaid coverage of nursing home care using a combination of state and federal statute and regulation. Personal income and assets must be below specified levels before eligibility can be established. Personal resources are sorted into two categories: those considered countable (those that must be spent down before eligibility criteria is met) and those considered non-countable (those that applicants can keep and still meet the eligibility criteria such as real estate that is the beneficiary's primary residence). Some assets held in trust, annuities and promissory notes are also not counted. If it is determined that the applicant has excess countable assets, these must be spent before they can become eligible. Personal income is applied to the cost of care after a personal needs allowance and a community spouse allowance is deducted.

Federal law requires states to review the assets of Medicaid applicants for a period of thirty-six months prior to application or sixty months if a trust is involved. This period is known as the "look back period." Financial eligibility screeners look for transfers from personal assets made during the look back period that appear to have been made for the purpose of obtaining Medicaid eligibility. Transfers made before the look back period are not reviewed.

Applicants are prohibited from transferring resources during the look back period for less than fair market value. Some transfers of resources are allowed, such as transfers between spouses. If a state eligibility screener finds a non-allowed transfer, current law (OBRA1993) requires the state to impose a "penalty period" during which Medicaid will not pay for long-term care. The length of the penalty period is calculated by dividing the amount transferred by the monthly private pay rate of nursing homes in the state. The penalty period starts from the date of the transfer. Using the date of the transfer as the start date provides an opportunity for applicants to preserve assets because some or all of the penalty period may occur while the applicant was not paying privately for long term care.

² Commissioner John Monahan submitted a letter to Chairman Sundquist and Vice-Chairman King on August 25, 2005, requesting that with regard to this recommendation, the Medicaid managed care organization rates should not be adversely impacted and that rate development continue to be subject to the federal regulations requiring actuarially sound rates. The letter is to be included as supplementary information to the report and can be found at <http://www.cms.hhs.gov/faca/mc/details.asp>.

Proposal

The Commission recommends moving the start date of penalty period from the date of the transfer to the date of application for Medicaid or the nursing home admission date, whichever is later.

Estimated Savings

\$1.4 Billion over 5 years (Congressional Budget Office)³

Increase the "Look-Back" Period from Three to Five Years

Current Law

Financial eligibility screeners look for transfers from personal assets of Medicaid applicants made during a period of time prior to application (this is referred to as the "look-back" period) that appear to have been made for the purpose of obtaining Medicaid eligibility. Applicants are prohibited from transferring resources during the look back period for less than fair market value. Currently, the "look back" period is 36 months (3 years).

Proposal

The Commission recommends increasing the "look-back" period from 36 months to 5 years.

Estimated Savings

Less than \$100 million over 5 years (CMS Office of the Actuary)

Tiered Co-Payments for Prescription Drugs

Current Law

Federal statute limits the amount of co-payments that can be charged. In most cases, co-payments of up to \$3 can be imposed for prescription drugs, physician visits, and outpatient hospital visits. However, certain categories of beneficiaries, such as children under 18, pregnant women, and the institutionalized cannot be charged co-payments. Co-pays are also prohibited for some services, including hospice care, emergency care, and family planning and services.

Proposal

The Commission recommends allowing States the flexibility to be able to increase co-payments on non-preferred drugs beyond nominal amounts when a preferred drug is available, to encourage beneficiaries to fill the least costly effective prescription for treatment. For beneficiaries at or below the federal poverty line, co-payments for preferred drugs should remain nominal. States should be given the ability to develop effective tiered co-pay structures to encourage cost-effective drug utilization where appropriate for all beneficiaries, regardless of income. All co-payments for the preferred drug list should become enforceable. States should be

³ Commissioner Douglas Struyk submitted a letter to Secretary Leavitt on August 29, 2005, outlining his concern that certain regulatory and/or legislative changes are needed to prevent long-term care providers from bearing the financial implications of this recommendation. The letter is to be included as supplementary information to the report and can be found at <http://www.cms.hhs.gov/faca/mc/details.asp>.

given broad authority to waive co-payments in cases of true hardship or where failure to take a preferred drug might create serious adverse health effects.

Estimated Savings

\$2 Billion over 5 years (CMS Office of the Actuary)

Reform of the Medicaid Managed Care Organization (MCO) Provider Tax Requirement

Current Law

Until 1991, when Federal law restricted the use of health care provider related taxes, states were able to tax health care providers as a way to raise their share of the Medicaid matching payment. These funds, used to draw down Federal Medicaid dollars were then returned to the provider, in effect, holding them harmless for the tax they originally paid. This loophole in Federal law permitted states to shift the cost of their Medicaid programs directly to the Federal government.

After 1991, state taxes on health care providers were required to:

- Be imposed on a permissible class of health care services;
- Be broad based or apply to all providers within a class;
- Be uniform, such that all providers within a class must be taxed at the same rate; and
- Avoid hold harmless arrangements in which collected taxes are returned to the taxpayers directly or indirectly.
- The Secretary shall approve broad based (and uniformity) waiver applications if the net impact of the tax is generally redistributive and that the amount of the tax is not directly correlated to Medicaid payments. The hold harmless requirements cannot be waived.

The loophole in current law, which defines as a separate class of health care services the services of a Medicaid managed care organization, permits states to impose taxes solely on Medicaid. Managed care organizations are increasingly taking advantage of this loophole by reorganizing in order to protect the commercial lines of business from tax liability that is then targeted only on the Medicaid subsidiary of the managed care organization.

If the reorganization of the managed care organizations with Medicaid contracts continues, all states could impose a tax only on the Medicaid revenues of the managed care organizations, effectively shifting the entire burden of the tax to the Medicaid program.

Proposal

The Commission recommends changing the law so that managed care organizations (MCOs) are treated the same as other classes of health care providers with respect to provider tax uniformity requirements. Specifically, States would be required to tax all managed care organizations, not just those with Medicaid contracts, in order to meet the uniformity requirements. States should be prevented from guaranteeing that tax revenues paid to states by MCOs be returned.

Estimated Savings

\$1.2 Billion over 5 years (Congressional Budget Office)

Future Work

As directed by the charter, the second mandate for the Medicaid Commission is as follows:

By December 31, 2006, the Commission is tasked with making longer-term recommendations on the future of the Medicaid program that ensure the long-term sustainability of the program.

The Commission shall develop proposals that address the following long-term issues:

- Eligibility, benefits design and delivery;
- Expanding the number of people covered with quality care while recognizing budget constraints;
- Long term care;
- Quality of care, choice, and beneficiary satisfaction;
- Program administration; and
- Other topics that the Secretary may submit to the Commission.

The Commission shall consider how to address these issues under a budget scenario that assumes federal and state spending under the current baseline; a scenario that assumes Congress will choose to lower the rate of growth in the program; and a scenario that may increase spending for coverage. The Commission shall assume that the basic matching relationship between the Federal government and the states will be continued.

Appendix

Summaries of the Options for the September 1, 2005 Report

Following are summaries of the proposals being recommended by the Commission. These narratives are excerpted from the full summary document that contained narratives of all the scored options, and were provided to the Commissioners for their deliberations during the August 17-18, 2005 meeting. The information presented below for each option is taken directly from the information provided by the author of the proposal. Each summary includes language used by the proposal author for the purpose of describing the summary, key points/findings, and final thoughts for each narrative. Any views presented in these summaries do not necessarily reflect the views of the Commission and should not be construed as doing so based on their inclusion in the Appendix section of this report.

Option 5/6: Change the start date of the penalty period for persons transferring assets for Medicaid eligibility.

Author: President's Budget FY 2006 & National Governors Association

Savings Generated: \$1.4 Billion over 5 years (2006-2010)

Scored By: Congressional Budget Office

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.

URL: <http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf>

This option was also submitted by the National Governors Association (NGA). NGA is the bipartisan organization of the nation's Governors.

BACKGROUND (Due to the complexity of this topic, an overview of current law regarding asset transfers is provided.)

Medicaid is the largest payer for long term care services in the county. Medicaid pays for long-term care services for persons who are poor and need long-term care, as well as for those who are made poor through paying privately the high cost of long-term care services. Determining eligibility for this later group presents a different challenge than for other Medicaid eligibility groups.

States determine financial eligibility for Medicaid coverage of nursing home care using a combination of state and federal statute and regulation. Personal income and assets must be below specified levels before eligibility can be established. Personal resources are sorted into two categories: those considered countable (those that must be spent down before eligibility criteria is met) and those considered non-countable (those that applicants can keep and still meet the eligibility criteria such as real estate). Some assets held in trust, annuities and promissory notes are also not counted. If it is determined that the applicant has excess countable assets, these must be spent before they can become eligible. Personal income is applied to the cost of care after a personal needs allowance and a community spouse allowance is deducted.

Federal law requires states to review the income and assets of Medicaid applicants for a period of thirty-six months prior to application or sixty months if a trust is involved. This period is known as the "look back period." Financial eligibility screeners look for transfers from personal assets made during the look back period that appear to have been made for the purpose of obtaining Medicaid eligibility. Transfers made before the look back period are not reviewed. Some states and others maintain that thirty-six months is not a long enough time to discourage transfers.

Applicants are prohibited from transferring resources during the look back period for less than fair market value. Some transfers of resources are allowed, such as transfers between spouses. If a state eligibility screener finds a non-allowed transfer, current law (OBRA '93) requires the state to impose a "penalty period" during which Medicaid will not pay for long-term care. The length of the penalty period is calculated by dividing the amount transferred by the monthly private pay rate of nursing homes in the state. The penalty period starts from the date of the transfer. Using the date of the transfer as the start date provides an opportunity for applicants to preserve assets because some or all of the penalty period may occur while the applicant was not paying privately for long term care. Some elder law attorneys advise their clients on how to use the penalty period to retain assets.

The following two proposals suggest ways to change the way Medicaid determines an applicant's financial eligibility for nursing home care. Both proposals alter aspects of the penalty period and one of them goes further to also change the length of the look back period.

SUMMARY

The Administration proposes to move the start date of penalty period from the date of the transfer to the date of application for Medicaid or the nursing home admission date whichever is later. Changing this date extends the time during which Medicaid applicants who made transfers are financially responsible for the cost of their care. Such a change decreases Medicaid expenditures and increases private payment.

KEY POINTS/FINDINGS

- There is concern among states and others that many persons who anticipate needing nursing home care are transferring their assets for less than fair market value in order to reduce private payment for care.
- Current law provides an incentive for such transfers because even if such a transfer is found, the application of the penalty period allows applicants to retain a significant share of their assets that might have been otherwise available to pay for long-term care.
- A cottage industry of elder law attorneys, as well as “half-a-loaf calculator websites”, inform consumers about how to time such transfers to maximize retained assets while still qualifying for Medicaid. Not only does this practice cost Medicaid in the near term, it also runs counter to the Department's efforts to encourage consumers to take control of their long-term care and plan ahead for the care they may need. It is difficult to make the case for advance financial planning while such other arrangements are available.

FINAL CONSIDERATIONS

Many consumer advocates fear that changes to the transfer of assets policy will impose hardship on persons needing long-term care. In cases in which a transfer is found and a penalty period is imposed they suggest that applicants, unable to pay for services privately, will be forced to go without care. States are required to have hardship provisions in place to assist those unable to make other arrangements; however, little research exists on well such provisions operate.

Commissioners Angus King, Julianne Beckett on behalf of Family Voices, Joseph W. “Chip” Marshall, III, and Douglas Struyk on behalf of the American Association of Homes and Services for the Aging and the American Health Care Association, submitted proposals that endorsed reforms of the asset transfer penalty and the look-back period, but did not provide sufficient detail to score as separate proposals. They did not endorse this specific proposal but are generally in support of reforming this area of Medicaid.

Commissioner Valerie Davidson has requested that the following recommendation be considered during the discussion of this reform option:

At a minimum, all assets of AI/AN individuals described in CMS's State Medicaid Manual, Section 3810.A.7 should be exempt from Medicaid eligibility calculations and estate recovery provisions.

OACT has estimated that amending the proposal to include this recommendation would result in approximately a 1 percent loss in the estimated savings overall.

State Medicaid Manual Section 3810.A.7:

American Indians and Alaska Natives.—*The Federal government has a unique trust responsibility for American Indian (AI) Tribes and Alaska Native (AN) Villages and their members. Section 1917(b)(3) of the Social Security Act gives the Secretary authority to establish standards for hardship. This includes exemptions from estate recovery for certain assets and resources.*

- a. **American Indians and Alaska Natives: Income, Resources and Property Exempt from Medicaid Estate Recovery.**—
The following AI/AN income, resources, and property are exempt from Medicaid estate recovery:
1. Certain AI/AN income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
 2. Ownership interest in trust or non-trust property, including real property and improvements:
 - a. Located on a reservation (any federally-recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
 - b. For any federally recognized Tribe not described in (a), located within the most recent boundaries of a prior Federal reservation.
 - c. Protection of non-trust property described in (a) and (b) is limited to circumstances when it passes from an Indian (as defined in section 4 of the Indian Health Care Improvement Act) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a Tribe and non-Indians, such as spouses and step-children, that their culture would nevertheless protect as family members; to a Tribe or Tribal organization; and/or to one or more Indians;
 3. Income left as a remainder in an estate derived from property protected in 2 above, that was either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.
 4. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights, and income either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and
 5. Ownership interests in or usage rights to items not covered by 1-4 above that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom.
- b. **American Indians and Alaska Natives Income, Resources and Property Not Exempt from Medicaid Estate Recovery.**
—You may recover the following income, resources and property from the estates of American Indians and Alaska Natives:
1. Ownership interests in assets and property, both real and personal, which are not described in 7.a, items 1-5 above.
 2. Any income and assets left as a remainder in an estate that do not derive from protected property or sources in 7.a, items 1-5.

Option 7: Extend the asset transfer look back period from three to 5 years.

Author: National Governors Association

Savings Generated: Less than \$100 Million over 5 years (2006-2010)

Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

States should have increased ability to prevent inappropriate transfer of assets by seniors to qualify for Medicaid. To that end, the look-back period should be increased from three to five years.

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

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

KEY POINTS/FINDINGS

- The CRS Report for Congress Medicaid and SCHIP: The President's FY2006 Budget Proposals, published February 15, 2005 states that Medicaid law includes provisions establishing penalties for individuals who transfer assets for less than fair market value for the purpose of becoming Medicaid-eligible.
- Specifically, Medicaid law requires states to delay Medicaid eligibility for persons needing institutional coverage (including nursing home care) and certain home and community-based services who transfer assets on or before a "look-back date."
- For most assets, this date is 36 months (three years) prior to Medicaid application.

FINAL CONSIDERATIONS

Commissioner Joseph W. "Chip" Marshall, III, endorsed asset transfer reforms consistent with this NGA proposal.

Option 10: Providing states flexibility in defining co-payment requirements for prescription drugs requirements.

Author: National Governors Association

Savings Generated: \$2 Billion over 5 years (2006-2010)

Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

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

For beneficiaries at or below the federal poverty level, co-payments for preferred drugs would remain nominal, although they would be enforceable. For this population, states would be able to increase these enforceable co-payments beyond nominal amounts for a non-preferred drug. States should be given broad authority to waive these co-pays in cases of true hardship or where failure to take a preferred drug might create serious adverse health effects.

KEY POINTS/FINDINGS

- There are approximately 6.3 million Medicaid beneficiaries who are currently eligible for or receiving benefits through both Medicare and Medicaid. Medicaid will no longer be responsible for providing prescription drug coverage to these beneficiaries beginning January 1, 2006.⁴
- On average 24 percent of all eligibles in Medicaid pharmacy benefit management managed care utilize prescription benefits.⁵

⁴ Medicare Modernization Act, Pharmacy MMA Information, Medicare Help at the Counter: Medicare Rx Update June 10, 2005. Available online at: <http://www.cms.hhs.gov/medicarereform/pharmacy/update061005.asp>.

⁵ Pharmaceutical Care Network, April 2004. *Pharmacy Benchmark Study for Managed Medicaid Health Plans*. Available online at: http://www.pharmcarenet.com/pdf/benchmarks_medicaid_2004.pdf.

FINAL CONSIDERATIONS

Commissioner Angus King submitted a broad proposal that endorsed applying enforceable co-payments for prescription drugs, but did not provide sufficient detail to score as a separate proposal. He did not necessarily endorse this specific proposal but is generally in support of reforming this area of Medicaid.

Option 16: Medicaid prescription drug reimbursement formula reform.

Author: National Governors Association

Savings Generated: \$4.3 Billion over 5 years (2006-2010)

Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

States negotiate prices on prescription drugs according to the published average wholesale price (AWP). There is widespread acceptance that AWP is inflated and does not reflect a valid benchmark for pricing. A different reference price should be established and made available to the states that more accurately reflects the actual price for drugs. The Average Manufacturer Price (AMP) should be used for this purpose.

KEY POINTS/FINDINGS

If AMP replaces AWP in pricing, reforms need to be made to ensure that manufacturers are appropriately reporting pricing data. Such improvements should include reforms to ensure: 1) clear guidance from CMS on manufacturer price determination methods and the definition of AMP; 2) manufacturer-reported prices are easily auditable so that systematic oversight of the price determination can be done by HHS; 3) manufacturer-reported prices and rebates should be provided to states monthly rather than the current quarterly reporting; and 4) new penalties are implemented to discourage manufacturers from reporting inaccurate pricing information.

FINAL CONSIDERATIONS

Recent reports by the General Accounting Office (GAO) and the Office of Inspector General (OIG) concluded that improvements in manufacturer price determination methods and reporting, and increased oversight by CMS are essential to ensure that AMP is a reliable and accurate reference price for states if AMP is to be used for the pharmacy reimbursement formula.

Option 20/21: Extension of the Medicaid drug rebate program to Medicaid managed care.
Author: National Governors Association & the Association of Community Affiliated Plans
Savings Generated: \$2 Billion over 5 years (2006-2010)
Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

The Association for Community Affiliated Plans (ACAP) is a national trade association representing "safety net health plans" that are Medicaid-focused and are non-profit or owned by non-profit entities like public hospitals or community health centers. As of July 2005, ACAP represents 19 plans serving 2.1 million Medicaid beneficiaries in 12 states. ACAP plans serve one of every six Medicaid managed care enrollees.

SUMMARY

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

KEY POINTS/FINDINGS

- A Center for Health Care Strategies (CHCS) report concluded that MCOs are able to reduce their average per member per month (PMPM) drug costs for families in Medicaid managed care to \$17.36 compared to \$20.46 in the state FFS programs.
- A Lewin report concluded that Arizona's managed care program was able to achieve the lowest pharmacy costs in the nation at the time of the study, 38 percent below the national Medicaid average.
- Support for this reform proposal from includes the following organizations: National Association of State Medicaid Directors, Medicaid Health Plans of America.

FINAL CONSIDERATIONS

Because managed care penetration varies widely by state, the fiscal impact of a reform of this nature would vary considerably across states. Therefore, while it may achieve overall savings for the Federal government, not all states would experience measurable savings.

Option 30: Reform of Medicaid Managed Care Organization provider tax requirements.

Author: President's Budget FY 2006

Savings Generated: \$1.2 Billion over 5 years (2006-2010)

Scored By: Congressional Budget Office

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.

URL: <http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf>

SUMMARY

The 2006 Budget proposes to require that managed care organizations (MCOs) be treated the same as other classes of health care providers with respect to uniformity requirements. Under this proposal, states would be prevented from guaranteeing that tax revenues paid to states by MCOs would be returned.

KEY POINTS/FINDINGS

- Provider taxes are a financing mechanism states have used to generate state funds needed to obtain federal Medicaid matching payments.
- During the mid 1980s, states began using provider taxes as a mechanism to leverage additional federal funds and cost shift Medicaid expenses to the Federal government. After the taxes were matched with federal funds and paid to the providers, the providers did not keep the payments. Instead, the providers returned most of the federal monies to the states, where the funds could be used for other purposes.
- In 1991, the Congress passed legislation to limit states' use of provider taxes.
- CRS reports that under current law, Medicaid MCOs are treated differently than other providers regarding provider taxes.
- As a result, states currently may tax Medicaid MCOs and provide a guarantee that the tax revenues will be returned to the MCOs. States may receive the full federal match for the tax funds that are returned.

FINAL CONSIDERATIONS

These proposals are intended to strengthen requirements and ensure the fiscal integrity of the Medicaid program.

CRS states that this proposal will pertain to both Medicaid and non-Medicaid MCOs.

Commissioners Grace-Marie Turner and Robert Helms endorsed payment reforms consistent with this Administration proposal.