MACPAC

Medicaid and CHIP Payment and Access Commission

Executive Summary

Report to the Congress on Medicaid and CHIP

As part of its statutory charge, each March the Medicaid and CHIP Payment and Access Commission (MACPAC) reports on significant issues affecting Medicaid and the State Children's Health Insurance Program (CHIP), two federal-state programs that play significant and growing roles in the nation's health care system. In fiscal year (FY) 2012, Medicaid financed care for an estimated 72.6 million people, over a fifth of the U.S. population, at a cost of $435.5 billion. CHIP served 8.4 million children in FY 2012, with spending of $12.2 billion.

The Commission's March 2013 *Report to the Congress on Medicaid and CHIP* focuses on several key congressional priorities including interactions between Medicaid, CHIP, and the new health exchanges and issues related to individuals who are dually eligible for Medicaid and Medicare. The report is divided into five chapters and a statistical supplement:

- Chapter 1: Setting the Context
- Chapter 2: Eligibility Issues in Medicaid and CHIP: Interactions with the ACA
- Chapter 3: The Roles of Medicare and Medicaid for a Diverse Dual-Eligible Population
- Chapter 4: Medicaid Coverage of Premiums and Cost Sharing for Low-Income Medicare Beneficiaries
- Chapter 5: Issues in Setting Medicaid Capitation Rates for Integrated Care Plans
- MACStats: Medicaid and CHIP Program Statistics

The Commission is charged with making recommendations to the Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide range of issues affecting Medicaid and CHIP. This report includes two recommendations related to eligibility, both of which address the changed context within which Medicaid and CHIP will function when major provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) go into effect in 2014.

Chapter 1: Setting the Context

Medicaid and CHIP are at a critical juncture in their evolution. The ACA, although not fully implemented, is already changing integral aspects of Medicaid and CHIP.

Medicaid is on the cusp of a major eligibility expansion that will heighten its role as a major purchaser of health services. At the same time, the Congress will be considering the future of CHIP in the context of both the Medicaid expansion and the subsidized coverage that will be offered through health insurance exchanges.

While preparing for the changes mandated by the ACA, Medicaid and CHIP are also responding to broader issues in the health care system. These include continued growth in health care spending, a desire to enhance program efficiency and promote better health care outcomes, and pressures with respect to the financing and delivery of long-term services and supports (LTSS).

Chapter 1 explores how these issues shape the context in which Medicaid and CHIP programs operate, focusing on how issues affecting health care in the U.S. are influencing the two programs.

Chapter 2: Eligibility Issues in Medicaid and CHIP: Interactions with the ACA

To increase the number of Americans with health insurance, the ACA created a continuum of coverage by expanding Medicaid eligibility, providing new premium tax credits for the purchase of private health insurance, and instituting numerous other changes effective in 2014. The design of the ACA specifically changes some aspects of Medicaid and CHIP as well as creates a new environment within which these programs operate. Chapter 2 makes recommendations related to two specific interactions between the ACA and the Medicaid and CHIP programs.

The ACA expands Medicaid eligibility in 2014 (effectively at state option, based on a 2012 Supreme Court decision) to nearly all adults with income up to 138 percent of the federal poverty level (FPL). Other ACA policies that streamline eligibility, enrollment, and renewal processes will increase insurance coverage of individuals who were previously eligible but not enrolled. The Congressional Budget Office projects that Medicaid and CHIP enrollment will increase by 8 million people in 2014 because of the ACA.

While states may choose not to expand coverage to low-income adults, in 2014 all states must implement other ACA changes to streamline eligibility determinations and to standardize income-counting methodologies across states and programs. In addition, states can no longer require face-to-face interviews for low-income applicants, can only schedule regular redeterminations every 12 months, and cannot require families to provide information already available to the state.

Churning, the phenomenon of individuals enrolling and disenrolling from different sources of health insurance over a relatively short period of time, is a long-standing problem in Medicaid and CHIP and can create barriers to access for enrollees as well as administrative burdens for providers, plans, payers, and states. While some ACA policies may mitigate churning, they will not eliminate it. Millions of individuals may continue to move between sources of coverage—or off of coverage altogether—when required to report what are typically modest income changes.

In the past, some state Medicaid programs have implemented a policy known as 12-month continuous eligibility to help reduce churning. Such policies allow individuals to enroll for a full

year regardless of changes in family income or composition. Twelve-month continuous eligibility is an explicit statutory option for children in Medicaid, and states have flexibility under existing rules to implement 12-month continuous eligibility for adults in Medicaid and in separate CHIP programs. However, this flexibility may no longer be available for some Medicaid and CHIP enrollees in 2014 as an unintended consequence of implementing the modified adjusted gross income requirements.

To retain states' authority to implement 12-month continuous eligibility and in order to mitigate some of the hazards associated with enrollment churning, the Commission recommends:

> **Recommendation 2.1:** In order to ensure that current eligibility options remain available to states in 2014, the Congress should, parallel to the existing Medicaid 12-month continuous eligibility option for children, create a similar statutory option for children enrolled in CHIP and adults enrolled in Medicaid.

Enactment of the ACA also creates new questions about Transitional Medical Assistance (TMA). TMA provides additional months of Medicaid coverage to millions of families who might otherwise become ineligible and uninsured due to an increase in earnings from employment. While TMA has been a provision of Medicaid law for nearly 40 years, states face perennial uncertainty about whether it will continue to be funded.

In states expanding to the new adult group, TMA may no longer be necessary to prevent uninsurance and could create unnecessary confusion and administrative burden for enrollees and eligibility workers. If states implementing the adult group expansion could opt out of TMA because of the presence of other coverage options, states would save money.

In the interest of promoting administrative simplification—for enrollees, providers, and payers, including the federal and state governments—and maximizing continuity of coverage and care, the Commission recommends:

> **Recommendation 2.2:** The Congress should permanently fund current Transitional Medical Assistance (TMA) (required for six months, with state option for 12 months), while allowing states to opt out of TMA if they expand to the new adult group added under the Patient Protection and Affordable Care Act.

Chapter 3: The Roles of Medicare and Medicaid for a Diverse Dual-Eligible Population

Individuals who are dually eligible are low-income seniors and persons with disabilities who are enrolled in both Medicare and Medicaid. In 2011, there were 10.2 million dual eligibles, including 7.5 million people with Medicare who qualified for full Medicaid benefits and 2.7 million partial-benefit dual eligibles, for whom Medicaid paid only for Medicare premiums or cost sharing. Annual Medicaid spending on dual eligibles exceeds $100 billion.

Persons dually eligible for Medicare and Medicaid are a diverse group, including people who are young and old, people who are relatively healthy as well as those who are gravely ill, and people who have no disabling or chronic conditions as well as those with significant disabilities. LTSS use accounts for the majority of Medicaid spending for dual eligibles but utilization varies from full-

time nursing home residents to those who do not use any Medicaid LTSS. The diversity of the population is reflected in its widely varying use of services and spending.

Chapter 3 describes the care needs and patterns of service use and spending among several subgroups of the dually eligible population, to better inform the design of policy solutions that take into account this diversity. The Commission plans to continue examining options for improving care and services for dual eligibles and the implications for both Medicare and Medicaid.

Characteristics of dual eligibles. The majority of dually eligible individuals are adults age 65 and older who qualify for Medicare on the basis of their entitlement to a Social Security retirement benefit; other dual eligibles are under age 65 and are enrolled in Medicare as a result of a serious disability.

Among all-year, full-benefit dual eligibles, 59 percent had no LTSS use in 2007 and 41 percent used some LTSS, including 19 percent who used institutional services in Medicaid, 10 percent who used Medicaid home and community-based waiver services as an alternative to institutionalization, and 11 percent who used Medicaid state plan LTSS only.

Average annual Medicare and Medicaid spending varied widely across these four subgroups, from $70,000 for people who used institutional services in Medicaid to about $15,000 for people who did not use any LTSS.

Medicare's role for dual eligibles. For all dual eligibles, Medicare is the primary source of health insurance, covering physician services, inpatient and outpatient hospital care, post-acute care, and prescription drugs. Full-benefit dual eligibles who do not use LTSS rely, on average, almost exclusively on Medicare. These individuals account for 59 percent of all-year, full-benefit dual-eligible enrollees but just 11 percent of Medicaid spending on those dual eligibles.

Medicaid's role for dual eligibles. Medicaid provides financial assistance with Medicare costs for poor and near-poor Medicare beneficiaries, as well as access to services not covered by Medicare, including LTSS, behavioral health services, vision, dental care, and other wraparound services.

People who need an institutional level of care (who used Medicaid institutional LTSS or waiver services) rely much more heavily on Medicaid and account for the majority of Medicaid spending on all-year, full-benefit dual eligibles (78 percent).

A small number of high-need, high-cost beneficiaries account for most Medicaid spending for dual eligibles. The highest-cost 10 percent to Medicaid account for roughly half of all Medicaid spending on all-year, full-benefit dual eligibles.

Chapter 4: Medicaid Coverage of Premiums and Cost Sharing for Low-Income Medicare Beneficiaries

The Medicare program was originally designed to serve eligible individuals without regard to their income and includes beneficiary cost-sharing requirements such as premiums, deductibles, and copayments similar to private health insurance. From its earliest days, Medicaid covered some of the costs of medical care for low-income Medicare beneficiaries, but many persons eligible for this assistance did not enroll.

Out of concern that low-income individuals would forgo needed care when faced with cost-sharing requirements beyond their means, the Congress enacted a series of provisions to make Medicaid's role in paying for these costs explicit and to

encourage greater enrollment. Today, there are four Medicare Savings Programs (MSPs), each with different income and asset-level requirements.

The Commission is examining MSPs as part of its ongoing analytic agenda related to individuals who are dually eligible for Medicaid and Medicare, as well as its longstanding interest in Medicaid payment policy. It seeks to better understand the interaction between the Medicaid and Medicare programs at the state level, and, ultimately, whether such interactions affect access to services for dually eligible individuals.

Chapter 4 describes the MSPs and mechanisms by which Medicaid contributes to the costs of medical care for low-income Medicare beneficiaries. These include payment of Medicare premiums, coinsurance payments, and deductibles for low-income persons who meet certain income and asset thresholds. Some low-income persons qualify for full Medicaid coverage for services that are not covered by Medicare.

While federal requirements set minimum standards for MSP eligibility and benefits, states vary in the methods used to determine MSP eligibility and the eligibility levels for full Medicaid benefits. As a result, MSP enrollment rates vary among states. The MSPs covered 8.3 million dual eligibles in 2011.

States have a certain amount of flexibility in how they pay for Medicare cost sharing, but current state policies have not been readily available at the federal level. For this report, MACPAC reviewed publicly available state policies in order to develop an up-to-date and complete picture of how states pay for these cost-sharing amounts. The study looked at payment policies for four provider types: inpatient hospitals, outpatient hospitals, skilled nursing facilities (SNFs), and physicians. State policies were classified into three categories:

- Full payment: the state pays the full amount of Medicare deductibles and coinsurance, regardless of the Medicaid payment rate.
- Lesser of: the state pays the lesser of the full Medicare deductible and coinsurance or the difference between the Medicaid rate and amount already paid by Medicare.
- Other: the state policy does not clearly fall into either of the above categories.

Most states use lesser-of policies, with 36 states using these policies for hospital inpatient and outpatient services, and 39 states using them for SNF and physician services. It also appears that there has been a substantial shift toward use of the lesser-of policy since it was explicitly authorized in the Balanced Budget Act of 1997 (P.L. 105-33). Thirteen states pay full cost sharing for inpatient hospital services, 12 states pay full cost sharing for skilled nursing facilities, and 11 states pay full cost sharing for outpatient hospital and physician services.

Medicare cost-sharing payment policies can vary within a state. About half of the states have a lesser-of policy for all four provider types and four states have a full-payment policy for all four provider types; the remaining 18 states mix and match policies in a variety of combinations.

Medicaid payments for acute care, which includes Medicaid services not covered by Medicare as well as Medicare coinsurance and deductibles, are estimated at $21.4 billion, or 20 percent of Medicaid spending for all dual eligibles in 2007. Medicaid payments for Medicare premiums accounted for another $10.5 billion in 2007.

The Commission will continue to explore the role that states play in assuring access to services for dual eligibles, including state enrollment policies and the effect of state Medicaid payment policies for Medicare cost sharing.

Chapter 5: Issues in Setting Medicaid Capitation Rates for Integrated Care Plans

Persons who are dually eligible for both Medicare and Medicaid are among the highest-need and highest-cost individuals in both programs. Several states are serving dual eligibles through risk-based care models and many are working with the Centers for Medicare & Medicaid Services (CMS) to develop more effective integrated care models.

The approach to setting Medicaid capitation rates for plans participating in these programs will be a key factor in determining whether the initiatives move forward, are sustained over time, and meet expectations for financial savings. Chapter 5 focuses on several policy and technical issues related to setting appropriate Medicaid capitation rates for integrated care programs serving dual eligibles.

Overview of rate setting for Medicaid managed care. Medicaid capitation rate-setting methods vary from state to state, although most follow the same general process. States begin with a baseline of historical claims and eligibility data and make adjustments to reflect expected costs. Capitation rates are set for groups of enrollees to reflect differences in predicted service use for each group. States may further refine their payment methodologies to mitigate financial risk and to create incentives related to performance and quality.

Ideally, the capitation rates should be set at levels that are neither so low that plans avoid enrolling individuals with the greatest needs or limit access to services, nor so high that there are no incentives for plans to be efficient. The biggest challenge in setting capitation rates for dual eligibles is properly accounting for the cost of LTSS, which constitutes approximately 70 percent of Medicaid spending for full-benefit dual eligibles. Putting plans at risk for LTSS should create incentives for plans to provide services in the most cost-effective setting. However, as noted in Chapter 3, spending on LTSS varies widely among dual eligibles, creating substantial financial risk for plans if the needs of the enrolled population do not match the assumptions built into the capitation rates.

Current experience with managed care for dual-eligible enrollees. States have experience with two existing integrated care programs for dual eligibles: (1) state arrangements with Medicare Advantage dual-eligible special needs plans (D-SNPs) and (2) Program of All-inclusive Care for the Elderly (PACE) plans. They have used a range of rate-setting tools to create financial incentives while accounting for population differences and financial risk to the plans.

However, while risk adjustment is one of the strongest tools for states to appropriately balance incentives and risk, only a few states have implemented a Medicaid risk adjustment process for dual eligibles. Commonly used risk adjustment models are based on diagnostic data that do not reliably predict LTSS costs, and the predictive power of new models that use LTSS-related measures (e.g., frailty, functional status) has not been widely researched. Given the differences in LTSS benefits in each state, a single risk adjustment model may not accurately predict LTSS costs across states and some states may need to develop their own models.

Medicaid payment in the financial alignment demonstrations. The CMS financial alignment demonstrations seek to coordinate the Medicare and Medicaid rate-setting process to take into account cross-program interactions and share overall cost savings across both programs. The Medicare rate-setting methodology will be consistent across all participating states and will be based on the existing Medicare Advantage and Medicare Part D rate-development processes,

including risk adjustment. States and their actuaries, with review from CMS, will develop the Medicaid payment rates and make separate payments to participating health plans.

Issues for consideration. As the financial alignment demonstrations and other efforts to expand risk-based models for this high-cost, high-need population move ahead, policymakers will need to consider several additional payment issues, including accounting for voluntary enrollment, the need for LTSS risk adjustment models and appropriate measures of functional status, and the treatment of supplemental payments.

MACStats: Medicaid and CHIP Program Statistics

MACStats is a standing section in all Commission reports to the Congress. In this report, MACStats includes state-specific information about program enrollment, spending, eligibility levels, optional benefits covered, and federal medical assistance percentages (FMAPs), as well as an overview of cost sharing permitted under Medicaid, and the dollar amounts of common FPLs used to determine eligibility for Medicaid and CHIP.

- Total Medicaid spending grew by only about 1 percent in FY 2012 to $435.5 billion. Total CHIP spending grew by less than 2 percent to $12.2 billion.
- The number of individuals ever covered by Medicaid grew by less than 2 percent from an estimated 71.7 million in FY 2011 to 72.6 million in FY 2012. CHIP enrollment grew from 8.2 million to 8.4 million. Few states changed income eligibility levels for Medicaid and CHIP in 2012.
- In FY 2012, federal Medicaid spending decreased and state spending increased due in part to the expiration of a temporary increase in FMAPs.
- The Medicaid and CHIP programs accounted for 15.5 percent of national health expenditures in calendar year 2011, and their share is projected to reach 20 percent in the next decade.

1800 M Street NW
Suite 350 North
Washington, DC 20036
Phone: (202) 273-2460

www.MACPAC.gov