Summary of Medicaid Related Issues in U.S. Senate Finance Committee Report on Expanding Health Care Coverage

Section One: Insurance Market Reforms (Pages 2-7)

- Would impose federal rating, guaranteed issue, and pre-existing condition exclusion requirements on the individual and small group markets.
- Proposes a Health Insurance Exchange to link people to private insurance. A pending decision point is whether there should be a single federal exchange, or state/regional exchanges.
- This section of the report has a less direct impact on Medicaid, although to the extent that it improves access to private coverage it could reduce the number of uninsured persons who might have to rely on the Medicaid program.

Section Two: Making Coverage Affordable (Pages 8-12)

- All plans would be required to offer a broad range of medical benefits including preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, maternity and newborn care, prescription drugs, radiation and chemotherapy, mental health and substance abuse services.
- Plans would be prohibited from imposing annual or lifetime limits on benefits.
- Long term care and therapies are not mentioned as required benefits.
- Insurers offering plans through the exchange would have to offer four different benefit plans that would have gradually reducing actuarial values, believed to be based on the SCHIP plan.
- Cost sharing would be prohibited for preventive services, but not for other services.
- Drug coverage would have to be equal to the requirements in Medicare Part D. It's not clear whether any of the plans would have to offer a Medicaid equivalent benefit.
- The plan describes various proposals to subsidize the cost of purchasing coverage through the exchange for those persons with incomes below 400% of the federal poverty level.

- A tax credit would be available for individual and or family coverage, and would be refundable and paid in advance.
- Cost sharing assistance to limit the amount of cost sharing an individual is required to pay up to the valuation of the high coverage option for those between 100 and 200 percent FPL.
- Small business tax credits for employers that provide employee health coverage.

Section Three: Public Health Insurance Options (Page 13)

- Three "public health insurance" options briefly described:
  - a "Medicare like Plan" operated by HHS,
  - a "Medicare like Plan" administered by a private third-party administrator,
  - a state run public option. There is virtually no description of this third option other than a reference to allowing individuals to purchase coverage through State-employee plans.

- The document also includes the suggestion of a "Proposed Option B" which would be no public health insurance option, and instead rely on private options in a "reformed and well-regulated private market."

Section Four: Role of Public Program (Pages 14-37)

- The bulk of Medicaid related issues live in this section of the document. It includes references to eligibility standards and methodologies, payment levels, increased coverage mandates, SCHIP, disproportionate share hospitals, dual eligibles and more.

- All State Medicaid programs would be required to raise income eligibility for pregnant women, children and parents. It gives an example of 150% FPL.

- States would also have MOE requirements and would be required to maintain income eligibility for all previously eligible populations. The MOE requirement would expire when HHS determined that an Exchange is fully operational.

- No income disregards would be permitted for any Medicaid eligible population Income would be measured based on modified adjusted gross income (MAGI), the same income used to determine eligibility for the exchange.

- Two different reimbursement options are proposed:
  - The federal government would "fully finance all expenditures for benefits provided to individuals newly eligible for Medicaid as a result of increases in income eligibility" through 2015, with federal subsidies being fully

phased out by 2020. By 2020, the state share of these costs would be equal to the state share under the FMAP formula.
    - The federal government would pay an increased share of costs for all populations for a certain time period. The proposals also envision that states would have to increase their payments to providers to a given percentage (e.g. 80%) of Medicare rates.

- The document outlines 3 options for coverage under the public plan:
    - increased coverage through the current Medicaid structure. Persons eligible for Medicaid would be deemed ineligible for tax credits in the Exchange. States would give the option, or possibly be mandated, to offer premium assistance through Medicaid for Medicaid-eligible persons who have access to employer-sponsored insurance.
    - increased coverage through the Exchange. Under this option the disabled, dual eligibles and other "special need" populations would continue to receive coverage through state Medicaid programs. Children, pregnant women, parents and childless adults would receive premium subsidies and Medicaid programs would be required to provide wrap around coverage for EPSDT and other services not provided by private plans.
    - increased coverage through a combination of both. Coverage could be purchased through the Exchange or the State Medicaid program. The tax credit would be treated as a "voucher" to buy into Medicaid. In the event that recipient uses services that exceed the value of the "voucher" the Exchange would reimburse the state at 100% of what the services would have cost if the provided to a parent in Medicaid.

<u>SCHIP</u>

- Once SCHIP expires (September 30, 2013) and the Exchange is fully operational SCHIP income eligibility would increase to 275 percent FPL. SCHIP programs though could no longer use income disregard and income would be measured based on MAGI.

- SCHIP enrollees would obtain their primary coverage through the Exchange, but SCHIP would be required to provide wrap around services (EPSDT) that fall outside the limits of Exchange coverage.

- It also proposed that all the quality measures that are contained in The Children's Health Insurance Program Reauthorization Act (CHIPRA) would be applied to all Medicaid populations. Funding would be provided for an enhanced Medicaid and CHIP Payment and Access Commission.

<u>Eligibility Determination and Benefits</u>

- States would be prohibited from relying on face to face interviews when determining eligibility for Medicaid and the ability to apply an assets test when determining eligibility for acute care services.

- States would be required to implement 12 month continuous eligibility, establish a Medicaid enrollment website, and would be given the ability to enroll and redetermine Medicaid eligibility at a number of sites (including the Department of Motor Vehicles!). It would also extend administrative automatic renewal and Express Lane renewal (CHIPRA) to all Medicaid beneficiaries.

- The proposal would add a new categorically eligible needy group to Medicaid for family planning services, and allow states to make presumptive eligibility decisions for this new group.

- It gives podiatrists, optometrists, and free-standing birth centers Medicaid provider status.

- It adds interstate coordination requirements for children who are Medicaid beneficiaries.

- It makes prescription drug services a mandatory service for the categorically and medically needy.

- Smoking cessation drugs, barbiturates, and benzodiazepines would be removed from Medicaid's excluded drug list. There are also other changes in Medicaid drug payments.

- Waivers would be required to meet increased statutory requirements for transparency in their development, implementation, and evaluation if they impact eligibility, enrollment, benefits, cost sharing, and or financing.

- The proposal envisions several new requirements on states and the federal government in the waiver process. Similar requirements would be imposed on states seeking to implement state plan amendments and changes in covered benefits.

FMAP

- A number of changes are proposed to the FMAP formula. The proposal describes them as revenue neutral – meaning some states will lose dollars while others will gain.

- Data on a state's poverty level would be included for the first time. OHP staff has done some initial review of the proposed formula and has uncovered some mathematical flaws which we have shared with NASMD. In general the projected impact on Ohio is either negative or neutral.

- There is also discussion of an automatic countercyclical stabilizer being added to FMAP, but states like Ohio that have recovered much slower in past recessions wouldn't experience much if any relief from this proposal.

- The proposal envisions significant changes in state Disproportionate Share Hospital allotments (known as HCAP in Ohio), with payments being made and determined directly by HHS. It also mentioned that DSH funds could be reallocated among states.

Medicare Dual Eligibles

- A Medicaid demonstration program of 5 years is created under the proposal to explore and develop new approaches for coordinating care for dual eligibles.

- States would be given the authority in Medicaid 1915(b) waivers to use savings from coordinating care for dual eligibles between Medicaid and Medicare in their waiver applications.

- An Office of Coordination for Dually Eligible Beneficiaries would be created within CMS.

- Medicare would reduce its Medicare disability waiting period over some period of time, and persons between 55 and 65 without employer sponsored insurance would be allowed to buy into Medicare prior to the operation of the Exchange.

Section Five: Shared Responsibility (Pages 39-41)

- This section includes mandates for individuals to obtain coverage with penalties imposed through the tax code on those that don't comply. There is also discussion surrounding employer mandates that include the possibility of interaction with Medicaid.

Section Six: Options to Improve Access to Preventive Services and Encourage Health Lifestyles (Pages 43-48)

- A United States Preventive Services Task Force is created which would define "screening and preventive services" for adults within Medicaid as being rated either "A" or "B" and the Advisory Committee on Immunization Practices would make recommendations regarding immunizations.

- If a state covers all these services they would receive a 1% increase in their federal share of FMAP for those services.

- States would be required to cover comprehensive tobacco cessation services for pregnant women without any cost sharing. Other options would limit cost sharing for any "A" or "B" services. States would also be eligible to apply for funds to create incentives for Medicaid enrollees to participate in evidence based behavior modification programs (e.g. smoking cessation, weight loss).

- States would also be able to apply for other grants related to health promotion and preventive health services, including local multi-disciplinary care teams.

- Tax credits would also be created for employers offering qualified wellness programs.

Section Seven: Long Term Care Services and Supports (Pages 49-55)

- States would be given the ability to seek HHS approval to offer additional services under 1915(c) waivers. It would also allow individuals to enroll in more than one waiver simultaneously.

- It would eliminate the existing institutional level of care requirement for eligibility for 1915(c) waivers and require states to replace it with less stringent criteria.

- It would also remove the prohibition against providing 1915(i) services to persons with income levels above 150 percent FPL.

- In addition states could confer eligibility for 1915(i) home and community based services as well as full Medicaid benefits with incomes up to 300% of the maximum SSI Payment, as long as these individuals would also meet the state-defined needs-based criteria.

- The FMAP rate for HCBS would be increased by 1 percent.

- States would be required to apply spousal impoverishment rules to persons receiving HCBS.

- It would give states the flexibility to allow HCBS applicants to retain higher level of assets and would reset the look back period for asset transfers to 36 months from the 60 month period created in the Deficit Reduction Act.

- Funding would be provided for a series of state grants related to HCBS, the Money Follows the Person project would be extended to 2016, and CMS would be required to implement the functional tool for post-acute long term care.

Section Eight: Options to Address Health Disparities (Pages 56-61)

- The Social Security Administration would be required to collect race, ethnicity, language data on Medicare enrollees, and provide funding so SSA databases can communicate with each other.

- Other proposals would substantially increase the amount of similar data that is collected from a variety of federal programs and activities, including disability related information.

- States would be allowed to waive the 5 year ban on Medicaid coverage for non-pregnant, adult, legal immigrants.

- Funding would be authorized under Title V- Maternal and Child Health Services Block grant to develop and implement targeted approaches to reducing infant mortality.