



## An Advocate's Guide to HHS Letter Defining State Medicaid Flexibility

As states struggle to balance their budgets, the U.S. Department of Health and Human Services (HHS) released a [letter](#) (and [attachment](#)) reminding governors of a variety of policy levers they have at their disposal to reduce Medicaid expenditures. While some of these state options would create a more efficient and effective Medicaid program and even improve the quality of care, others would weaken the quality of care and shift costs from the state onto vulnerable Medicaid beneficiaries.

### Options that save money by creating a stronger Medicaid program

Many of the policies laid out in the HHS letter would create efficiencies in Medicaid, enabling it to provide better care while shrinking its fiscal footprint.

**1. Reform the way services are delivered and paid for in Medicaid.** The sickest five percent of Medicaid beneficiaries account for over half of Medicaid spending.<sup>1</sup> HHS encouraged states to provide more effective care to high-cost enrollees through a variety of payment and delivery system reforms.

For the chronically-ill. Those with chronic illnesses often end up in hospitals for care that could have been provided in less expensive settings. And when they are discharged from the hospital, they are too often readmitted because they didn't get the follow-up care they needed. HHS encouraged states to improve care and lower costs for this population by:

- ***Promoting medical homes in children's hospitals*** to better coordinate the care of children with severe chronic illnesses.
- ***Taking up the new Health Homes state option.*** As of January 2011, states can qualify for two years of enhanced federal funding to set up health homes to better coordinate the care of Medicaid beneficiaries with chronic physical or mental illnesses. States can elect this new option by filing an amendment to their Medicaid state plan.
- ***Improving care management for children and adults with asthma*** by using nontraditional educators to help patients self-manage the condition.
- ***Reducing hospital readmissions*** by developing initiatives such as those that reimburse nurse discharge advocates to arrange follow-up appointments and to help high-risk beneficiaries understand their discharge instructions.

For those eligible for both Medicaid and Medicare (dually-eligible). While they face many of the same delivery system challenges as those with chronic illnesses, the dually-eligible also experience

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<sup>1</sup> US Department of Health and Human Services, "Medicaid Cost-Savings Opportunities", Feb 3 2011. [http://www.hhs.gov/news/press/2011pres/02/20110203tech.html#\\_edn10](http://www.hhs.gov/news/press/2011pres/02/20110203tech.html#_edn10)

the confusion of having two, often misaligned, insurance programs (Medicare and Medicaid), which only further fragments the care they receive. HHS encouraged states to lower costs and improve quality of care for dually-eligible beneficiaries by:

- ***Taking advantage of reforms emerging from the Federal Coordinated Health Care Office.*** This office was created by the Affordable Care Act (ACA) to direct resources and provide support to states for improving the care of the dually-eligible and better integrating the Medicare and Medicaid programs. For example, the Office will [soon award contracts](#) to up to 15 States to help them design a demonstration proposal aimed at improving the quality, coordination, and cost-effectiveness of care for the dually-eligible.
- ***Using newly available Medicare data to reduce unnecessary spending on the dually-eligible.*** The Centers for Medicare and Medicaid Services (CMS) will make Medicare data available to states for the first time in early 2011.

For those needing long-term care. Medicaid can provide home- and community-based long term care services for three individuals for the same cost as serving one person in a nursing home, and many seniors and people with disabilities would prefer to remain in their homes and communities.<sup>2</sup> HHS encouraged states to shift their Medicaid long-term care budgets away from institutions and towards home- and community-based care by taking advantage of some optional programs:

- ***The Community First Choice Option.*** Created by the ACA, this option will offer states a six percent increase in their Federal matching rate to cover certain optional long-term care services and supports that can help beneficiaries stay in community-based settings. This option begins in October 2011, and states can elect it through their Medicaid state plan.
- ***The Money Follows the Person program*** which provides federal funds to help Medicaid-eligible individuals transition from institutions back to the community; 43 states and D.C. are using or planning on using these funds. In its letter, HHS indicated that CMS is open to ideas on new and innovative ways to use these funds.

For high-risk pregnant women. Premature births lead to higher medical costs. They can be reduced by lowering the rate of medically unnecessary cesarean sections and ensuring that pregnant women get the pre-natal care they need.<sup>3</sup> HHS encouraged states to:

- ***Adopt clear protocols guiding the use of cesarean sections*** to ensure that cesarean sections are used only when medically necessary.
- ***Reimburse mid-level providers*** in an integrated care delivery setting to improve care coordination for expectant mothers.

**2. [Use a more accurate pricing standard for prescription drugs.](#)** Pharmacy costs account for about eight percent of Medicaid spending.<sup>4</sup> Most states currently set their payment rates for

<sup>2</sup> AAPR Public Policy Institute, "Medicaid Cost-Savings Opportunities", [http://www.hcbs.org/files/160/7952/fs\\_hcbs.pdf](http://www.hcbs.org/files/160/7952/fs_hcbs.pdf)

<sup>3</sup> US Department of Health and Human Services, "Medicaid Cost-Savings Opportunities", Feb 3 2011. [http://www.hhs.gov/news/press/2011pres/02/20110203tech.html#\\_edn10](http://www.hhs.gov/news/press/2011pres/02/20110203tech.html#_edn10)

prescription drugs on a flawed benchmark, the average wholesale price (AWP.) This benchmark is based solely on manufacturer-reported information. Numerous lawsuits have successfully challenged this benchmark as unreliable and easily inflated by manufacturers, wholesalers, and others.<sup>5,6</sup> States can save money in their Medicaid programs by switching to a more accurate pricing benchmark.

For example, Alabama is replacing the AWP with an average acquisition cost (AAC), which is an average of the actual prices pharmacies paid to the manufacturer, plus a dispensing fee to cover the pharmacy's overhead costs. Alabama expects to save six percent (\$30 million) on its prescription drug spending in the first year of implementing this new benchmark. However, it had to hire a third party to audit pharmacies to establish the AAC benchmarks. To make this transition more appealing to states, CMS will undertake a national survey of pharmacies to create a single federal database of AACs, which will be available to states later in 2011.

**3. Improve payment accuracy.** About 9.4 percent of Medicaid spending is paid inappropriately.<sup>7</sup> HHS encouraged states to reduce fraudulent charges to Medicaid by:

- *Utilizing a new Federal database to obtain information about providers who were found defrauding Medicare or another state's Medicaid program.* This new portal will be available soon, and will help states to keep problematic providers from enrolling in their Medicaid programs.
- *Taking advantage of free training seminars from the Medicaid Integrity Institute.* Specifically, the Institute is planning a series of webinars for state Medicaid agencies to share best practices and to inform states about how to take advantage of provisions in the ACA aimed at preventing fraud.

### Options that merely shift Medicaid costs and harm care

Some of the cost-saving options laid out in the HHS letter would lower state expenditures only by shifting them onto vulnerable enrollees. These policies would harm the health of the seniors, low-income parents and people with disabilities who rely on Medicaid for their care.

**1. Offer less comprehensive benefits.** HHS outlined states' options for slimming down their benefit packages for adults, noting that 40 percent of Medicaid benefits spending is on "optional" services. While states have little flexibility in setting benefit packages for children (limitations on services for children must be based solely on medical necessity), many services are considered optional for the adult population, including prescription drugs, home- and community-based care, physical and occupational therapy, and eye glasses. States can eliminate these benefits for adults altogether, or

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<sup>4</sup> US Department of Health and Human Services, "Medicaid Cost-Savings Opportunities", Feb 3 2011. [http://www.hhs.gov/news/press/2011pres/02/20110203tech.html#\\_edn10](http://www.hhs.gov/news/press/2011pres/02/20110203tech.html#_edn10)

<sup>5</sup> Department of Justice, Press Release, "Pharmaceutical Manufacturers To Pay \$421.2 Million to Settle False Claims Act Cases," Dec. 7, 2010, <http://www.justice.gov/usao/ma/Press%20Office%20-%20Press%20Release%20Files/Dec2010/PressReleaseD-MA.html>.

<sup>6</sup> John Kell, "McKesson Settles With Connecticut for \$15 Million" Oct. 19, 2010, WSJ Online. <http://online.wsj.com/article/SB10001424052702304510704575562541223541052.html>

<sup>7</sup> US Department of Health and Human Services, "Medicaid Cost-Savings Opportunities", Feb 3 2011. [http://www.hhs.gov/news/press/2011pres/02/20110203tech.html#\\_edn10](http://www.hhs.gov/news/press/2011pres/02/20110203tech.html#_edn10)

they can limit their scope or duration, for example by imposing a limit on prescriptions that can be filled in a month.

**2. Impose higher cost-sharing.** HHS also reviewed the allowable cost-sharing levels in Medicaid. Children and pregnant women are exempt from cost-sharing, but states have considerable discretion in setting cost-sharing levels for parents and childless adults as long as families' total cost-sharing (including premiums) is capped at five percent of their income.

HHS encouraged states to experiment with cost-sharing to incentivize use of more cost-effective services, such as to steer individuals toward generics or preferred brand-name drugs. While this type of selective cost-sharing may be appropriate in limited circumstances, states should be extremely cautious about imposing even modest cost-sharing on this very low-income population.

Benefit restrictions or even modest cost-sharing can:

- ***Prevent vulnerable beneficiaries from accessing needed health care services.*** A considerable body of evidence suggests that for very low-income people, cost-sharing of even \$2 or \$3 dollars can significantly reduce health care access and utilization of effective and necessary services. This reduction in access can lead to poorer health. For example, the RAND Health Insurance Experiment found that copayments increased the risk of dying by about 10 percent for low-income adults at risk of heart disease.<sup>8</sup>
- ***Shift costs onto very low-income Americans.*** Rather than tackling a root cause of health care costs, copayments and benefit restrictions merely shift the costs onto those who can least afford them: vulnerable Medicaid beneficiaries. For example, when Utah imposed copayments of \$2 or \$3 per service or prescription in its Medicaid program, four of ten affected beneficiaries below the poverty line reported these costs imposed "serious" financial hardships on their households and two-fifths reported resorting to strategies like reducing the amount spent on food or housing or taking fewer prescriptions than prescribed. Further, cost-sharing on very low-income adults often amounts to a back door rate cut for providers because beneficiaries that still seek treatment often can't afford – and therefore don't pay – their copayments.
- ***Lead to less savings for the state than estimates might suggest.*** When patients delay or forgo certain services because of cost-sharing or benefit restrictions, their illnesses can worsen and eventually require more expensive care, canceling out some of the state's savings. For example, when Quebec imposed copayments for prescription drugs on adults receiving welfare, the reduction in patients filling necessary medications led to a 78 percent increase in emergency room use.<sup>9</sup> Another study found that when New Hampshire imposed a three drug per patient per month limit, the rate of nursing home admissions among chronically ill

<sup>8</sup> Center on Budget and Policy Priorities, "The Effect of Increased Cost-Sharing in Medicaid", July 5 2005. <http://www.cbpp.org/cms/?fa=view&id=321>

<sup>9</sup> Center on Budget and Policy Priorities, "The Effect of Increased Cost-Sharing in Medicaid", July 5 2005. <http://www.cbpp.org/cms/?fa=view&id=321>

elderly patients nearly doubled. The authors found that the costs of these institutionalizations may have overwhelmed any savings from the prescription drug limit.<sup>10</sup>

## Conclusion

HHS outlined dozens of options at states' discretion for reducing Medicaid expenditures. Some of these policies should be encouraged – they create a Medicaid program that works better for its beneficiaries at a lower cost for taxpayers. Other options would harm patient care and shift costs onto the most vulnerable members of our society. States should not resort to higher cost-sharing or restrictions on benefits until they have exhausted the lengthy list of opportunities for reducing costs while strengthening the program.

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<sup>10</sup> Soumerai et al, New England Journal of Medicine, "Effects of Medicaid Drug-Payment Limits on Admission to Hospitals and Nursing Homes", October 10 1991.  
<http://www.nejm.org/doi/full/10.1056/NEJM199110103251505#t=article+Conclusions>.