

## Conference Summary

On June 4-6, more than 450 people attended the 2006 Medicaid Congress to discuss recent changes to the Medicaid program. The conference was sponsored by Avalere Health, along with Milbank Memorial Fund, Health Affairs, FDC Reports, and other leading healthcare organizations. Participants heard from state Medicaid program directors and state legislators implementing new reform models as well as representatives from the Centers for Medicare and Medicaid Services (CMS) and the U.S. Congress, who are encouraging states to reform their programs. Industry, provider, and beneficiary stakeholders also offered their perspectives on the new Medicaid reform models and other important changes that are shaping state programs.

Several key themes emerged from the three-day discussion. Presenters clearly indicated that states have entered a new era of Medicaid policy with the passage of the Deficit Reduction Act (DRA) of 2006, which offers states new flexibilities to reform their programs. Nonetheless, while the DRA provides states tremendous new opportunities, significant issues remain. Specifically, long-term care costs and the growing number of uninsured are pressing concerns, requiring broader solutions than the policies considered to date.

As the federal Medicaid Commission, Congress, CMS, and the states consider additional changes to Medicaid programs, the themes presented during the Medicaid Congress will guide future policy direction. The themes will also require new strategies and relationships for all Medicaid program stakeholders. For more information about the conference discussion and their implications for the future, please contact Jon Blum at 202-207-1338 or [jblum@avalerehealth.net](mailto:jblum@avalerehealth.net).

### Key 2006 Medicaid Congress Themes

**The DRA grants states tremendous flexibility to design different coverage options for different populations within their states.** Mark Birdwhistell, the Secretary of the Kentucky Cabinet for Health and Family Services, remarked that the “DRA gives states the tools that they have been asking for, for years, and years, and years.” While Medicaid programs have varied from state to state, now states can offer different types of coverage without pursuing a Medicaid waiver. States are pleased about the new flexibility; three states—Kentucky, West Virginia, and Idaho—have already used the new DRA authority. Idaho successfully obtained CMS approval under a state plan amendment in a fraction of the approval time usually required for a federal Medicaid waiver. The flexibility to change cost sharing and benefit packages

without needing to meet traditional waiver requirements, particularly federal budget neutrality requirements, will likely lead many more states to modify their programs and that the variation across states will continue to flourish.

**However, the DRA is not a silver bullet for long-term cost containment; the legislation made relatively few changes to long-term care financing.** Much of the DRA reforms focus on parents and children, who comprise the majority of Medicaid beneficiaries, but constitute less than 25 percent of total Medicaid spending. Medicaid is funding 50 percent of nursing home costs for elderly and disabled populations; long-term care (LTC) is currently the largest expenditure within the Medicaid program. While the DRA grants states greater flexibility to encourage beneficiaries to move into lower-cost home and community settings, these changes may not reduce costs in absence of other long-term care reforms. States remain frustrated at the cost of long-term care and believe that other payors must assume greater responsibility for the costs. Tony McCann, Secretary of Maryland's Department of Health and Mental Hygiene, noted that much of long-term costs are actually housing costs, not medical costs. Several speakers argued that the Medicaid program should not bear the responsibility of these non-medical-related costs. Speakers cited other potential strategies to reduce Medicaid LTC costs, including reverse mortgages and the promotion of private LTC insurance. But for the foreseeable future, Medicaid will continue to be the primary payer of long-term care.

**While federal debate continues, states are implementing LTC reforms and achieving cost savings.** For example, Connecticut is encouraging residents to purchase private LTC insurance through its LTC Partnership program. David Gutte, the Project Director for Connecticut's Partnership for Long-Term Care, stated that it has already saved \$2.8 million under the program and has received calls from 30 states interested in developing a similar program. Other speakers noted that the DRA has opened the door for more states to pursue Partnership Programs for LTC. Another example is Vermont, which is implementing a program under a federal waiver to eliminate Medicaid's institutional bias and to encourage beneficiaries to receive care in lower-cost home and community settings. The state estimates it saved \$10 million since April 2005 by treating patients outside of the nursing home setting. Vermont also reduced waiting lists to participate in its home- and community-based demonstration program by 85 percent.

**States are viewing coordination of care through managed care and disease management as ways to control costs and improve quality.** Melanie Bella, Vice President for Policy at the Center for Health Care Strategies, noted that there is an evolution in the way that states are using managed care. Previously, healthy beneficiaries were the primary targets of mandatory managed care. But increasingly, states are viewing managed care as a way to coordinate care and predict costs for more vulnerable populations, including dual eligible beneficiaries, to ensure better quality outcomes. States are also expanding the use of disease management programs for Medicaid beneficiaries enrolled in traditional fee-for-service programs. Dr. Dexter Shurney, Chief Medical Officer of Healthways, stated that states have focused their disease management efforts on traditional Medicaid populations, but that more cost savings opportunities exist if states focus their efforts on smaller segments of the Medicaid population, including beneficiaries with significant chronic illnesses and service needs.

**States and the federal government continue to make progress to promote the use of health information technology and reduce fraud and abuse in Medicaid programs.** Despite slight progress on the advancement of Medicaid systems, Medicaid programs are not currently incorporating health technology tools (such as electronic and/or personal health records and e-prescribing) into their basic claims processing systems. Nevertheless, increased interest at the state and federal level is leading more states to focus on incorporating health information technology (HIT) initiatives into their Medicaid reform plans. Dr. Carolyn Clancy, Director of the Agency for Healthcare Research and Quality (AHRQ), stated that there are significant opportunities for Medicaid agencies to use HIT to achieve higher-quality healthcare, especially for chronically ill and high-utilizing populations. AHRQ is sponsoring a learning collaborative on HIT with states' Medicaid medical directors. Meanwhile, the federal government will become much more aggressive in reducing Medicaid fraud and abuse. The DRA creates a Medicaid Integrity Program, which, among other things, provides CMS additional staff to focus on recovering improper payments to states, providers, and pharmaceutical manufacturers in the Medicaid program.

**States remain concerned about the quality of care for dual-eligible beneficiaries because of less-than-ideal coordination between Medicare and Medicaid.** While most agree that dual eligible beneficiaries need more coordinated care, states are struggling to integrate these two programs due to different roles and incentives of different payers. Of great concern to states is the lack of prescription drug data from Part D plans which is affecting their ability to implement disease management and care coordination programs. Medicare prescription drug plans have shown some willingness to share data, but not to the degree necessary to improve care coordination. States and CMS have renewed efforts to integrate Medicare and Medicaid services through Medicaid Advantage and Special Needs Plans. States are now looking to integrate the two programs through private capitated plans rather than through traditional federal waiver processes. Gail Arden, Director of Disabled and Elderly Health Programs at CMS, noted that CMS has received proposals from 44 different Medicare Advantage plans which also have contracts with Medicaid to coordinate care for dual eligible beneficiaries.

**Many Part D implementation problems experienced by states have been resolved, but some problems persist.** State representatives indicated that although many problems have been resolved, there is still a lag in the time when a beneficiary chooses to enroll into a new plan and when the plan recognizes his/her low-income subsidy status. This data glitch leads to pharmacies charging beneficiaries improper co-pays. California continues to cover emergency prescriptions for dual eligible beneficiaries, although the number of prescriptions filled by the state has dropped considerably. Kevin Concannon, the Director of Iowa's Department of Human Services, cited similar co-pay issues as well as the closure of independent rural pharmacies in Iowa as a result of the Part D benefit. Disabled dual eligible beneficiaries in the community face several challenges; communication is a particularly difficult barrier. Tom Clark, Director of Policy and Advocacy at the American Society of Consultant Pharmacists, stated that beneficiaries in LTC facilities have been minimally affected by Part D because facilities are still legally obligated to provide beneficiaries with needed medications, but the impact on physicians, nursing homes, and LTC pharmacies has been significant. Finally, coordinating Medicare coverage of prescription drugs between Medicare Parts B and D remains a major challenge for LTC providers.

**States believe that the federal government will not address the rising number of uninsured in the near future, so they must take the lead.** States intend to use Medicaid as a central component of their strategy to reduce the growing problem of the uninsured. Massachusetts, implementing a comprehensive approach to reduce their number of uninsured, is focusing on changing dynamics in the private sector as well as individual and employer mandates. Brian Wheelan, the Deputy Director of Massachusetts Medicaid, indicated the state is implementing a proposal to make the individual market more attractive to uninsured individuals by combining it with the small group market to expand its risk pool. Massachusetts is also seeking to make hospital and physician cost and quality information more transparent to consumers so they can make wiser healthcare decisions. State Senator Jim LeDdy (VT) indicated that Vermont is following Massachusetts' lead and is levying fees on employers to finance health plans for low- and moderate-income people who do not qualify for public health programs.