The Future of ID System Funding & Service Delivery

2012 Fall Conference

Pennsylvania Association of County Administrators of Mental Health and Developmental Services

State College, PA
November 8, 2012
Presentation Aims

• Explore linkages between deficit reduction & future Medicaid funding
• Review emerging developments in federal Medicaid policy
• Examine I/DD managed care initiatives nationwide
Cross-Cutting Themes

- Managing in an era of severe resource constraints
- Coping with the uncertainties of an unsettled federal & state policy environment
- Charting a course toward enhanced accessibility & quality in the midst of turmoil
The Rocky Road Ahead
State Fiscal Crisis

- Fiscal outlook has improved in most states despite lingering effects of the Great Recession.
- State revenues declined by 17% in 2009 & remain below pre-recession levels.
- Fewer states face large deficits in FY 2013 but the loss of enhanced Medicaid FFP has forced states to sharply increase general revenue match.
- Public employee retirement & unemployment insurance trust funds are seriously underfunded in many states.
Deficit Reduction & the Fiscal Cliff

- Federal deficit reached $16 trillion in Sept. – up from $5.7 trillion in Jan. 2001
- The nation’s debt equals 73% of GDP, or more than double the level in 2007
- $1.3 trillion in automatic budget cuts are scheduled to go into effect on January 1st
- Moreover, unless Congress acts to averts the fiscal cliff:
  - federal tax rates will revert to pre-2001 levels;
  - Medicare physician payment rates will be cut by 27%
  - Millions more Americans will be affected by AMT rates
Growth in the National Debt
Cyclical & Structural Deficits

- Two components of the federal deficit problem:
  - Cyclical deficits are caused by effects of a weak economy
  - Structural deficits are caused by a chronic imbalance between revenues and spending obligations

- In 2011, cyclical factors contributed $367 billion to the $1.3 trillion deficit. The remainder ($928 billion), or 71%, was attributable to structural factors

- To succeed a deficit reduction plan must address both the cyclical and structural components of the problem
Health Costs & the National Debt

- Health care outlays are being driven by market forces plus demographic factors:
  - Over 65 population is expected to grow from 13% to 20% of the American population by 2037
  - Health care expenditures have increased by an average of 2.5% faster than the GDP over the past 50 years
- At the current growth rate, federal health outlays will increase from 5% of GDP to 10% of GDP by 2037
- Health outlays alone will account for $\frac{4}{5}$th of the increase in the national debt over the next 25 years
The Risks of Growing Entitlement Spending

Sometime between 2030 and 2040, mandatory spending will exceed government revenues.

Source: GAO Citizen's Guide 2007
Causes of Higher Health Costs

- Doctors/hospitals rewarded for volume not results
- Americans are growing older, sicker and fatter
- High cost of new drugs, procedures & technologies
- Low out-of-pocket costs; tax exempted premiums
- Poorly informed consumers of health services
- Growing marketplace leverage of mega-hospital chains
- Barriers to trimming costs due to supply & demand + legal issues
Fundamentals of Lowering the Deficit

- No deficit reduction plan can succeed without reducing the growth rate in health care outlays
- How to accomplish that goal without destabilizing the national economy is the central question confronting national policymakers
- Economists warn that wrenching changes in fiscal policy (deep spending cuts & higher taxes) could sent the fragile economy back into a tailspin
- Yet, the status quo is likely to lead to a catastrophic financial meltdown
Medicaid & Deficit Reduction

- No shortage of deficit reduction plans
  - Simpson-Bowles Comm.
  - Rivlin-Domenici plan
  - Ryan/House budget plan
  - President Obama’s budget plan

- Big, unanswered question is the proportion of savings from spending cuts, tax code revisions & new revenues

- All major plans aim to curtail Medicaid spending but in different ways & to different extents
# Medicaid & Deficit Reduction

<table>
<thead>
<tr>
<th>Plan</th>
<th>Principal Medicaid Proposals</th>
<th>Estimated Savings</th>
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<tbody>
<tr>
<td>Nat. Comm. on Fiscal Responsibility &amp; Reform (Simpson-Bowles)</td>
<td>Reduce/eliminate state authority to levy provider taxes; Enroll all dual eligibles in Medicaid managed care plans; Reduce funding of admin costs; Expedite approval of Medicaid waivers; Set federal budget targets for Medicaid spending post 2020</td>
<td>$58 B FY 2012-FY 2020</td>
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<tr>
<td>President’s Shared Responsibility Framework</td>
<td>Increase state flexibility; Replace current matching formula with a single matching ratio; Limit state use of provider taxes; impose upper limit on purchase of durable equipment &amp; improve program integrity</td>
<td>$100 B over 10 years</td>
</tr>
<tr>
<td>Pathway to Prosperity (Ryan’s Budget Plan)</td>
<td>Convert Medicaid to a block grant program in FY 2013; tie future funding growth to population and inflation; Afford states greater flexibility in designing &amp; operating their programs; Replace Medicare premium payments for dual eligibles with Medical Savings Plans; Repeal Affordable Care Act.</td>
<td>$1.4 T over 10 years ($771B w/o ACA repeal)</td>
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Impact of a Medicaid Block Grant

- House-passed budget resolution would cap FFP and turn Medicaid into a block grant program
  - Future federal aid would be adjusted for inflation and population growth only
  - Aid to the states to be reduced by $1.7 billion or 38% compared to current law (including ACA repeal)
  - States would be able to serve 20.5 million fewer persons assuming current spending patterns. Even if they lowered per capita costs to GDP growth rate, they would have to eliminate 14.3 million from the eligibility rolls
Impact of a Medicaid Block Grant

- States collectively would have to increase general revenue spending by $273 billion, or 77%, over 10 years to replace lost federal aid

- As high-cost users with few other options, people with severe disabilities would be especially vulnerable

- Block grant funding, historically, has lead to a decline in federal aid (e.g., experience with TANF)
Impact of the 2012 Elections

- Pres. Obama’s reelection reduces prospects of a Medicaid block grant & Medicare prem. support plan
- Major changes in entitlement funding still likely to occur within the next 4 years
- Methods of controlling federal Medicaid & Medicare outlays will be the key to deficit reduction
- Expect continued partisan battles in Congress
- Agility & foresight will be the keys to survival
Medicaid Today & Tomorrow
Basic Program Features

- Medicaid is the largest single source of federal aid to the states (comprising 44% of all federal aid in 2008)
- Second largest source of state spending (16%) -- exceeded only by elem. & secondary education
- Accounts for 40% of all long-term care expenditures
- Enrollment/expenditures are countercyclical
Impact of a 1% Point Increase in Unemployment on State Revenues, Medicaid, CHIP & Uninsured

1% Increase in National Unemployment Rate = Decrease in State Revenues

3-4% Decrease in State Revenues

1.0 Increase in Medicaid and CHIP Enrollment (million)

1.1 Increase in Uninsured (million)

Basic Program Features

- Medicaid offers low-income Americans access to acute health and long-term services.
- Nearly 63M Americans enrolled in Medicaid, of whom about 7% (4M) receive LTS.
- Federal-state cost sharing, with FMAPs ranging from 50% to 76%.
- Federal law establishes basic program parameters, but states have latitude in designing their programs.
Medicaid Today

Health Insurance Coverage
29 million children & 15 million adults in low-income families; 14 million elderly and persons with disabilities

Assistance to Medicare Beneficiaries
8.8 million aged and disabled — 21% of Medicare beneficiaries

Long-Term Care Assistance
1 million nursing home residents; 2.8 million community-based residents

Support for Health Care System and Safety-net
16% of national health spending; 41% of long-term care services

State Capacity for Health Coverage
Federal share ranges 50% to 76%; 44% of all federal funds to states

SOURCE: Kaiser Commission on Medicaid and the Uninsured, 2010
Impact of Health Reform

- Expand eligibility to all adults under 65 with incomes up to 138% of poverty
- Newly eligible adults assured benchmark plan benefits including mental health coverage
- 100% federal funding of new eligibles in FY 2014-16, declining to 90% in 2020
- Increase Medicaid primary care payments to 100% of Medicare payment level in FY 2013 and FY 2014
- Expansion effective January 1, 2014
State Health Reform Roles

- Create health benefit exchanges for individuals & small businesses that conform to fed. Requirements
- Enroll new Medicaid beneficiaries by Jan. 2014
- Coordinate exchanges and Medicaid enrollments
- Maintain Medicaid/CHIP enrollment for children thru 2019 and adults until exchanges are fully operational
- Establish consumer assistance & ombudsman offices
- States may create Basic Health Plans for uninsured individuals with incomes between 138-200 % of FPL
Medicaid Today and Tomorrow

- Health Insurance Coverage for Certain Categories
- Minimum Floor for Health Insurance Coverage to 133%
- Shared Fed.-State Financing
- Enhanced Fed. Financing for New Coverage
- Assistance for Duals/LTC
- Additional LTC Options; Coordination for Duals
- Support for Health Care System
Medicaid: Key to Health Reform

Medicaid Coverage to 133% FPL

Employer-Sponsored Coverage

Individual Mandate

Health Insurance Market Reforms

Exchanges with Subsidies (133% - 400% FPL)
Is Managed Care the Answer?
Managed care became a mainstream Medicaid service delivery model in the 1980s and 1990s.

71% of Medicaid beneficiaries received at least a portion of their services through a managed care plan in 2008.

But, MC participation rates were much higher among non-disabled children (85%) and adults (57%) than they were among seniors (4%) and people with disabilities (14%).
Medicaid Managed Care

- In recent years, however, states have begun to:
  - Enroll more persons with chronic health conditions in managed care plans;
  - Apply managed care principles to the deliver of long-term services and supports (LTSS);
  - Create medical/health homes for persons with complex health and behavioral health needs;
  - Coordinate Medicaid and Medicaid services to dual eligibles;
  - Integrate physical and behavioral health services.
Medicaid Managed Care Vehicles

- Combination 1915(b) & 1915(c) waivers
- Sec. 1115 research & demonstration waivers
- Sec. 1915(a): voluntary enrollment -- any willing provider
- Sec. 1932(a)/Sec. 1915(c) waivers -- concurrent authority
Medicare/Medicaid Integration

- PACE (Program of All Inclusive Care for the Elderly)
- Special Needs Plans
- Medicare/Medicaid Service Integration Demonstrations
- States are permitted to co-manage Medicare & Medicaid funding of health care and long-term supports under each of these three vehicles
Medicare/Medicaid Service Integration Demonstrations

- CMS to fund a series of pilot projects testing new approaches to coordinating the delivery of Medicare and Medicaid services to dual eligibles
- 25 states have submitted applications with proposed start dates in 2013 and 2014
- Massachusetts & Washington are the only states with approved applications to date but CMS is expected to approve 13 more
- CMS’ intent is to partner with the states in the search for more cost-effective ways of providing high quality services to high-need beneficiaries
Managed LTSS Approaches

- Separate Medicaid LTSS Only
- Combined Medicaid Acute + LTSS
- Fully Integrated Medicare & Medicaid Acute + LTSS
# State Managed LTS Models

<table>
<thead>
<tr>
<th>LTSS Only</th>
<th>Medicaid Acute + LTSS</th>
<th>Medicare/Medicaid</th>
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<tbody>
<tr>
<td><strong>MI</strong>: Managed MH/DD/SA Specialty Services &amp; Supports</td>
<td><strong>AZ</strong>: Long-Term Care System</td>
<td><strong>CA</strong>: SCAN Connections at Home</td>
</tr>
<tr>
<td><strong>NC</strong>: MH/DD/SA Health Plan Waiver</td>
<td><strong>DE</strong>: Diamond State Health Plan – Plus</td>
<td><strong>MA</strong>: Senior Care Options</td>
</tr>
<tr>
<td><strong>NY</strong>: Managed LTC</td>
<td><strong>FL</strong>: LTC Community Diversion</td>
<td><strong>MN</strong>: Senior Health Options</td>
</tr>
<tr>
<td><strong>PA</strong>: Adult Comm. Autism Program</td>
<td><strong>HI</strong>: QUEST Expanded Access</td>
<td><strong>NY</strong>: Medicaid Advantage Plus</td>
</tr>
<tr>
<td><strong>WI</strong>: Family Care Services</td>
<td><strong>MN</strong>: Senior Care Plus</td>
<td><strong>WI</strong>: Family Care Partnership</td>
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<tr>
<td></td>
<td><strong>NM</strong>: CoLTS</td>
<td></td>
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<td></td>
<td><strong>TN</strong>: Choices</td>
<td></td>
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<tr>
<td></td>
<td><strong>TX</strong>: Star + Plus</td>
<td></td>
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<tr>
<td></td>
<td><strong>WA</strong>: Medicaid Integration Partnership</td>
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</tbody>
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Growth in Medicaid MLTSS: 2004-2012

Grew from 8 to 16 states

States with MMLTSS Programs

- Arizona
- California
- Delaware
- Florida
- Hawaii
- Massachusetts
- Michigan
- Minnesota
- New York
- New Mexico
- North Carolina
- Pennsylvania
- Tennessee
- Texas
- Washington
- Wisconsin
Key Feature of MMLTSS Plans

- Mandatory enrollment in 8 states; voluntary enrollment in 7 states; one state with both
- Number of MCO in MMLTSS in managed care market expanding
- Participant-directed support options offered in 12 out of 16 states
Projected Growth Medicaid MLTSS: 2012-16

Grows from 16 to 26 States

Emerging Trends in Medicaid Services to the IDD Population

- Some states have enrolled I/DD recipients in Medicaid managed health care plans for years
  - PA, NJ and TN since the 1990s
- Enrollment in Medicaid managed LTSS has evolved more slowly
- Many states have carved I/DD out of MMLTSS and integrated (Medicare/Medicaid) initiatives (CA & MA)
- But it’s only a matter of time before managed care is applied broadly to the I/DD service sector
Early Adopters

- AZ, MI, WI & VT have been operating I/DD services under a managed care format for 10+ years
- Each state has built its MC system on pre-existing service delivery structures. As a result, the service system in each state is unique.
- Other states are in the process of creating their own approaches to managed I/DD services (NY, KS, TN, TX & MN)
# Comparison of Existing Models

<table>
<thead>
<tr>
<th>Key Feature</th>
<th>Arizona</th>
<th>Michigan</th>
<th>Wisconsin</th>
<th>Vermont</th>
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</thead>
<tbody>
<tr>
<td><strong>Target Population</strong></td>
<td>Elder/disabled &amp; I/DD</td>
<td>MI/DD/SAS</td>
<td>Elder/disabled &amp; DD</td>
<td>Elder/disabled MI/DD/SAS</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>Acute, LTSS &amp; psychiatric</td>
<td>LTSS only</td>
<td>Family Care: LTSS only</td>
<td>Separate acute &amp; LTSS programs</td>
</tr>
<tr>
<td><strong>Statutory Authority</strong></td>
<td>Sec. 1115 waiver-demo</td>
<td>Sec. 1915(b)/(c) combo</td>
<td>Sec 1915(b)/(c) combo</td>
<td>2 Sec. 1115 waivers</td>
</tr>
<tr>
<td><strong>State Admin.</strong></td>
<td>AHCCCS +DDD</td>
<td>Dept. of Comm. Health</td>
<td>Dept. of Health Services</td>
<td>Health Care Authority; DHS</td>
</tr>
<tr>
<td><strong>Local Admin.</strong></td>
<td>DD reg. offices; MCOs – elder/disabled</td>
<td>Prepaid Health Plans + County MH/DD/SAS</td>
<td>Area-wide MCOs</td>
<td>DD Area &amp; Specialty Agencies</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Capitated @ state level; FFS at provider level</td>
<td>Capitated payments to PHPs</td>
<td>Capitated payments to MCOs</td>
<td>AAs have global budgets; FFS @ provider level</td>
</tr>
<tr>
<td><strong>Initiation</strong></td>
<td>1987</td>
<td>1999</td>
<td>Phase-in: 2005 to present</td>
<td>2005-06</td>
</tr>
</tbody>
</table>
Role of Local Authorities

- Federal law impedes assignment of responsibilities to local MH/DD/Aging authorities
  - Role of single state Medicaid agency
  - Freedom of choice principle
  - Enrollment of all willing providers
  - Statewideness
  - Factoring payments

- States have struggled to assign local authorities roles in operating Medicaid managed LTSS (MI, TX, WI)
Local Authority Options

- Section 1915(b) “freedom of choice” waivers
  - 1915(b)(1): mandate manage care enrollment
  - 1915(b)(2): authority to use a central broker of services
  - 1915(b)(3): permission to reinvest savings in service expansion
- Combination of Sec. 1915(b) and 1915(c) waivers (WI, MI)
- Sec. 1115 research and demonstration waivers (AZ, VT, TN, TX)
Organizing Principles of Managed Care

- National Disability Council’s principles to guide enrollment of people with disabilities in MC plans
  - Summary principles issued in early 2012
  - Full report to be released later in the year
- 22 principles addressing key design and operational aspects of managed care for people with disabilities
- Aim is to offer consumers, families, providers & state & local officials guidance on designing & operating a MC system that works for persons with disabilities
Key Managed Care Principles

- A state’s MC system must reflect fundamental disability values (comm. living; personal control; employment; family support; Everyday Lives)
- Stakeholders must be involved in designing & implementing a state MC plan
- The delivery system must be sensitive to – and able to address – the differing needs of disability sub-groups
- States should be required to complete a two-tiered readiness assessment before its MC plan is approved
Key Managed Care Principles

- A state’s capitation methodology must yield sufficient payments to ensure that all service needs are met.
- States should co-manage inst. & comm.-based services and build-in deinstitutionalization incentives.
- Savings should be reinvested in expanded services.
- States should have a comprehensive, outcome-based quality management systems.
- The rights of MC participants should be safeguarded & include the right to appeal adverse actions.
Other Key Federal Policy Initiatives

- CMS to issue essential plan benefit rules applicable to health plans offered thru state exchanges
- Proposed new CMS definition of community residence
- New CMS webpage on Medicaid managed LTSS and is working on managed LTSS submission format
- Pending legislation to eliminate special wage certificates for sheltered employment
- Justice Dept. has adopted a more aggressive posture on Olmstead enforcement
Summary Observations

- Entitlements to Medicaid, Medicare, SSI & Social Security benefits will be modified.
- Growing cost containment pressures will drive service delivery reforms.
- Use of managed care will expand within the disability sector, including to LTSS.
- Operative Rules: Be proactive & innovate to survive.
Additional Medicaid Resources

- Kaiser Commission on Medicaid and the Uninsured
  [http://www.kff.org/about/kcmu.cfm](http://www.kff.org/about/kcmu.cfm)
- Centers for Medicare & Medicaid
- Center on Budget & Policy Priorities
- Clearinghouse for Home & Community-Based Services
Managed Care Resources

- Centers for Medicare & Medicaid Services
  http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html
- Medicaid Managed Long-Term Services & Supports
  http://www.medicaid.gov/mltss/
- National Assoc. of States United for Aging & Disabilities
  http://www.nasuad.org/medicaid_integration_tracker.html
Managed Care Resources

- Medicaid Payment and CHIP Access Commission
  [http://www.macpac.gov/reports](http://www.macpac.gov/reports)
- Integrated Care Resource Center
- Center for Health Care Strategies
- National Disability Council
Medicaid Policy Resources

- Medicaid Block Grants
  
  [http://www.kff.org/medicaid/8185.cfm](http://www.kff.org/medicaid/8185.cfm) (House budget plan)
  
  [http://www.kff.org/medicaid/8278.cfm](http://www.kff.org/medicaid/8278.cfm) (managed care and people with disabilities)

- Definition of a community-based residence
  
Questions