Medicaid Systemswide Administration

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Medicaid Commission Meeting

CENTER FOR HEALTH PROGRAM DEVELOPMENT AND MANAGEMENT

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Preview of Presentation

- Matching rates
- Oversight
- Workforce issues
- Medicaid reform/global waivers

Matching Rates

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Medicaid is a program jointly financed by states and the federal government . . .

- Medicaid costs are shared:
  - For health services, a state's federal medical assistance percentage (FMAP) relates to a complex formula ***that is not counter-cyclical***, and that includes a factor for per capita income. FMAP range: 50-80%.
  - For administrative services performed by states, the rates are the same for all states. Most administrative services are 50% (fed) /50% (state).
  - Selected exceptions to the 50/50 admin matching rate are:
    - Development of IT systems are matched at 90/10
    - Operation of claims payment systems are 75/25
    - Services performed by skilled medical professionals, for tasks that require this training: 75/25
    - Utilization review activities by qualified organizations: 75/25

. . . with FMAPs that look like this.

Maryland and Virginia	50.00%
District of Columbia	70.00%
Mississippi (highest)	75.89%
On average	about 57 %
States ↑ 65%:	AL, AR, AZ, ID, KY, LA, MS, MT, NM, OK, SC, UT, WV
States at 50%:	CA, CO, CT, DE, IL, MD, MA, MN, NV, NH, NJ, NY, VA

FY 2007

S-CHIP matching rates are an even better deal for the states.

- S-CHIP has an "enhanced" match rate to incentivize active participation by states
- In S-CHIP, the federal government picks up an additional 30% of the state's "Medicaid" share
- Example:

Maryland's FMAP (Medicaid)	50.00%
plus 30% of the state's Medicaid share (50%)	15.00%
Maryland's S-CHIP Federal Match	65.00%

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Oversight

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Oversight takes several forms

- Independent "Medicaid Fraud and Abuse Control Unit"
  - Prosecutorial authority, usually at the Attorney General's office
- Mandatory external contractors
  - For example, EQROs for managed care
- Mandatory Fraud and Abuse programs
- Federal oversight

Medicaid fraud, waste and abuse activities have many forms.

- Cost avoidance
- "Pay and chase" third-party insurance
- Recoveries (tort and estate)
- Provider audits and settlements

“Perfecting” fraud and abuse prevention is difficult and ongoing work, given the link to access . . .

		Did Medicaid pay for the care?	
		Yes	No
Was the care appropriate?	Yes	Correct	Type II Error
	No	Type I Error	Correct

Type I Error: Medicaid paid for medically-inappropriate care. Fraud and abuse problem.

Type II Error: Medicaid did not pay for medically-appropriate care. Access problem.

. . . improving fraud and abuse prevention risks denial of appropriate care . . .

Did Medicaid pay for the care?

Was the care appropriate?		Yes	No
	Yes	Correct	Type II Error
	No	Type I Error	Correct

Type I Error: Medicaid paid for medically-appropriate care. Fraud and abuse problem.

Type II Error: Medicaid did not pay for medically-appropriate care. Access problem.

. . . to discern whether care should be paid requires good data on whether the care is appropriate for that patient.

Did Medicaid pay for the care?

Was the care appropriate?		Yes	No
	Yes	Correct	II
	No	I	Correct

Type I Error: Medicaid paid for medically-appropriate care.
Fraud and abuse problem.

Type II Error: Medicaid did not pay for medically-appropriate care.
Access problem.

Workforce Issues

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For licensed health professionals, Medicaid faces many of the same issues in health care generally

- Demographic challenges
- Recruitment and retention keyed to reimbursement rates
- Providers' increasing attention to lifestyle issues as health care is delivered in an increasingly corporate model

For paraprofessionals, states have increasing flexibility

- States set provider participation criteria in their state Medicaid plans
- There is a movement in favor of consumer-directed care, which expands the available workforce
- Countervailing factors:
  - State scope of practice laws
  - Medicaid “freedom of choice” creates crude tools to open or close workforce options

Medicaid Reform/Global Demonstration Waivers

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An 1115 demonstration waiver permits the Secretary to waive otherwise required elements of the state plan

- An 1115 waiver specifically allows waiver of the terms of 42 USC Section 1396a (“Section 1902”)
- Must be budget neutral (cannot cost the federal government more money than the status quo)
- Theoretically, this governs many key elements. E.g.:
  - Mandatory eligibility groups
  - Mandatory benefits
  - Delivery system/managed care

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. . . but many areas are not “waiveable” by the Secretary under the law (since they aren’t in Section 1902) . . .

- FMAP rates
- Rx rebate provisions
- Prohibition on copayments for services by pregnant women, kids, others
- Spousal impoverishment protections
- Estate recovery
- Payment rates to FQHCs and IHS
- Medicare cost sharing

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. . . and others have not been considered “waiveable” under longstanding policy from HHS.

- Provision of mandatory benefits to mandatory populations

- Entitlement nature of program for mandatory populations (i.e., the prohibition of an enrollment cap for these groups)

This reflects a view about federalism

Reform/Global waivers

- Emerging model involves re-directing large sources of Medicaid uncompensated care funds, often initially built through provider tax or upper payment limit techniques
- These funds generally used for:
  - Expansions of insurance to low-income uninsured working adults, where
  - The Medicaid program designs the program in coordination with, and to fill in gaps, in employer-sponsored insurance models, often with small employers, and where
  - The product is a basic benefit package with sliding scale out-of-pocket, and where
  - There are elements of consumer-directed care and personal responsibility
- 1115 waivers are discretionary, and CMS uses its carrot to drive policy

Questions

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