UPDATE ON MEDICAID AND MEDICAID REDESIGN

A Report Prepared for the

Legislative Finance Committee

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INTRODUCTION

Medicaid costs comprise about 20 percent of state expenditures nationally, and about 19 percent of funds appropriated in the general appropriations act (HB 2). Medicaid services are a significant component of state expenditures and fund important health and medical services for the disabled, elderly, children, and parents of children who have low incomes and meet other financial and resource tests. As noted during the most recent legislative session, Medicaid expenditures also support important segments of local economies. Because of its significance, the Legislative Finance Committee (LFC) receives periodic updates on Medicaid. In addition, the 2003 legislature endorsed HJ 13 that encouraged the Department of Public Health and Human Services (DPHHS) to review and present options to redesign Medicaid, the Children's Health Insurance Program (CHIP), the Mental Health Services Plan (MHSP), and other public health programs to the 2005 legislature.

This memorandum summarizes:

- Federal Medicaid changes and approval of the hospital provider tax (HB 481)
- Selected issues related to the Governor's Health Care Advisory Council (Advisory Council), which is providing input on the redesign of Medicaid as requested in HJ 13
- Issues related to timeliness and receipt of Medicaid projections as required by statute

FEDERAL MEDICAID CHANGES

There are two potential changes in federal Medicaid administration that would affect the Montana Medicaid program: 1) a reduction in federal matching funds for Medicaid administrative costs; and 2) potential changes to the IGT (intergovernmental transfer) program. The IGT issue has been reported more extensively than the administrative cost reduction and would have a much greater financial impact on some Medicaid providers, according to press reports.

POTENTIAL INTERGOVERNMENTAL TRANSFER CHANGES

Federal agencies are considering rule changes to approve the source of state matching funds in order to draw-down federal Medicaid match and to measure the upper payment limit facility-by-facility rather than over an entire class of providers. If this change resulted in total disallowance of Montana IGTs, then nursing homes, county hospitals and mental health centers would lose about $22 million annually in federal matching funds. It is difficult to predict the impact of measuring the upper payment limit facility-by-facility, but it would impact the amount of IGT payments that could be made compared to the current amount.[1]

Recently, federal approval of a proposed amendment to a state Medicaid plan was tied to the condition that the state agree to the termination of its approved IGTs. The proposed plan amendment was not related to IGTs.[2] The conclusion of staff from the National Conference of State Legislatures (NCSL) is that the federal administration is trying to end the use of IGTs.

[1] It is important to note that Montana has used IGTs under federally approved rules published in January 2003, when the first round of federal changes were made to ensure that federal Medicaid matching funds were used for health care purposes and not diverted for other state programs. Montana has always used IGT payments for Medicaid services.

[2] Joy Johnson Wilson, Federal Affairs Counsel, Director Health Policy, Office of State-Federal Relations, National Conference of State Legislatures, e-mail, February 26, 2004.

MEDICAID ADMINISTRATIVE COSTS

President Bush's proposed budget includes a reduction in federal matching funds for Medicaid administrative costs. Prior to the implementation of the TANF (Temporary Assistance for Needy Families) block grant, eligibility for cash assistance (old AFDC program) was linked to eligibility for both food stamps and Medicaid. Most states charged eligibility determination to the AFDC program rather than distributing eligibility costs among AFDC, food stamps, and Medicaid administration. Under the TANF block grant program, eligibility for TANF funded services was "delinked" from eligibility for Medicaid and food stamps. After the implementation of TANF funded programs, states allocated eligibility costs among the three programs. Since the TANF block grant was based on historic state expenditures, the federal position has been that states received funds for a portion of Medicaid and food stamp eligibility determination costs in the TANF block grant, and subsequent to receipt of the grant began "double dipping" by accepting the block grant and also charging eligibility costs to Medicaid and food stamps.

The federal government already withheld federal matching funds for food stamp administration beginning October 1, 1998. Originally, the reduction for Montana was slated to be $646,000 annually and was to have been time limited. DPHHS staff was able to get the amount reduced to $444,615 and recent federal legislation has extended the period of applicability beyond the original time frame. Depending on the source consulted, Montana is estimated to lose at least $444,615 in federal Medicaid matching funds up to $646,000. Although the President's budget now assumes the reduction would be for one year only, there is historic precedent in the food stamp program to extend the reduction. If federal Medicaid matching funds are withheld, this shortfall could be covered by either:

- Using federal TANF block grant funds to offset the shortfall in federal Medicaid funds if the TANF 10 percent administrative cap is not met
- Reducing administrative costs (potentially up to double the amount of loss in matching funds)
- Reducing other general fund costs and transferring the general fund to cover the short fall
- Requesting general fund in the executive budget proposal if the reduction affects the coming fiscal year or requesting a supplemental appropriation if it affects the current fiscal year or
- A combination of the these options

HOSPITAL TAX APPROVAL

In January, Centers for Medicare and Medicaid Services (CMS) approved the use of the hospital bed fee (approved in HB 481 by the 2003 legislature) for use as state matching funds to draw down about $42 million in federal Medicaid matching funds over the 2005 biennium to reimburse hospital services at the maximum allowable rate under federal Medicaid rules. Montana is the only state in this region to receive approval for such a tax over the last two years.[3] The fee will expire June 30, 2005, unless another bill is passed to extend it. However, use of such funding mechanisms may be altered depending on changes in federal Medicaid administration.

MEDICAID REDESIGN

The Governor appointed the Advisory Council to review public health programs as encouraged in HJ 13 and make recommendations on selected topics. HJ 13 notes the rising costs of public health programs and the implications for state management flexibility due to federal regulations governing administration

[3] Amendments were made to HB 481 to include Shodair Children's Hospital in the hospital bed fee if allowed by federal rule. It is still uncertain whether CMS will allow payments to be made to Shodair. John Chappuis, Deputy Director and State Medicaid Director, personal conversation, February 25, 2004.

of these programs, including federal requirements to conduct three formal consultations with tribal governments regarding any major changes in existing Medicaid and related programs. HJ 13 also requests that DPHHS provide an analysis of the economic and social costs associated with recommendations made to the 2005 legislature.

Medicaid programs have evolved, on an incremental basis, over a long period of time. System changes and differences in services have grown because of federal law, legislative initiatives and executive proposals approved by the legislature. That is one reason that DPHHS supported HJ 13. While the Medicaid Redesign committee is considering changes that are significant, it would be very difficult to accomplish truly revolutionary change in the entire program in one biennium. The main reason that DPHHS supported HJR 13 was to begin the process of positive change for the program while recognizing the difficulty of instituting such changes within the biennium.[4]

The LFC received the first update on the Medicaid redesign project at its December meeting. Since then, the Advisory Council has held two meetings. The Advisory Council has mapped out meeting dates and topics to be discussed in order to meet the timeline of including recommendations in the executive budget proposal for the 2005 legislative session (see attachment 1).

Several future topics, including review of eligibility criteria (and resulting Advisory Council recommendations) could prove useful to legislators for the 2005 session. During the last legislative session, the Joint Public Health and Human Services Appropriation Subcommittee considered eligibility criteria among programs administered by DPHHS and requested a bill to change eligibility levels in the Montana Telecommunications Access Program. That request was subsequently canceled when the sponsor of a like bill agreed to incorporate subcommittee recommendations. The subcommittee discussed eligibility and service equity among programs, and believed that some of those topics could be addressed as part of Medicaid redesign.

ARTICULATION OF OVER-ARCHING POLICY ON PROVISION OF PUBLICLY FUNDED SERVICES

The Advisory Council is scheduled to consider eligibility for Medicaid services at a future meeting. To date, the information that has been presented for council discussion is centered on discreet eligibility changes, such as how long the "look back period" should be for asset transfers that make persons eligible for Medicaid nursing home services, rather than articulation of broad policies that guide management of all programs within DPHHS. If the Advisory Council makes recommendations that provide over-arching policies that guide administration of all programs, such information could be valuable to legislators.

For example, currently there is no statute or DPHHS rule or policy statement that articulates the differences in eligibility for services among different disability groups, eligibility for services for similarly situated individuals within the same group, or differences in types of service provided to different disability groups.

Consideration of such policies is important because of recent and historic litigation. Several recent court cases address a state's responsibility to provide community services for disabled individuals, including

[4] John Chappuis, Deputy Director and State Medicaid Director, Department of Public Health and Human Services, e-mail communication, February 25, 2004.

the Olmstead decision[5] by the U.S. Supreme Court and the settlement in the Montana Travis D. lawsuit. There are also historic actions where plaintiffs were successful in compelling Montana to pay either higher rates for services, provide equitable services, or provide certain services.

ISSUE

Since groups sometimes pursue litigation to compel access to services, the legislature may wish to consider options to limit potential future liability or blunt the emergence of such litigation, while providing necessary services to the individuals most in need. The legislature may wish to review eligibility criteria for services and other mechanisms to accomplish such purposes.

Options

1) The LFC could request that staff provide additional information on the eligibility and services differences among disability groups at the next LFC meeting, with options for consideration.

This option would allow the LFC to become more familiar with the differences among eligibility and services provided for different disability groups and to decide what types of policies could or ought to be articulated with respect to provision of publicly funded services for disabled persons.

2) The LFC could request the Children, Families, Health and Human Services Interim Committee (Children and Families Interim Committee) partner with the LFC in preparing draft statutory language to articulate either:
   a) The rational basis for providing different eligibility standards and different services among different disabled populations; or
   b) A policy that provides for eligibility standards and services that are more uniform across disability groups

This option would allow the LFC to receive input and assistance from the Children and Families Interim Committee to gain perspectives from a broader group of legislators and form a partnership between appropriation and health committees that would likely hear any legislative proposals that would be presented during the 2005 session.

3) The LFC could specifically request that DPHHS provide as part of the Medicaid redesign effort proposed language to articulate either:
   a) The rational basis for providing different eligibility standards and different services among different disabled populations; or
   b) A policy that provides for eligibility standards and services that are more uniform across disability groups

This option would allow the LFC to receive input from DPHHS and to know what values the Advisory Council might consider important.

[5] The Olmstead decision found that states must serve disabled individuals in the least restrictive setting. However, the court also recognized that state financial resources were a constraining factor in meeting such obligations. The decision also implies that if a state has a plan to show movement of persons from institutions and waiting lists to community settings, states may be able to demonstrate compliance with the decision even though not all eligible persons are served in community settings at any given point.

4) Take no action

This option is always available to the LFC and is listed for consideration.

HIFA WAIVER AND COMPREHENSIVENESS OF REDESIGN

Implementation of a HIFA waiver is probably the most significant component of the Medicaid redesign proposals. A HIFA waiver can be used to waive federal Medicaid criteria, such as eligibility, freedom of choice, and types of services offered. The waiver must also provide expansion of health care coverage to uninsured persons and CMS officials are very interested in waivers that demonstrate partnerships with the private sector. The waiver must be cost neutral to the federal government over a five-year period and if not, a state must pay all costs in excess of the cost neutrality threshold. Cost neutrality is determined by measuring the increase in per person costs under the waiver compared to a pre set, capped rate of increase.

DPHHS staff and consultants traveled to Washington, D.C. and Denver to meet with national and regional staff for the CMS who administer the Medicaid program. Points to note from the CMS meetings:

- CMS officials observed that the Montana Medicaid redesign effort is the most comprehensive among states pursuing Medicaid changes
- The second highest ranking federal official for Medicaid administration at CMS will be the contact for Montana's HIFA waiver
- At this point in time, a HIFA waiver growth rate cap would be 8 percent per year over the life of the waiver, measured by changes in the per person cost over 5 years
- The base year expenditures for calculation of the growth rate is assumed to be the most recently completed federal fiscal year once negotiations for the HIFA waiver were complete

Comprehensive Reform

At the last LFC meeting, staff raised the issue that the Medicaid redesign seemed to be more focused on changes in Medicaid services for persons with mental health disabilities and physical health services for the nondisabled. As stated, CMS has noted that the Montana Medicaid redesign effort is the most comprehensive in a national forum. And although legislative staff notes that it is certainly the most comprehensive change in the history of the Montana Medicaid program, staff still has concerns that some components of the program may not be integrated into the redesign process or the Advisory Council deliberations.

It is not clear how changes being made to Medicaid services administered by the Senior and Long Term Care Division (SLTC) and the Disability Services Division (DSD) will be incorporated into the Advisory Council deliberations. While the Advisory Council has received updates on the Rate Methodology Project being pursued by DSD[6], it has not been apprised of policy decisions that are arising in the project and that will be incorporated into recommendations and potentially the budget request. Some of the policy decisions are significant and could be applicable to other Medicaid services and to the work of the Advisory Council.

[6] The Rate Methodology Project is more thoroughly discussed in the staff report "Developmental Disabilities Program Emerging Issues and Eastmont Status" to be presented at the March LFC meeting.

SLTC is pursuing implementation of a "cash and carry" demonstration grant for the physically disabled and elderly in community services, which has some similarities to the changes being considered in the DSD Rate Methodology Project. Yet the program has not been discussed with the Advisory Council. It is also unclear how similar policies and procedures for the two projects are being coordinated within DPHHS.

Waiver Growth Cap

Cost neutrality is a significant consideration in the decision to implement a HIFA waiver. At this time, CMS officials said that the growth cap would be the one used in the President's budget – 8 percent per eligible person per year. The growth cap would be calculated over entire state Medicaid expenditures over 5 years. So, if growth in the first year was 10 percent, but subsided in later years, the waiver could be cost neutral. However, if growth rates exceeded 8 percent and did not abate, DPHHS would need to reduce services, eligibility, or payment rates to avoid shifting costs to the general fund.

The growth in per person expenditures would be impacted by the types of medical care needed, the utilization of services, and rates paid for services. So if a higher percentage of persons entered nursing home services or if cases were more medically complex in future years than compared to the base year, cost neutrality could be adversely impacted.

DPHHS believes that the 8 percent per person growth cap has rarely, if ever, been exceeded. However, within certain Medicaid service types, the legislature has authorized rate increases that exceeded 8 percent. For instance, during the 2003 legislative session, nursing homes received a 5 percent compounded annual rate increase, which, coupled with increases from an IGT, exceeded 16 percent from FY 01 to FY 02. Additionally, some services such as ambulance services were given a one time 25 percent rate increase in the 2003 session. So, the legislature could face tradeoffs among services and other types of expansions if costs neared the 8 percent threshold.

Another trade off could result if additional IGTs were possible. The last legislative session passed two bills (HB 481 and HB 705) to impose bed day fees in order to maximize receipt of federal Medicaid matching funds and to increase hospital and nursing home rates to the allowable federal maximum. The legislature also approved IGTs for county hospitals, nursing homes, and community mental health centers to help reimburse county run facilities, and in some instances private facilities, at higher Medicaid rates at no additional cost to the general fund. If Montana has not maximized federally allowable draw-down of federal Medicaid funds, it could find its opportunity to do so constrained by a too low growth cap in a HIFA waiver.

HIFA Waiver Dependent on Renewal of One-Time Appropriation

At this point in time, it appears that the component of the HIFA waiver to expand health care services to a segment of the uninsured would depend on the appropriation of either additional general fund or continued diversion of tobacco settlement funds appropriated in SB 485. The preliminary HIFA waiver concept uses $6.5 million of tobacco settlement funds appropriated over the biennium in SB 485 to expand Medicaid eligibility for persons currently served in the Mental Health Services Plan (MHSP) and for an undetermined number of uninsured persons. It is also not clear what services would be provided to the expansion group, other than medications for MHSP participants whose medications are now funded entirely from a one-time appropriation of tobacco settlement funds. Staff will continue to provide information about the HIFA waiver as the concepts are finalized.

MEDICAID ESTIMATES

The legislature has determined that Medicaid cost estimates are important to overall state spending and significant enough to include the requirement of availability and review of such estimates by the LFC in statute. However, the wording of the statute makes it difficult to interpret and potentially difficult to enforce because it is vague as to when estimates are to be provided. Statute (53-5-110(4), MCA) states:

> (4) Whenever the department of Public Health and Human Services establishes an estimate of Medicaid expenditures for Medicaid services, the department shall submit the estimate to the Legislative Finance Committee. The Legislative Finance Committee shall consider the estimate at its next regularly scheduled meeting.

Although legislative staff has received DPHHS budget status reports periodically, and sometimes sporadically, this section of statute has not been regularly complied with nor enforced. During the interim last biennium, legislative staff was invited to participate in DPHHS meetings where Medicaid estimates were developed, but that practice has been discontinued. This fiscal year, staff has received one estimate of Medicaid expenditures, which was received January 22, 2004.

Medicaid estimates for current fiscal year expenditures are problematic in the first quarter of a state fiscal year because of payment lags and the incomplete nature of the data. Development of estimates becomes more critical by December at the latest, and DPHHS usually begins current fiscal year estimates by November at the latest because of the time it takes to plan to reduce expenditures if necessary. So in the normal course of business, the LFC could have expected to receive at least 2 if not 3 estimates of Medicaid expenditures by late February.

Staff requested an update of Medicaid estimates, with the request that the data be provided February 20, in time for analysis and inclusion in issues and comments for this report and the spending pressures report to the LFC. Staff was notified that an update was not available. Specifically, staff was told: "The estimates based on January have not been finalized yet, but do not appear to be significantly different than the previous estimates. Please use the projections provided with the budget status report in January."[7]

DPHHS also routinely estimates prior fiscal year Medicaid costs because payment data lags can infrequently cause prior year expenditures to exceed available remaining appropriation authority. In such instances, DPHHS has either paid prior year costs from current appropriations or requested a supplemental appropriation. Either way, cost overruns in a prior period can impact the current fiscal situation.

The budget status report received in January did not include prior year Medicaid cost estimates. The 2003 biennium was noteworthy in that Medicaid costs exceeded appropriations and DPHHS reduced Medicaid services to avoid at least $23 million in estimated general fund cost over runs. Without estimates of prior year costs, the LFC does not have access to the information compiled by DPHHS to determine if those actions resulted in enough cost savings or if cost trends did not abate and will affect current or prior year appropriations.

DPHHS staff notes that DPHHS is forming an Office of Policy, Planning and Analysis, using existing FTEs, which will report to the Deputy Director. The Office will be up and running prior to the

[7] Scott Sim, Chief of the Fiscal Bureau, Operations and Technology Division, Department of Public Health and Human Services, e-mail communication, February 20, 2004.

convening of the next session and that timeliness and availability of Medicaid estimates would be improved.[8]

ISSUE

Medicaid expenditures comprise a significant share of HB 2 expenditures and historically large supplemental appropriations have influenced the state general fund balance. The LFC has a significant interest in receiving and reviewing estimates of current and prior year cost estimates.
The LFC has not received regular Medicaid estimates as required by statute. The wording of the statute makes compliance and enforcement problematic.

Options

The LFC can consider the following options:

1) Amend the statute

The LFC could consider amending the current statute to require definitive times at which the estimates for current and/or prior year Medicaid estimates were due from DPHHS for LFC review. This option would allow clear interpretation of and potential enforcement of the requirement for DPHHS to provide data. The LFC could direct staff to provide draft language at the next LFC meeting for review.

2) Enforce the current statute despite the lack of clarity in the wording of the statute

This option involves action of some type to compel DPHHS to provide data. This action might have the advantage of enforcing statute for compliance and to allow the LFC access to and review of data produced by DPHHS as legally required. (The word "might" is used to reflect the vague wording of the statute and the difficulty in clear enforcement of the statute.)

However, this option can be problematic for several reasons:

- Vagueness of the statute
- Negative public perceptions of one branch of government taking legal action against another
- Costs associated with legal action
- Unintended consequences of resulting court rulings

3) Take no action

This option is always available to the LFC and is listed for consideration. However, if the LFC takes no action, the issue of timely receipt of data and compliance with statute is not resolved.

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[8] John Chappuis, e-mail communication, February 25, 2004.