Legislative Research Council
SouthDakota

Issue Memorandum 04-02

MEDICAID – A STUDY FOCUSING ON COST CONTAINMENT, DEMOGRAPHICS AND COMPARISON WITH THE SYSTEMS IN OTHER STATES

Background

Medicaid is the state-federal partnership health program which serves about 50 million people in all 50 states and the U.S. territories. The program is complex in structure, and varies from state to state, but for most locales it is the single largest health program in place. Medicaid provides medical benefits to low-income people who have no medical insurance or inadequate medical insurance.

The federal role in Medicaid is limited to setting standards, issuing regulations and guidelines, and overseeing operation of the program by the states. Specific program requirements are actually established by each state. Whether a person is eligible for Medicaid and what services are available will depend on the state where he or she lives. Because Medicaid is an entitlement, once rules for eligibility and reimbursement are set, the program cannot be terminated when funds run out without legislative action.

President Truman first proposed a prepaid health insurance plan on November 19, 1945, in a special message to Congress. On July 30, 1965, President Johnson signed the Medicare and Medicaid Bill (Title XVIII and Title XIX of the Social Security Act). Since its enactment, Medicaid has evolved over time. In the proposed FY05 federal budget, 1 in every 5 federal dollars will be spent for federal health programs. In South Dakota 30.3 percent of the general fund expenditures will be for health, human services and social services categories.

Which People Does Medicaid Cover?

Federal law requires state Medicaid programs to cover certain populations and allows states the option of covering others. Medicaid is an "entitlement" program, which means that states may not exclude anyone who applies for coverage if he or she meets specified eligibility criteria. This provision makes budgeting for Medicaid somewhat difficult because enrollment may not be limited and the number of eligible people fluctuates with the economy and other variables. Although 52 million people nationally were covered by Medicaid at some point during 2003, month-by-month variations exist as people move in and out of the program.

Mandatory populations

Although state participation in Medicaid is optional, states that have Medicaid programs - and all do - must provide coverage to certain groups or "categories" of people (sometimes referred to as "categorically eligible"). Mandatory groups include the following:

- AFDC-related populations (certain parents and children). {Eligibility for children and parents in the former "Aid to Families with Dependent Children" program once automatically qualified people for Medicaid. The 1996 federal welfare reform legislation, which replaced AFDC with Temporary Assistance for Needy Families (TANF) and delinked welfare from automatic Medicaid eligibility, froze Medicaid's welfare-related eligibility levels at the former AFDC eligibility levels that were in place on July 16, 1996. The national average eligibility threshold at that time was about 40 percent of federal poverty guidelines, or $6,268 for a family of three in 2004. States may expand eligibility, but may not reduce it.}

- People who receive Supplemental Security Income (SSI), a federal cash assistance program for low-income people with disabilities who meet specified eligibility criteria.

- Pregnant women with incomes up to 133 percent of federal poverty guidelines ($12,382 for a single woman in 2004).

- Infants of women enrolled in Medicaid at the time of birth, or those in families with income up to 133 percent of poverty guidelines.

- Children under age 6 in families with income up to 133 percent of poverty guidelines.

- Children ages 6 through 18 in families with incomes at or below the poverty level.

- Children in adoption or foster care.

- Some low-income Medicare recipients (for services not covered by Medicare).

Optional populations

For many years, states had little discretion about covering additional people under Medicaid. The program was mainly designed to assist very low-income, welfare-related populations. However, the program expanded over time, most notably for children and pregnant women. The most common additional populations that states may choose to cover in their Medicaid programs include the following:

- Infants and pregnant women with family incomes up to 185 percent of federal poverty guidelines.

- Additional families, by disregarding a portion of family income, eliminating asset tests, raising income levels to adjust for inflation, or extending benefits to two-parent working families.

- Additional Medicaid recipients by increasing income eligibility levels.

- "Medically needy" people (specified low-income people who do not meet income criteria, but who have large medical expenses in proportion to their income).

- People with disabilities who would lose eligibility because of higher income, who may buy Medicaid coverage under a sliding-scale premium (the "Ticket to Work" initiative).

- Low-income uninsured women with breast or cervical cancer who have been diagnosed through the National Breast and Cervical Cancer Early Detection Program, for their cancer treatment.

- Children under the State Children's Health Insurance Program (SCHIP). Under the federal SCHIP legislation passed in 1997, states may extend Medicaid coverage to children through age 18 with family incomes of up to 200 percent of federal poverty guidelines (or they may create a non-Medicaid insurance option).

Waiver populations

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration projects which, in the judgment of the Secretary, are likely to assist in promoting the objectives of the Medicaid statute. Such waivers, usually five-year demonstration projects, must be "cost neutral" over the life of the waiver, meaning states must achieve savings in some program areas in order to cover additional people.

Although South Dakota has not sought any 1115 waivers, several states have, including the following examples:

- Minnesota covers children under age 2 in families with incomes up to 280 percent of poverty guidelines, pregnant women with incomes up to 275 percent, and other children through age 18 in families with incomes of up to 170 percent of federal poverty guidelines, and several other categories of people with incomes up to 100 percent of poverty guidelines.

- Oregon covers children and pregnant women in families with incomes of up to 185 percent of federal poverty guidelines and parents and childless adults with incomes up to poverty guidelines. Childless adults, covered by a less comprehensive benefits package, pay both monthly premiums and service copayments. In addition, Oregon subsidizes employer-sponsored insurance or individual insurance coverage for certain low-income populations through its Family Health Insurance Assistance Program. The state received a Medicaid waiver in October 2002, which allows it to receive federal Medicaid matching funds for the program.

2004 Poverty Guidelines

Size of family unit	Poverty guideline
1	$ 9,310
2	12,490
3	15,670
4	18,850
5	22,030
6	25,210
7	28,390
8	31,570
Each additional member above 8 add	3,180

For many programs, the federal government issues a poverty test criterion to determine eligibility. This table shows the current (2004) poverty guidelines.

History of South Dakota Persons Eligible for Medicaid Services

Fiscal Year Monthly Average	1998	1999	2000	2001	2002	2003
Total Eligible	61,096	65,543	70,559	77,443	85,542	91,145
Adults	26,200	25,959	26,910	27,847	29,235	30,528
Children	34,896	39,584	43,649	49,596	56,307	60,617

Appendix A gives the detail of South Dakota's Optional Coverage groups.
Appendix B is a chart comparing selected benefits of random states.

What Services Are Covered?

Similar to mandatory and optional populations for Medicaid eligibility, federal Medicaid law requires states to cover certain services and allows states to select from a menu of other optional services. Because Medicaid covers so many low income elderly people and people with serious disabilities who cannot obtain private sector coverage, its benefits package reflects these special needs. For example, Medicaid covers some services that most private insurance plans do not cover, such as nursing home and other long-term care services, and that can be especially expensive. Covered services must be available statewide, must be comparable (equal for all in a group), and must be sufficient in "amount, duration and scope" to achieve their purpose. States retain considerable flexibility in defining certain services and setting coverage guidelines.

States can, and have, set "reasonable" limits on both mandatory and optional services, such as the number of prescriptions or the number of visits to a particular type of provider. In practice, with the exception of required services for children, states have exercised wide discretion in the amount, duration, and scope of services they cover.

Influences on State Medicaid Costs

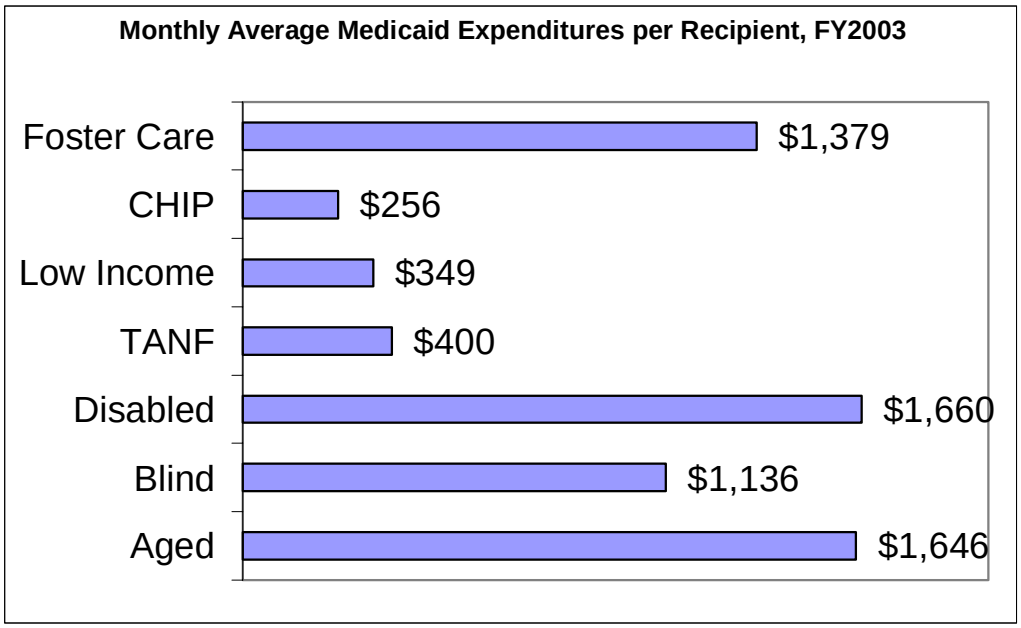
The state's Medicaid costs depend on: how many people receive care; what care they receive; who provides it; what the provider is paid; and, the basis for the payment. When unemployment rose during the recent economic downturn, more individuals qualified for Medicaid coverage as incomes declined and access to employer-sponsored insurance became more limited.

Who is covered has more of an effect on Medicaid costs than how many people are covered. On average, Medicaid spends more than nine times as much for an elderly recipient as for a child, and spending for elderly, blind and disabled people accounts for more than 70 percent of health services spending. During FY03 in South Dakota, an average 73 percent of the enrolled Medicaid population was composed of TANF and low income persons; however these two groups only used 26 percent of the actual budget. The largest two shares of the budget (68 percent) were used by the disabled and the elderly, two of the smaller groups.

Among the more expensive groups covered under Medicaid are individuals with developmental disabilities, chronic and severe mental illnesses, and the frail elderly. These groups depend on states to act as their advocates and also to fund their care. This can place state agencies in conflicting roles, with one agency having protective responsibility for the vulnerable patients while another must manage budgetary demands. Legislators face both responsibilities.

As baby boomers approach retirement age more stress will be put on Medicaid. In 1960 shortly before the Medicaid system was enacted the over 65 population in South Dakota was 71,513. The State Data Center projects that number to be 119,322 in 2005 and by 2020 it is projected to climb to 179,009. As a percentage of South Dakota's total population, that represents a 10 percent increase in the elderly population from 2000 to 2020.

Another factor on the horizon influencing health care and Medicaid is nutrition and obesity. Being overweight or obese results from daily lifestyle choices, the consequences of which gradually accumulate. In March 2004, the Centers for Disease Control announced that the second leading cause of death in 2000 was poor diet and physical inactivity. This trend is sure to have a growing role in Medicaid programs as well.



How Can States Control Medicaid Costs?

States have taken a number of longer term reforms to help control Medicaid costs, including the following examples:

FOCUS ON THE SICKEST PEOPLE. At least 21 states attempt to "manage diseases" such as asthma and diabetes in their Medicaid programs. Florida reports a $42.2 million savings over five years by providing intensive services to certain chronically ill people. CMS announced support for disease management initiatives under Medicaid in a letter to state Medicaid directors on February 25, 2004. *(Appendix C is the CMS Letter)*

REFORM LONG-TERM CARE. Long-term care services consume about 40 percent of Medicaid budgets. Maine cut the total per-person spending of Medicaid-funded long-term care by 12 percent by increasing community-based services, cutting the time that Medicaid clients stay in nursing homes, billing Medicaid for appropriate services, and tightening medical eligibility standards. Promoting private long-term care insurance also may help lessen future burdens on state budgets.

EMPHASIZE PREVENTION. Children make up about half of Medicaid enrollees. By focusing on prevention and timely acute care services for Medicaid-enrolled children, a North Carolina pilot program cut emergency room visits by 20 percent and also reduced hospital stays.

REDUCE PRESCRIPTION DRUG COSTS. States have saved millions of dollars by implementing prior authorizations, preferred drug lists and supplemental rebates, and by requiring use of generic drugs.

PROMOTE WELLNESS AND DISEASE MANAGEMENT. A statewide fitness campaign in Texas called "Texercise" educates and involves seniors and their families in physical activities and proper nutrition. This type of strategy can slow the rise of medical and social services costs, and ultimately benefit people of all ages.

USE ELECTRONIC RECORDS. Arkansas saved an estimated $30 million over 17 months by creating an integrated electronic billing, eligibility verification, payment, data collection and analysis system.

MAXIMIZE FEDERAL FUNDING. By identifying programs funded by the state that could qualify for federal matching funds under Medicaid, states could reap significant benefits. For example, certain special education, foster care, and substance abuse services may qualify for Medicaid reimbursement. In addition, states that sponsor pharmacy assistance programs for low-income residents may qualify for federal Medicaid assistance under a new Medicaid Pharmacy Plus waiver.

LEVERAGE FEDERAL FLEXIBILITY. Medicaid's 1115 waivers give states more flexibility to craft Medicaid demonstration projects. For example, Utah expanded its program to cover up to 25,000 additional low-income adults for primary and preventive services. The state projects savings in hospital and emergency room costs for previously uninsured adults. Missouri estimates savings of $11.4 million in 2002 through its premium assistance program, which subsidizes employer-sponsored insurance for eligible Medicaid workers (instead of enrolling individuals in the state's regular Medicaid plan).

EVALUATE THE PROGRAM. A number of states have achieved savings in their Medicaid programs by conducting studies or audits to identify areas where the program could be refined or improved. For example, South Carolina's Legislative Audit Council recommended a preferred drug list to save $12.8 million and an enrollment fee to save an estimated $1.4 million.

Challenges

The most obvious ways for states to trim Medicaid costs involve cutting program eligibility, services, or payments to service providers. However, each of these options has its drawbacks.

- Cutting eligibility may shift costs elsewhere, such as to other state or locally funded programs, to emergency rooms, to private insurance plans in the form of higher premiums, and to providers in the form of bad debt or charity care. These alternatives are less desirable and without the generous federal cost sharing.

- Imposing overly stringent restrictions on services such as prescription drugs may result in higher costs associated with sicker patients, including expensive hospital or nursing home care.

- Paying less can have unexpected effects on the rest of the system, as the excess costs are absorbed by other payers. Underpaid providers may shift costs to private insurance or refuse to treat Medicaid patients altogether. If providers and plans find lower payments unacceptable, paying less can reduce access as well.

Several trends can be misleading as to their impact on the entire system. Rapid growth in one category of spending is not necessarily bad because increasing the use of some services may decrease the use of more expensive services and lower costs over time.

- Outpatient and physicians' office visits increased a decade ago due to a shift from inpatient to less expensive outpatient care.

- Pharmaceutical spending has swelled alarmingly in recent years; however, it is not clear that this is undesirable. For at least some conditions, such as chronic mental illness, pharmaceuticals are an alternative to more expensive care or procedures and may slow the costly progression of disease and disability.

- Home and community-based care have been growing at double-digit rates, encouraged by the view that it often is less expensive than institutional alternatives. New community-based services create budget problems if they are not offset by decreased use of nursing facilities. More than half of Medicaid long-term care spending goes to nursing homes, although the proportion varies from state to state.

No Easy Answers

Medicaid provides literally vital-life-giving-services to the most vulnerable populations. Since its enactment, Medicaid has evolved from a program providing federal financing to states to support health coverage for their welfare population to a federal and state partnership that now provides health and long-term coverage to millions of low-income Americans. It has become the nation's largest health care program both in terms of enrollment and spending, with children and families making up the vast majority of program enrollment and the elderly and disabled accounting for the bulk of program spending.

Underlying factors point to continuing growth in Medicaid enrollment and costs adding further pressure to state budgets. Although states receive at least half their program costs from the federal government, Medicaid still accounts for a substantial portion of state budgets. Ideally, costs are saved by giving care more efficiently, eliminating unnecessary and wasteful systems, and keeping people well by preventing rather than treating illnesses. Because health care strategies tend to have complicated interaction with one another changes are not simple and do not happen overnight.

This issue memorandum was written by Sue Cichos, Senior Fiscal Analyst for the Legislative Research Council. It is designed to supply background information on the subject and is not a policy statement made by the Legislative Research Council.

Appendix A

Mandatory and Optional Eligibles

M - Mandatory O - Optional	Description: Mandatory Coverage	Individuals	
M1.1	TANF Cash	6,013	
M1.2	Non TANF	16,454	
M2	SSI	12,969	
M3	Auto NewBorns	3,648	
M4.1	Pregnant Women	2,414	
M4.2	Children Under 6	10,167	
M5	Children 6 and Over	12,688	
M6.1	Subsidized Adoption with IVE Funds	736	
M6.2	Out of home Placement with IVE Funds	694	
M7.1	Medicare Beneficiaries below FPL	2,683	
M7.2	Medicare Beneficiaries between 100% and 120% of FPL	1,350	Eligible ONLY for Part B premium, Not included in Totals
M7.3	Medicare Beneficiaries between 120% and 135% of FPL	576	Eligible ONLY for Part B premium, Not included in Totals
M8	Former SSI recipients with Medicaid Protection	294	
M9	Transitional Medical Benefits	6,629	
	Total Mandatory Individuals	**75,389**	

	Yearly Income	
Family Size	Federal Poverty Level	Low Income Family Income Limit
1	9,310	6,756
2	12,490	8,436
3	15,670	9,552
4	18,850	10,620
5	22,030	11,724
6	25,210	12,840
7	28,390	13,920
8	31,570	14,988
Each Additional Member above 8 add	3,180	1,092

	Description: Optional Coverage	Individuals	
O1	NA	-	
O2.1	Children with family income from 133% to 140% under 6	884	
O2.2	Children with family income from 100% to 140% 6 and over	2,918	
O3.1	Title XXI (CHIP) children up to 6; family income between 133% and 200% of FPL	2,004	
O3.2	Title XXI (CHIP) children 6 and over; family income between 100% and 200% of FPL	7,883	
O4	NA	-	
O5.1	Children in DSS Custody	1,247	
O5.2	Children in DOC Custody	535	
O5.3	Adjudicated under guardianship of DHS	29	
O6	Individuals in Nursing Homes/State Institutions	3,902	
O7	Individuals who if not for a waiver would be in a Nursing Home/State Institution	1,562	
O8.1	Adult Foster Care		See Note Below
O8.2	Assisted Living		See Note Below
O9	NA		
O10	Breast and Cervical Cancer	30	
O11	Former Foster Care Child	42	
O12, O13, O14	NA	-	
	Total Optional Individuals	**21,036**	

Total Individuals Eligible for Medical Services	**96,425**

Individuals in the Services below can be a Mandatory Title XIX coverage individual or an individual eligible under an optional coverage group.

Program	Number Enrolled
Adult Foster Care	20
Assisted Living	248
Family Support Waiver	379
Personal Attendant Services	100

Source: Department of Social Services 09/21/04

Appendix B

Selected Medicaid Benefits of Random States - As of January 2003

	SD	ND	Iowa	NE	Indiana	WY	MN	PN
Clinical Services-Freestanding Ambulatory Surgery Center								
Is the benefit offered?	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN		CN - MN	CN - MN	CN	CN	CN - MN	CN - MN
Copayment requirement								
Clinic Services-Public and Mental Health Clinics								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN - MN	CN - MN	CN - MN	CN	CN	CN - MN	CN - MN
Copayment requirement								
Federally Qualified Health Certer Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN - MN	CN - MN	CN - MN	CN	CN	CN - MN	CN - MN
Copayment requirement	$2/visit	$2/visit				$2/visit		
Outpatient Hospital Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN - MN	CN - MN	CN - MN	CN	CN	CN - MN	CN - MN
Copayment requirement	yes			yes		yes		Yes
Religious Non-Medical Health Care Institution and Practitioner Services								
Is the benefit offered?	No	No	No	No	Yes	No	No	No
Population covered					CN			
Copayment requirement								
Rural Health Clinic Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN - MN	CN - MN	CN - MN	CN	CN	CN - MN	CN - MN
Copayment requirement	$2/visit	$2/visit				$2/visit		
Dental Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN - MN	CN - MN	CN - MN	CN	CN	CN - MN	CN
Copayment requirement	Yes	$2/visit	$3/day	Yes			Yes	
Dentures								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Population covered	CN	CN-MN	CN	CN-MN	CN		CN-MN	CN-MN
Copayment requirement	Yes			Yes			Yes	
Eyeglasses								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN-MN	CN - MN	CN-MN	CN	CN	CN-MN	CN-MN
Copayment requirement				$2/pair			$25/pair	
Hearing Aids								
Is the benefit offered?	No	No	Yes	Yes	Yes	No	Yes	No
Population covered			CN - MN	CN-MN	CN		CN-MN	
Copayment requirement				$3/aid				
Services for Speech, Hearing, Language Disorders								
Is the benefit offered?	Yes	Yes	No	Yes	Yes	Yes	Yes	No
Population covered	CN	CN - MN		CN-MN	CN	CN	CN-MN	
Copayment requirement								
Lab and X-Ray Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN - MN	CN - MN	CN-MN	CN	CN	CN-MN	CN –MN
Copayment requirement								Yes

	SD	ND	Iowa	NE	Indiana	WY	MN	PN
Medical Equipment and Supplies								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Population covered	CN	CN - MN	CN - MN	CN-MN	CN	CN	CN-MN	
Copayment requirement	yes		$2/day					
Prosthetic and Orthotic Devices								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Population covered	CN	CN - MN	CN - MN	CN-MN	CN	CN	CN-MN	
Copayment requirement	yes		$2/day					
Inpatient Hospital Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN - MN	CN - MN	CN-MN	CN	CN	CN-MN	CN –MN
Copayment requirement	$2/admit.						yes	yes
Rehabilitation Services: Mental Health and Substance Abuse								
Is the benefit offered?	Yes	No	No	Yes	Yes	Yes	Yes	No
Population covered	CN			CN-MN	CN	CN	CN-MN	
Copayment requirement	50%							
Nurse Anesthetist Services								
Is the benefit offered?	Yes	No	Yes	Yes	No	Yes	Yes	No
Population covered	CN		CN -MN	CN-MN		CN	CN-MN	
Copayment requirement								
Chiropractor Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Population covered	CN	CN – MN	CN -MN	CN-MN	CN		CN-MN	CN – MN
Copayment requirement	$.50/svc	$1/visit	$1/day	$1/visit				
Medical Surgical Services of a Dentist								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN – MN	CN -MN	CN-MN	CN	CN	CN-MN	CN – MN
Copayment requirement		$2/visit		$2/visit				
Medical Surgical Services of a Dentist								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN – MN	CN -MN	CN-MN	CN	CN	CN-MN	CN – MN
Copayment requirement		$2/visit		$2/visit				
Nurse Midwife Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN – MN	CN -MN	CN-MN	CN	CN	CN-MN	CN – MN
Copayment requirement		$2/visit						
Nurse Practioner Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN – MN	CN -MN	CN -MN	CN	CN	CN-MN	CN – MN
Copayment requirement	$2/visit	$2/visit		$2/visit		$1/visit		
Optometrist Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN – MN	CN -MN	CN -MN	CN	CN	CN-MN	CN
Copayment requirement	$1/visit		$2/visit	$2/visit		$1/visit		
Physician Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN – MN	CN -MN	CN -MN	CN	CN	CN-MN	CN – MN
Copayment requirement	$2/visit	$2/visit		Specialist		$1/visit		Yes
Podiatrist Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Population covered	CN	CN – MN	CN -MN	CN -MN	CN		CN-MN	CN
Copayment requirement		$2/visit	$1/day	$1/visit				

	SD	ND	Iowa	NE	Indiana	WY	MN	PN
Prescription Drugs								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN – MN	CN -MN	CN -MN	CN	CN	CN-MN	CN – MN
Copayment requirement	$2/Rx	$3/Rx	$1/Rx	$2/visit	yes	$2/Rx	yes	$1/Rx
Physical Therapy Services								
Is the benefit offered?	Yes	Yes	No	Yes	Yes	Yes	Yes	No
Population covered	CN	CN – MN		CN -MN	CN	CN	CN-MN	
Copayment requirement				yes				
Ambulance Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN – MN	CN – MN	CN -MN	CN	CN	CN-MN	CN-MN
Copayment requirement			$2/trip					
Non-Emergency Medical Transportation								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN – MN	CN – MN	CN -MN	CN	CN	CN-MN	CN-MN
Copayment requirement			$2/trip					
Home Health Services								
Is the benefit offered?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Population covered	CN	CN – MN	CN – MN	CN -MN	CN	CN	CN-MN	CN-MN
Copayment requirement								
Personal Care Services								
Is the benefit offered?	Yes	No	No	Yes	No	No	Yes	No
Population covered	CN			CN -MN			CN-MN	
Copayment requirement								
Personal Care Services								
Is the benefit offered?	Yes	No	No	Yes	No	No	Yes	No
Population covered	CN			CN -MN			CN-MN	
Copayment requirement								

Abbreviations:

CN: Categorically Needy

MN: Medically Needy

Source: The Kaiser Commission on Medicaid and the Uninsured

Appendix C

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #04-002

February 25, 2004

Dear State Medicaid Director:

Disease management represents an exciting opportunity to significantly improve the care delivered to Medicaid beneficiaries with chronic conditions. It has emerged in both the public and private sector as a strategy to bring the benefits of care coordination techniques honed in managed care organizations (MCOs) to populations and regions that traditionally have not had access to those comprehensive capitated systems.

This letter provides guidance on how states can cover disease management in their Medicaid programs. This letter outlines some of the more common options; states interested in other strategies should contact us for assistance.

Background

Disease management is a set of interventions designed to improve the health of individuals, especially those with chronic diseases. Disease management programs usually include:

- identification of patients and matching the intervention with need;
- support for adherence to evidence-based medical practice guidelines, including providing medical treatment guidelines to physicians and other providers, and providing support services to assist the physician in monitoring the patient;
- services designed to enhance patient management, and adherence to an individualized treatment plan (e.g., patient education, monitoring and reminders, and behavior modification programs aimed at encouraging lifestyle changes);
- routine reporting and feedback loops (may include communication with patient, physician, health plan and ancillary providers, and practice profiling); and
- collection and analysis of process and outcome measures.

Traditionally, disease management was part of the comprehensive care furnished by MCOs. Today, we are seeing a multitude of strategies in order to bring disease management to fee-for-service (FFS) populations. States are building comprehensive systems in-house or contracting out the function to Disease Management Organizations (DMOs). This letter outlines some of the options available to states with regard to designing and operating disease management programs.

Disease Management as a Medical Service

Disease management programs that focus interventions on the beneficiary may qualify as medical services under Medicaid. In order to qualify as a medical service, disease management must include direct services. Direct services require the use of licensed practitioners such as nurses, pharmacists, or physicians who provide services directly to individual beneficiaries in order to improve or maintain their health. Examples include medical assessments, disease and dietary education, instruction in health self-management, and medical monitoring. These medical state plan services are eligible for Federal financial participation at the state's regular Federal Medical Assistance Percentage rate. Each proposal will be assessed to determine whether it qualifies as a medical service or administrative function, which in turn determines the Federal matching rate. There are a number of disease management models that may qualify as medical services under Medicaid, and we outline three major ones below.

Disease Management through Contracting With a Disease Management Organization (DMO)

One model is to contract with a DMO. The DMO manages the overall care of the beneficiary, but does not actually prior authorize or otherwise restrict access to other Medicaid services. In this model, the state often requires performance guarantees, including capitating the DMO for disease management services, as well as putting the DMO at risk for reducing overall expenditures. Capitated DMOs qualify as Prepaid Ambulatory Health Plans and are subject to a limited subset of the managed care regulations at 42 CFR Part 438.

Disease Management through an Enhanced Primary Care Case Management (PCCM) Program

A second model of beneficiary-focused disease management is to enhance a PCCM managed care program. In these programs, the state works with PCCM providers to enhance the care it delivers to its enrollees with certain chronic conditions. The state also may provide additional support in the form of case managers for complex cases and furnish ongoing monitoring reports on enrollee utilization. PCCM providers are often paid enhanced case management fees for providing disease management, in addition to the regular FFS reimbursement for other state plan services they provide.

Disease Management through Individual Providers

States can also offer disease management through individual FFS providers in the community (e.g., physicians, pharmacists, or dietitians). The providers often agree to undergo specified training, and bill on an FFS basis for disease management services provided. States may simply offer this option to interested providers, or build a more comprehensive system that provides additional support, training, and oversight.

Operating Authorities

All of the above models can be authorized through state plan amendments (SPAs) or waivers. Waiver authority can provide states with greater flexibility to design more focused programs. For instance, states that want to limit the number of disease management providers in order to achieve better cost and administrative efficiencies may request selective contracting authority under section 1915(b)(4) of the Social Security Act (the Act). Waiver authority also can be used to intentionally restrict geographic areas where disease management is available; restrict eligible beneficiaries (e.g., exclude Medicare beneficiaries); or mandate beneficiary enrollment.

Additionally, a SPA authorized under section 1932(a) of the Act provides much of the same flexibility available under waivers, and also does not require the periodic renewals associated with programs operating under waiver authority. This SPA authority to mandate enrollment was created by the Balanced Budget Act of 1997 and applies to PCCM or MCO-model disease management programs. As with waiver authority, section 1932(a) SPA authority provides flexibility with respect to limiting providers, eligible populations, and geographic areas that is not normally available under traditional SPAs. In particular, states offering disease management delivered as part of an enhanced PCCM program may want to consider this option.

A SPA may authorize disease management activities through expansions of the covered benefits for "other licensed practitioners" or "preventive services," as appropriate. A disease management SPA must meet the requirements of section 1902(a) of the Act, including statewideness, comparability, and freedom of choice. These requirements apply to both capitated and FFS disease management providers.

Disease Management as an Administrative Function

A disease management program that is limited to administrative activities by the state and its contractors would not constitute "medical assistance," but could be eligible for Federal matching funds for administration of the State plan at the standard administrative matching rate of 50 percent. For example, states or their contractors (e.g., a Quality Improvement Organization, Pharmacy Benefits Manager, or other outside vendor) may work with providers to: promote adherence to evidence-based guidelines; improve provider-patient communication skills; and provide routine feedback on beneficiary utilization of services. In this model, contact with beneficiaries is indirect: the change in provider practice patterns enhances beneficiary care. In addition, there may be targeted mailings to beneficiaries, but no face-to-face contact. The examples here are generally considered administrative functions, and may be eligible for Federal administrative match. State plan requirements such as statewideness and comparability do not apply to administrative functions.

Funding from Outside Sources

Pharmaceutical manufacturers may offer to fund disease management programs for Medicaid beneficiaries. Such funding would be considered a supplemental rebate under section 1927 of the Act, and, in accordance with the September 18, 2002, State Medicaid Director letter, the state needs to report an offset in the amount of Federal funds claimed based on the value of what the state received from the manufacturer.

Dual Eligibles

In general, disease management is not a Medicare-covered service. As a result, states may voluntarily or mandatorily enroll dual eligibles into a Medicaid disease management program. This is because in either case, enrollment does not affect their access to Medicare services. When enrolling dual eligibles, states must ensure that Medicare is the primary payer with respect to the limited Medicare coverage of diabetes self-management training sessions, and when disease management is available through a Medicare demonstration (please see the CMS Web site at http://cms.hhs.gov/healthplans/research).

For Further Information

We are available to provide technical assistance to states interested in establishing disease management programs for their populations. We encourage states to take advantage of the opportunities disease management programs offer to provide coordinated, cost-effective care that improves the health of Medicaid beneficiaries. If you have any questions about providing disease management, please call Ms. Jean Sheil, Director of the Family and Children's Health Programs Group at (410) 786-5647, or e-mail her at jsheil@cms.hhs.gov.

Sincerely,

/s/

Dennis G. Smith
Director