kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

MEDICAID FACTS

July 2006

KYHEALTH CHOICES MEDICAID REFORM: KEY PROGRAM CHANGES AND QUESTIONS

On May 3, 2006, Kentucky obtained a state plan amendment (SPA) for its Medicaid program, becoming one of the first states to utilize new options available through the Deficit Reduction Act of 2005 (DRA). Under the plan, the state will enroll most of its current Medicaid population into four targeted benefit plans and utilize new options to increase cost sharing and expand access to community based long-term care services. The state still needs waiver approval for some changes proposed in the plan.

Through these changes, the state is seeking to "improve health status; ensure people receive the right care, in the right setting, at the right time; ensure the solvency of Kentucky Medicaid, and transform Kentucky Medicaid into a 21st Century Health Care System."[1] The state expects these changes to generate $1 billion in savings over the next seven years. These changes could have significant implications for beneficiaries and providers and provide an early example of how states can use the new benefit, cost sharing and home and community-based services options in the DRA.

How Did the DRA Change Medicaid Options?

The DRA, signed into law on February 8, 2006, includes a number of Medicaid policy changes focused on reducing program spending. Kentucky uses new options related to benefits, cost sharing and long-term care.

Cost Sharing. Prior to the DRA, states could impose nominal (e.g. up to $3) cost sharing for certain populations, but premiums were generally prohibited. The DRA allows states to impose copayments to most Medicaid beneficiaries and premiums to beneficiaries with family incomes above 150% of the federal poverty level and to vary cost sharing across beneficiary groups and areas of the state. Certain groups and services remain exempt from cost sharing. Total cost sharing and premium amounts cannot exceed five percent of family income over a one month or quarterly period. The DRA also allows states to make copayments enforceable, meaning that providers can deny services if beneficiaries cannot pay their copayments.

Benefits. Before the DRA, states were required to provide certain mandatory services, but could also receive federal matching funds to cover some people and services not mandated by federal law. States determined the amount, duration, and scope of the services they offered. A state generally had to offer a covered service to all of its Medicaid beneficiaries as long as it was medically necessary. The DRA allows states to replace the Medicaid benefit package for certain groups with "benchmark" coverage or "Secretary-approved" coverage, which is any coverage the Secretary of Health and Human Services determines is appropriate for a population and to vary benefits across beneficiary groups and areas in the state. States must continue to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to children as a wraparound benefit to cover all medically necessary care.

Long-Term Services. The DRA allows states to provide home and community-based services and self-direction of personal services for individuals with long-term care needs through a state plan option instead of a waiver. The self-direction uses the cash-and-counseling model of providing beneficiaries an individual budget to purchase a range of services included in a plan of care.

What Changes Are Occurring in Kentucky?

Most beneficiaries will be moved into four targeted benefit plans using Secretary approved coverage.

Global Choices covers pregnant women and parents, foster children, medically fragile children, SSI-related groups and women with breast and cervical cancer (235,000 people). Kentucky currently covers working parents with incomes up to 68% of poverty ($10,880 for a family of three in 2006). Global Choices includes basic medical services, not including long-term care services, but with increased cost sharing and new benefit limits compared to the state's current benefit package.

Family Choices covers most children, including SCHIP children (263,000 people). Kentucky currently covers infants up to 185% of poverty and children through age 19 up to 150% of poverty under Medicaid and up to 200% of poverty through SCHIP. Compared to Global Choices, Family Choices has no prescription drug limits and a higher vision care maximum.

Optimum Choices covers individuals with mental retardation and developmental disabilities in need of long-term services (3,500 people). It includes all benefits in Global Choices and three levels of long-term care services determined by individualized plans of care: high intensity, targeted, and basic. The high intensity level includes institutional care.

Comprehensive Choices covers the elderly and persons with disabilities in need of a nursing facility level of care (27,900 people) covering all benefits in Global Choices plus services offered through the state's current home and community based waivers in two care levels: high intensity and basic. The high intensity level includes institutional care.

Kentucky uses DRA options to impose cost sharing and limit benefits for Medicaid enrollees. New cost sharing requirements for most beneficiaries went into effect on June 1, 2006. For example, Global Choices includes a $50 co-pay for inpatient services; $3-6 for physician services and $1 co-pay for generic drugs, $2 for preferred drugs and 5% coinsurance for non-preferred drugs; $225 annual out-of-pocket maximum for prescription drugs; and $225 annual

1330 G Street, NW, Washington, DC 20005
Phone: (202) 347-5270, Fax: (202) 347-5274
www.kff.org/kcmu

out-of-pocket maximum for medical services.[2] There are no co-pays for preventive services and mandatory children and pregnant women are exempt from cost sharing.

The plan also includes new benefit limits, including a limit of four prescription drugs per month and 15 occupational or physical therapy visits per year. None of the limits are hard limits; services beyond these limits may be approved through a prior authorization process. Currently, Kentucky Medicaid has very few limits on services.

The plan includes premium assistance for individuals to enroll in employer sponsored coverage. KYHealth Choices allows individuals to voluntarily choose to receive a subsidy for employer sponsored coverage (ESI) rather than direct coverage. Individuals can choose any plan that meets the state employee plan benchmark, but the state determines if the coverage meets "economy and efficiency" criteria. There is no wraparound coverage but individuals may move back to direct coverage at any time.

The plan includes an emphasis on disease management and incentives to adopt healthy behaviors. Individuals can earn "Get Healthy Benefits" after one year of compliance with a disease management program. The state will offer disease management programs for diabetes, adult and pediatric asthma, pediatric obesity, and cardiac or heart failure care. These benefits can be used for additional dental and vision services (up to $50) or nutritional or smoking cessation counseling. After selecting their benefit, individuals have six months to access it. An individual loses Get Healthy Benefits if he or she loses Medicaid eligibility.

Kentucky plans to offer individual budget plans to individuals needing long term services. The state will offer new Consumer Directed Options (CDO) for individuals who qualify for Optimum and Comprehensive Choices plans. CDO services are non-traditional Medicaid services, such as minor home adaptations to enable individuals to remain in their home. Kentucky also has plans, which require an 1115 waiver, to expand self-direction options and alternative community living options.

Key Questions

How will the changes in benefits and cost sharing affect beneficiaries? The state anticipates that the most immediate effect on beneficiaries will be due to increased cost sharing requirements. For many, this will be the first time that they will face copayments in Medicaid. Research shows that premiums and cost sharing can create barriers to coverage, reduce the use of essential services and increase financial strain on low-income families.[3] The DRA caps out-of-pocket spending for cost sharing and premiums at five percent of monthly or quarterly income for a family. It is not clear how these out-of-pocket limits will relate to the annual caps for the KYHealth Choices plan (i.e. $225 for drugs and $225 for medical services).

Although the state maintains that the new benefit limits will be soft, the ability to get care beyond the limits will depend on the ease and speed of the prior authorization process as well as patient / provider awareness of the ability to access these services. Cost sharing and benefit limits tend to have the greatest impact on those who need many medical services.

How will the new benefit packages interact with children's right to EPSDT benefits? The Family Choices plan covers most children. The state is required to continue to provide Medicaid children EPSDT benefits, which are intended to guarantee children access to all medically necessary care. It is unclear how EPSDT benefits will interact with the new benefit limits in this plan. Families will need to be educated about their right to EPSDT benefits and how to access them.

How will long term care changes affect beneficiaries? The goals of the long-term care redesign efforts are to provide members with expanded choices and equal access to institutional and community based long-term care options. Under the new plan, only individuals with "high intensity" needs are guaranteed nursing facility services. It is unclear whether the level of community services will meet individual long-term care needs. The state lists only case management as a required service to elderly and disabled beneficiaries in the "Basic" tier. There is little information about how beneficiaries can move between levels of care when needs change.

Will the state achieve its stated goals? Two key goals that the state has are to improve health status and to save money. Measuring changes in health status, especially in the near term, will require careful evaluation and selection of performance measures. The state also is seeking to save about $120 million in the first year and up to $1 billion over the next seven years. The individuals enrolled in global choices and family choices are already relatively low cost populations, so the ability to achieve savings is likely to come more from the populations utilizing long-term care services. Evaluation will be needed to ensure that saving money does not come at the expense of individuals losing access to needed care and services.

Conclusion

KYHealth Choices represents a significant change in the benefit structure for most of Kentucky's Medicaid population and imposes new cost sharing requirements along with new benefit limits. The plan also seeks to emphasize disease management and premium assistance. The overall goals of the plan are to improve health status and reduce Medicaid spending, but the ultimate impact on the adequacy and affordability of Medicaid for the program's beneficiaries are largely unknown. Given the significance of the changes, they should be closely monitored and evaluated.

For additional copies of this publication (#7530), please visit www.kff.org/kcmu.

[1] KYHealth Choices: Governor Fletcher's Medicaid Reform Initiative. Slide Presentation.
[2] Ibid
[3] Health Insurance Premiums and Cost Sharing: Finding from the Research on Low-Income Populations. KCMU, March 2003.

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.