



QUESTIONS FOR ACS EVALUATIVE FRAMEWORK FOR ASSESSING PROPOSALS FOR CHANGE IN THE MEDICAID PROGRAM

ACS has developed a tool to assist ACS staff and volunteers in evaluating health care reform issues at the national, state, and local levels. The tool examines four criteria related to availability, affordability, adequacy of coverage, and administrative simplicity. It can be tailored to evaluate specific program features and questions that are relevant to any particular type of coverage.

The questions in this Evaluative Framework are designed to illustrate the kinds of inquiries and analyses related to proposed changes in state Medicaid programs that should be considered in determining whether ACS should take a position on these proposals. Since the passage of the Deficit Reduction Act of 2005, states have had more flexibility in how they design and operate their Medicaid programs; many are considering significant modifications to Medicaid, often in response to fiscal pressures. Although the questions in this evaluative tool are far from exhaustive, they reasonably cover the spectrum of major issues that are likely to arise as Divisions learn about the Medicaid programs in their regions, seek opportunities to strengthen the programs, or evaluate proposals that would fundamentally alter the Medicaid program.

PRINCIPLES ON WHAT CONSTITUTES MEANINGFUL HEALTH INSURANCE

Statement of Principles

It is a fundamental principle of the American Cancer Society that everyone should have meaningful public or private health insurance.

Meaningful health insurance is adequate, affordable, available and administratively simple.

Adequate health insurance means:

- ✓ *timely access and coverage of the complete continuum of quality, evidence-based healthcare services (i.e., rational, science-based, patient-centered), including prevention and early detection, diagnosis, and treatment*
- ✓ *supportive services should be available as appropriate, including access to clinical trials, chronic disease management, and palliative care*
- ✓ *coverage with sufficient annual and lifetime benefits to cover catastrophic expenditures*

Available health insurance means:

- ✓ *coverage will be available regardless of health status, or claims history*
- ✓ *policies are renewable*
- ✓ *coverage is continuous*

Affordable health insurance means:

- ✓ *costs, including premiums, deductibles, co-pays, and total out-of-pocket expenditure limits, are not excessive and are based on the family's or individual's ability to pay*
- ✓ *premium pricing is not based on health status or claims experience*

Administratively simple health insurance means:

- ✓ *clear, up-front explanations of covered benefits, financial liability, billing procedures, and processes for filing claims, grievances, and appeals are easily understood and timely, and required forms are readily comprehensible by consumers, providers and regulators*
- ✓ *consumers can reasonably compare and contrast the different health insurance plans available and can navigate health insurance transactions and transitions*

AN INTRODUCTION TO THE MEDICAID PROGRAM

Medicaid is a public health insurance program that provides free or low-cost health and long-term care coverage to certain categories of low-income Americans.¹ The program is jointly financed and administered by the federal and state governments. As a condition of receiving federal funds, all states must cover certain groups or categories of people, called “mandatory” populations and they must provide certain “mandatory” benefits for most individuals. States may expand their Medicaid programs by choosing to cover “optional” populations or by providing “optional” benefits.²

States have always had flexibility to determine the amount, duration and scope of the Medicaid services they provide, but have been required to offer all covered benefits or services to all beneficiaries statewide when they are medically necessary.

In recent years, a number of states have used “Section 1115” waivers, to make changes in core elements of the Medicaid program. The Deficit Reduction Act of 2005 (DRA) gave states even more flexibility to make changes without having to request a waiver. Within certain limits, the DRA now allows states to:

- Replace the Medicaid benefit package for certain groups with “benchmark” coverage and to offer different plans to different groups of people.
- Charge copayments to most beneficiaries (In addition, providers can now deny services if beneficiaries do not make copayments).
- Charge premiums to beneficiaries with family incomes greater than 150 percent of the federal poverty level.
- Vary cost-sharing across beneficiary groups and areas of the state.

In a number of states that have made significant changes to their Medicaid programs, coverage has become more like that found in the private marketplace. Also, as the proportion of Medicaid beneficiaries enrolled in managed care plans has increased (to about two-thirds of beneficiaries in 2006), more beneficiaries are subject to plan rules and procedures.

Children are less likely to be affected by plans to restructure Medicaid because protections for children are much stronger than for adults. Financial eligibility limits for children generally are much higher, and states must provide a comprehensive benefit package for children known as the Early Periodic Screening, Diagnostic and Treatment benefit (EPSDT).

Some administrative features of the Medicaid program over which states have control – the application and enrollment processes and the procedures for appealing program

¹ This evaluative tool pertains to Medicaid coverage for acute, but not for long-term care services provided in nursing homes or in the community.

² State Medicaid programs also are mandated to provide coverage to targeted groups of beneficiaries such as certain women diagnosed with breast and cervical cancer under federal the BCCPTA program.



decisions – also affect the adequacy and availability of coverage, and the administrative simplicity of obtaining and keeping coverage.



ACS CAN Evaluative Framework for Assessing Proposals for Changes in the Medicaid Program

	Issue	Questions	Examples	
			Helpful policies and practices	Policies and practices of concern
Availability				
1	Eligibility-categorical	In addition to the "mandatory" groups, which "optional" or other categories of beneficiaries are covered?	Coverage of: <ul style="list-style-type: none"> Pregnant women, children and parents with income exceeding the mandatory thresholds "Medically Needy" individuals Childless adults 	
2	Eligibility – financial	For each group that is categorically eligible, <ul style="list-style-type: none"> What are the income criteria? What are the resource criteria? 	<ul style="list-style-type: none"> Increase income limits above the mandatory thresholds Eliminate, increase, or index resource limits Spend-down/buy-in programs 	
3	Application process	Is the application process reasonable or cumbersome?	<ul style="list-style-type: none"> Applications can be submitted by mail, phone, or online. Self-declaration of income allowed Existing information from other program records (income, citizenship, etc) is used for the application Application and materials are short, simple, and can be understood by a typical beneficiary Application materials available in languages other than English Assistance in person or by telephone 	<ul style="list-style-type: none"> Face-to-face interviews required
4	Enrollment process	Is the enrollment process timely?	<ul style="list-style-type: none"> Expedited enrollment Presumptive eligibility 	<ul style="list-style-type: none"> Enrollment determination is lengthy Mandatory waiting periods, no exceptions based on health status
5	Enrollment capacity	Is coverage guaranteed for those who are categorically and financially eligible?		<ul style="list-style-type: none"> Caps on enrollment Global spending caps (VT waiver) Waiting lists Specified number of "slots" in for waivers
6	Renewal process	Is the renewal process reasonable or cumbersome?	<ul style="list-style-type: none"> Passive renewal 	<ul style="list-style-type: none"> Renewal required more frequently than



Issue	Questions	Examples
		<p>Helpful policies and practices</p> <ul style="list-style-type: none"> Existing information from other program records (income, citizenship, program participation, etc) is used at the time of renewal Also online, phone, mail renewal <p>Policies and practices of concern</p> <p>annually</p>
Affordability		
1 Premiums	Are premiums charged?	<ul style="list-style-type: none"> Premiums not charged
2 Premiums – Payment options	Are there options for making premium payments?	<ul style="list-style-type: none"> Multiple payment options, including monthly, annual, periodic, etc. Payment through payroll deduction Option for debit card or online payment
3 Premiums – Cash flow	Is there a grace period for late payments?	<ul style="list-style-type: none"> > required 60-day grace period Premium invoices, late payment reminders
4 Cost sharing	What cost sharing applies?	<ul style="list-style-type: none"> No cost-sharing for services and preferred drugs for “mandatory” children and pregnant women or for preventive services for children, pregnancy-related services or emergency services (DRA requirement)
	What co-pays apply?	<ul style="list-style-type: none"> No exemptions from cost-sharing for non-preferred prescription drugs. Families with incomes above 150% FPL could face copayments up to 20%. Services can be denied at point of service if co-payment is not made
	Is there a limit on cost sharing?	<ul style="list-style-type: none"> Total cost-sharing and premium amounts cannot exceed five percent of a family’s income over a one-month or quarterly time period.
Adequacy		
1 Covered benefits	Are “mandatory” services covered?	<ul style="list-style-type: none"> “Benchmark” plans replace traditional package of mandatory services and are more restrictive Adequacy of benefit package, particularly



Issue	Questions	Examples	
		Helpful policies and practices	Policies and practices of concern for individuals with above-average needs (i.e., case management)
	Are certain "optional" services covered?	<ul style="list-style-type: none"> • Prescription drugs • Coverage of off-label use of drugs • Mental health services • Case management • Key cancer prevention, early detection, diagnosis, treatment including clinical trials, and palliative care services • Cessation counseling and medications • Defined benefit approach 	
	Are enrollees guaranteed a particular scope of benefits?		<ul style="list-style-type: none"> • Change to a defined contribution approach (FL waiver for acute care)
	Are all services offered for all coverage groups?		<ul style="list-style-type: none"> • Tiered benefits based on health status with more benefits available for "less healthy" and less for "healthier" enrollees (DRA: ID, KY) • Tiered benefits based on health behavior with "enhanced" benefits available for enrollees who comply with requirements (DRA: WV) • Tier to which women with breast and cervical cancer, others with cancer are assigned • Ease and speed of movement to another tier when health status changes • Certain services not offered to certain tiers (Mental health and diabetes for WV Basic Plan) • Beneficiaries excluded from coverage for certain behaviors (12-month waiting period to re-sign member agreement and re-enroll in an enhanced plan after failing to comply with plan requirements-WV)
2	Benefit limits	<ul style="list-style-type: none"> • Open formulary • Formulary exceptions process for 	<ul style="list-style-type: none"> • Annual benefit limit • Lifetime limit • Number of prescriptions per month limited • Limited preferred drug lists
	Are there limits on the total amount of benefits that will be covered?		
	Are there limits on prescriptions?		

Issue	Questions	Examples	
		Helpful policies and practices	Policies and practices of concern
		medically necessary drugs	<ul style="list-style-type: none"> Generic-only policy Restrictions on pain medications
	Are there other benefit-specific limits?		<ul style="list-style-type: none"> Limits on number of treatments, office visits, etc.
4	Is coverage restricted to a network of providers that includes sufficient number, geographic distribution of cancer specialists? Can patients reasonably seek out-of-network care if necessary?		<ul style="list-style-type: none"> Provider reimbursement is not sufficient to attract adequate numbers of providers
	Can patients reasonably seek out-of-network care if necessary?		<ul style="list-style-type: none"> No out-of-network coverage
5	Is prior authorization required for hospitalization, surgery, or other care?	<ul style="list-style-type: none"> Authorization process is timely, straightforward 	<ul style="list-style-type: none"> Burdensome prior authorization procedures Plan not responsive to request for prior authorization Protocols for approving care proprietary, not disclosed
6	Can beneficiaries readily discern what services are covered or how much they have to pay?	<ul style="list-style-type: none"> Plan materials include examples to illustrate how coverage works Plan materials are written in simple language and include appropriate illustrations Translations are available, easy to obtain 	<ul style="list-style-type: none"> "Fine print" or vague contract language limits coverage Formularies, care authorization rules are unpublished Directory of network providers is unpublished or out of date
Administrative Simplicity			
1	Public awareness Is there effective outreach to make general public/target populations aware of coverage?	<ul style="list-style-type: none"> Plan/program advertises widely Hotline available to answer questions Providers and community organizations help recruit beneficiaries. 	<ul style="list-style-type: none"> No information on Internet Outreach materials not available in languages other than English
2	Ease/transparency of procedures to use coverage effectively How transparent is the availability, affordability, and adequacy of coverage (see above) for beneficiaries?	<ul style="list-style-type: none"> Requirements that applications and plan descriptions be written in clear, concise language Access to a live operator/staff to help explain benefits Plan materials are written in simple language and include appropriate illustrations Translations are available, easy to obtain 	<ul style="list-style-type: none"> Materials not available in languages other than English

	Issue	Questions	Examples	
			Helpful policies and practices	Policies and practices of concern
3	Plan assignment	How is the assignment to managed care plans accomplished and explained?	<ul style="list-style-type: none"> Information is easily available and accessible to beneficiaries Member services representatives meet with new members Attempts to reassign beneficiaries to the same plan after break in coverage Simple, established, publicized methods for switching plans 	
4	Grievances and appeals	<p>Are the processes for filing grievances, and appeals easily understood and decisions are timely?</p> <p>Are beneficiaries aware that some benefit limits are "soft" limits that can be appealed?</p>	<ul style="list-style-type: none"> Required forms are simple and may be easily completed Information is easily available and accessible to beneficiaries and providers Process to request exception to limits is simple and quick 	<ul style="list-style-type: none"> Notice in legalese, fine print Decisions are lengthy and time-consuming
		<p>Do beneficiaries understand agreements that they are asked to sign regarding behavior?</p> <p>Is there an established process to appeal determinations of change in coverage tiers because of failure to meet responsibilities for behavior? (WV)</p>	<ul style="list-style-type: none"> Counselors are available to assist beneficiaries Process to appeal a determination is well publicized Process to appeal a determination to limits is simple and quick 	

Appendix – Glossary

- **Benchmark coverage:** The DRA allows states to replace the Medicaid benefit package for certain groups of beneficiaries with “benchmark” coverage that includes: the standard Blue Cross Blue Shield Plan offered under the Federal Employee Health benefits Plan, health coverage for state employees, health coverage offered by the largest commercial HMO in the state, or “Secretary-approved” coverage, coverage that the Secretary of the Department of Health and Human Services determines is appropriate for a population.
- **EPSDT:** The *Early Periodic Screening, Diagnostic and Treatment* benefit is a comprehensive benefit package that, under federal law, must be provided to children with Medicaid coverage.
- **Co-Pay:** A type of cost sharing that imposes a flat dollar amount (for example, \$10 or \$25) of the cost that patients must pay at the time of service. Co-pays are often charged per office visit or per prescription, but may also be required for other services, including emergency room care or hospital care.
- **Cost Sharing:** Any out-of-pocket payment the patient makes for a portion of the costs of covered services. Different forms of cost sharing include deductibles, co-insurance, and co-payments.
- **Defined benefit:** Coverage is available for a certain set and scope of benefits, regardless of cost.
- **Defined contribution:** Coverage is available only up to a pre-determined level of spending for each person.
- **Formulary:** List of preferred pharmaceutical products – generic and brand name – to be used by a managed care plan’s network physicians. Formularies are based on evaluations of the efficacy, safety, and cost effectiveness. Insurers may not cover drugs that are not listed on the formulary, or they may cover such “non-preferred” drugs at a lower level.
- **FPL:** *Federal Poverty Level*; The amount of income determined by the federal Department of Health & Human Services to provide a bare minimum for food, clothing, transportation, shelter, and other necessities. FPL is reported annually and varies according to family size. *The 2007 HHS Poverty Guidelines* are available at: <http://aspe.hhs.gov/poverty/07poverty.shtml>.
- **Mandatory benefits:** In order to receive federal matching funds, state Medicaid programs must cover certain “mandatory” benefits or services such as physician, hospital, and laboratory services.

- **Mandatory populations:** In order to receive federal matching funds, state Medicaid programs must cover certain “mandatory” populations, including pregnant women and children with family income below 133% FPL; children age 6-18 with family income below 100% FPL; parents with income below states’ July 1996 welfare eligibility levels; and most elderly individuals and individuals with disabilities receiving Supplemental Security Income benefits.
- **Medically Needy:** The “medically needy” comprise a category of Medicaid beneficiaries who have high health expenses relative to their income. In states that cover the medically needy, individuals may qualify for Medicaid by deducting their medical expenses from their income to bring their net income below the state’s “medically needy income level.”
- **Optional benefits:** States can receive federal matching funds for certain specified optional Medicaid services such as prescription drugs, dental and vision services, physical therapy and rehab services, or hospice services.
- **Optional populations:** Optional eligibility groups that can be covered under Medicaid include pregnant women, children, and parents with income greater than the mandatory thresholds; elderly individuals and individuals with disabilities up to 100% FPL; and the “medically needy.”
- **Premium:** The cost of health plan coverage, not including any required deductibles or co-payments.
- **Presumptive eligibility:** Presumptive eligibility provides children immediate access to health services by giving them temporary health insurance through Medicaid or SCHIP if they appear to be eligible. The eligibility generally lasts 60 days while an application is reviewed.
- **Section 1115 waivers:** allow states, with federal approval, to use federal funds in ways that do not conform to federal rules. They have been used over the course of the program to demonstrate new ways to provide coverage and deliver services. In some instances states have expanded coverage to new groups of beneficiaries. In others the waivers have been used to reduce coverage or shift some responsibilities to beneficiaries in an effort to relieve state fiscal pressures.
- **Tiered benefits:** Different benefit packages are provided for different groups of enrollees who are divided on the basis of health status, health behavior, or other factors.