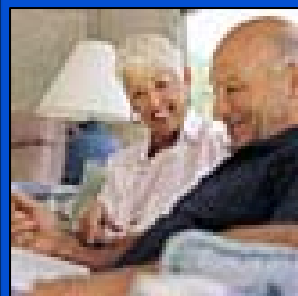


The Deficit Reduction Act: An Overview



June 13, 2007

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The DRA

- The Deficit Reduction Act is the most sweeping Medicaid legislation passed in decades
- The opportunities for states to transform their Medicaid programs abound due to a recognition of the need to streamline the reform process

Pre-DRA Medicaid

- One size fits all model
- Statewide approach only
- Little to no consumer involvement
- Focused on providing episodic and acute care
- Managed care and demonstrations only through cumbersome waiver process

Post DRA Medicaid

- Recognizes differences in populations and geography
- Seeks consumer awareness and involvement
- Focuses on long term health solutions such as disease and case management
- Allows implementation through state plan amendment process

DRA Medicaid Goals

States need flexibility in order to serve the needs of the unique groups in the Medicaid program. The new options allow states to:

1. **Expand access to affordable mainstream coverage**
2. **Promote personal responsibility for health and in accessing health care**
3. **Improve quality and cost effective coordination of care**

Expanding Coverage

- Benchmark plans
 - Flexible benefit packages like those in private sector
 - Able to mandate for non-disabled, non-elderly populations
 - Provides “wrap around” for services like EPSDT
- Premium assistance with employer sponsored health insurance
 - Allows states to draw down Medicaid money to pay a portion of employer sponsored premiums
- Develop high risk pools with Seed and Operational Grants
 - To allow states to develop programs like KY Access

Personal Responsibility

- Income based cost-sharing
 - Copayments and coinsurance amounts now able to exceed “nominal”
 - 100-150% FPL- no premiums, but cost sharing of up to 10% of the service cost
 - Above 150% FPL- premiums permitted and cost sharing of up to 20% of the service cost
 - All cost sharing cannot exceed 5% of the family’s income
- Health Opportunity Accounts and other incentives
 - HOA is a 10 state demonstration to allow flexible consumer based accounts
 - Kentucky is testing the incentive arena with Get Healthy Benefits

Quality and Coordination

- Expand services through managed care
 - Waivers are no longer necessary
- Realign prescription drug prices
 - Feds will lower drug spending by limiting payment for drugs to the Federal Upper Limit in the aggregate to 250% of the Average Manufacturer's Price
 - Reimbursement can be targeted to local pharmacies
- Implement disease and case management
 - Implement evidence based medical guidelines
 - Support members with chronic conditions through education and provider coordination
- “E-prescribing”
 - Reduces medical errors and prescription duplication

DRA Long Term Care Goals

With the changing landscape of long term care, states need to be able to keep pace with where society is seeking services. The DRA focuses on three main priorities in this arena:

- 1. Expand coverage for individuals with disabilities**
- 2. Increase access to community supports**
- 3. Promote personal responsibility, independence, and choice**

Individuals with Disabilities

- Expand coverage by:
 - Allowing families with disabled children to purchase Medicaid
 - Create coverage options for the working disabled
 - Help individuals with disabilities remain independent and enter the workforce

Increase Community Supports

- Seek ways, such as grants, to “rebalance” the long term care system
- Use grants and demonstration projects to create enhanced community living opportunities like community alternatives to PRTF’s for children
- Offer HCBW services without a waiver

Promote Choice and Independence

- Offer self-directed personal care services without a waiver
- Participate in the State Long-Term Care Partnership Program
 - Allows states to provide long term care insurance
- Focus on those at risk of becoming nursing home level of care (1/07)

State Buzzwords

- In evaluating how to approach this newfound flexibility it is important to know the key concepts on the minds of today's Medicaid agencies such as:
 - Personal Responsibility
 - Consumerism
 - Health Status
 - eHealth

Personal Responsibility

- States want their recipients to be engaged participants in the health care system
- Managed care has successfully shifted behavior through financial consequences (both positive and negative)
- The government is betting on the fact that recipients will choose the most cost effective options for care
- Thus, we will likely see cost sharing for services like 3rd tier drugs in the hopes that utilization will shift to 1st and 2nd tier options

Consumerism

- Consumerism, once just a term in the private sector, has crept into the vocabulary of the state and federal government
- The addition of flexible spending account/HRA/HSA options is a key part of many state Medicaid reform plans and is recognized in the DRA under the “HOA” demonstration projects
- Additionally, the goal of the cost sharing provisions dovetail into the move toward consumerism by having members evaluate their care options (PCP v. ER) based on cost implications

Health Status

- With the growth of the SSI population and the elderly, Medicaid now has more recipients who will be on the plan for the long haul
- Thus, states are now looking to disease and case management programs to control the rate of growth over time through improving the health of these populations

eHealth

- States are looking to technology to reduce costs and improve quality
- Provider information such as patient summaries (Rx data is a must) and e-prescribing are the hottest items in this arena
- eHealth tools for the consumer such as cost and quality data and on-line disease and case management functions are also garnering quite a bit of attention

The Deficit Reduction Act

Focus on Waste, Fraud & Abuse

Dramatic Changes for Medicaid

- “With these changes, you’re either on the wave of change or under it” *Brian Flood. Esq. Inspector General for the State of Texas Health & Human Services*
- “Implementing the Medicaid Integrity Program... gives CMS the unique opportunity to provide leadership to states and law enforcement in their fraud, waste, and abuse control efforts.” *Leslie G. Aronovitz Director, Health Care, United States Government Accountability Office*

The Budget Buster

- Medicaid is the largest health insurance program in the United States
- The Federal contribution for FY 2004 was \$176 billion and is expected to exceed \$193 billion in FY 2007
- In FY 2004 Medicaid covered 43.7 recipients and is expected to go over 46 million in FY 2007
- DRA goal is to reduce spending by \$11 billion in five years

What is a billion

- A billion seconds ago Harry Truman was president
- A billion minutes ago was just after the time of Christ
- A billion hours ago man had not yet walked on the earth
- A billion dollars ago was late yesterday at the U.S. Treasury

State Incentives

- Increase states interest in uncovering Waste, Fraud and Abuse by rewarding the state's with 10% of the funds recovered
- States must pass Legislation in order to participate in the recovery

Legislative Requirements

- Establish liability to the state for false or fraudulent claims as described in the federal False Claims Act
- Contain provisions that are at least as effective in rewarding and facilitating *qui tam* (*whistle blower*) actions as those in the federal False Claims Act
- Contain a requirement for filing action under seal for 60 days with review by the state's attorney general
- Contain a civil penalty not less than the amount authorized by the federal False Claims Act
- Contain provisions that are designed to prevent a windfall recovery for "whistle blowers" that file both a state and federal action for the same fraudulent claim

Federal False Claims Act

31 USC 3279

- Original legislation was signed by President Lincoln to curtail fraud amongst civil war contractors
- Federal statute covers fraud involving any federally funded contract or program and establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment

The Purpose of the Law

- “Laws are partly formed for the sake of good men, in order to instruct them how they may live on friendly terms with one another, and partly for the sake of those who refuse to be instructed, whose spirit cannot be subdued, or softened, or hindered from plunging into evil.”

Plato (427 BC – 347 BC)

Whistle Blower “Qui Tam” Action

- Encourages people to come forward and report misconduct
- Allows a person (relator) to file a lawsuit on behalf of the U.S. government
 - The law suit must be filed in a federal district court
 - If the government intervenes the prosecution of the lawsuit will be directed by the U.S. Department of Justice (DOJ)

Whistle Blower Protection

- If fired, demoted, threatened or harassed or discriminated against in any way in terms of employment the “whistle blower” is eligible to recover all relief necessary to make them whole which includes:
 - Reinstatement
 - Two times back pay plus interest
 - Emotional Distress Damages
 - Cost of Attorney Fees
 - 15% - 30% of the recovery

States With False Claims Act Legislation

Arkansas	Ark. Stat. §§ 20-77-901 et seq
California	Cal. Gov't Code §§ 12650 et seq.
Colorado	Rev. Stat. §§ 25.5-4-304 & 305 (previously codified at Colo. Rev. Stat. §§ 26-4 1101 et seq.) S-06-219 65th Leg., 2d Spec. Sess. (Colo. 2006)
Delaware	Del. Code Ann. tit. 6, §§ 1201 et seq.
District of Columbia	D.C. Code Ann. §§ 2-308.13 et seq.

States With False Claims Act Legislation

Florida	Fla. Stat. §§ 68.081 et seq. (2000) Fla. Stat. § 112.3187 Fla. Stat. § 409.920 Fla. Stat. § 409.9201 Fla. Stat. § 409.913 Fla. Stat. § 414.39 Fla. Stat. § 775.082 Fla. Stat. § 812.035 Fla. Stat. § 817.155 Fla. Stat. § 837.06 Fla. Admin. Code Ann. r. 59G-9.070
Hawaii	Haw. Rev. Stat. §§ 661-21 et seq.

States With False Claims Act Legislation

Illinois	740 Ill. Comp. Stat. Ann. §§ 175/1 et seq.
Indiana	Ind. Code §§ 5-11-5.5 et seq.
Louisiana	La. Rev. Stat. Ann. §§ 46:439.1 et seq.
Massachusetts	Mass. Ann. Laws Ch. 12, §5(A)-(O)
Michigan	Mich. Comp. Laws Ann. §§ 400.601 et seq.

States With False Claims Act Legislation

Montana	Mont. Code Ann. §§ 17-8-401 et seq.
Nevada	Nev. Rev. Stat. §§ 357.010 et seq.
New Hampshire	N.H. Rev. Stat §§ 167:58 et seq.
New Mexico	N.M Stat. Ann. §§ 27-14-1 et seq.
Tennessee	Tenn. Code. Ann. §§ 4-18-101 et seq. Tenn. Code. Ann. §§ 71-5-181 et seq.

States With False Claims Act Legislation

Texas	Tex. Hum. Res. Code § 32.039 Tex. Hum. Res. Code. §§ 36-001 et seq.
Virginia	Va. Code Ann. §§ 8.01-216.1 et seq.

Company Penalties

- Companies that defraud the government are subject to treble damages and civil monetary penalties ranging from \$5,000 to \$11,000 for each false claim
- In addition, companies can be required to pay three times the amount of damages sustained by the government

Examples of Medicaid Fraud

- Double Billing for items or services
- Billing for undocumented services
- Billing for services not rendered
- Billing for medically unnecessary services
- Making false statements
- Participating in kickbacks
- Including improper entries on cost reports
- Assigning incorrect codes to secure higher payment

Recent False Claims Act Cases

- East Tennessee Heart Consultants
- All Medical Solutions, Inc (Florida)
- Maryland Psychiatrist

Vender Responsibility

- Any company receiving \$5 million or more must educate their employees
- The company must establish written policies for all employees (including management) and any contractors or agents about the False Claims Act and any applicable state laws in preventing and detecting fraud, waste or abuse in any federal health care program.
- The company must also include details on their policies for detecting and preventing waste, fraud and abuse
- These policies must also be in the companies' employee handbook

Companies Concerns

- Honest mistakes could result in charges
- Could encourage frivolous reports
- Increased education and training requirements
- Development of written policies if not already established

Medicaid Integrity Program

- First national strategy to detect waste, fraud & abuse
- Budget Increases
 - \$5 million in FY 2006
 - \$50 million in FY 2007 & 2008
 - \$75 million thereafter
- Staff Increases
 - Hire an additional 100 full time equivalent employees

Medicaid Integrity Program

- The Medicaid Integrity Program is to:
 - Review the actions of those providing Medicaid services.
 - Provide support and assistance to the States to combat Medicaid fraud, waste, and abuse.

Medicaid Integrity Program Principles

- National leadership in Medicaid program integrity.
- Accountability for its own activities and those of its contractors and States.
- Collaboration with internal and external partners and stakeholders.
- Flexibility to address the ever-changing nature of Medicaid fraud.

Medicaid Integrity Program Functions

- Creation of the Comprehensive Medicaid Integrity Plan in consultation with internal and external partners to guide CMS' efforts.
- Procurement and oversight of Medicaid Integrity Contractors who will conduct reviews, audits, and education.
- Field Operations to conduct state program integrity oversight reviews and provide training and technical assistance to States.
- Fraud Research & Detection to provide statistical data support, identify emerging fraud trends and conduct special studies.

Medicaid Integrity Program Contractor's Functions

- review of actions of those seeking payment from State Medicaid plans;
- the audit of those claims;
- the identification of overpayments related to those claims; and
- the education of providers and others with respect to payment integrity and quality of care.

Medicare – Medicaid Data Match Project (Medi-Medi)

- Matching Medicare and Medicaid claims data to find patterns of fraud which would be undetectable in the programs individually
- Increased funding
- Through FY 2005, Medi-Medi has resulted in the initiation of 335 investigations and 42 referrals to law enforcement.
- Fifteen million four hundred thousand dollars (\$15.4 million) in overpayments have either been denied or identified.

Summary of State DRA Reform Plans:

- Kentucky
- West Virginia
 - Idaho

Kentucky

- Kentucky was the first state to gain approval for a DRA reform plan, KyHealth Choices
- The plan design focuses on benefit packages based on population, targeted disease and case management, community based services and creating consumerism in Medicaid

West Virginia

- Later on the same day of KY's approval, WV launched their DRA reform initiative
- WV will require recipients to sign a Medicaid Member Agreement which requires a commitment to staying healthy and using appropriate care settings
- If members comply, they receive services through the “**Enhanced Plan**” if not members are given a lesser benefit “**Basic Plan**”

Idaho

- Medicaid will have three plans to meet different health needs:
- The **Medicaid Basic Plan** is for low-income children and adults with eligible dependent children.
- The **Medicaid Enhanced Plan** is for individuals with disabilities or special health needs.
- Coming later this year, the **Medicare-Medicaid Coordinated Plan** is for participants who are eligible for both Medicare and Medicaid and are enrolled in certain Medicare Advantage Plans.

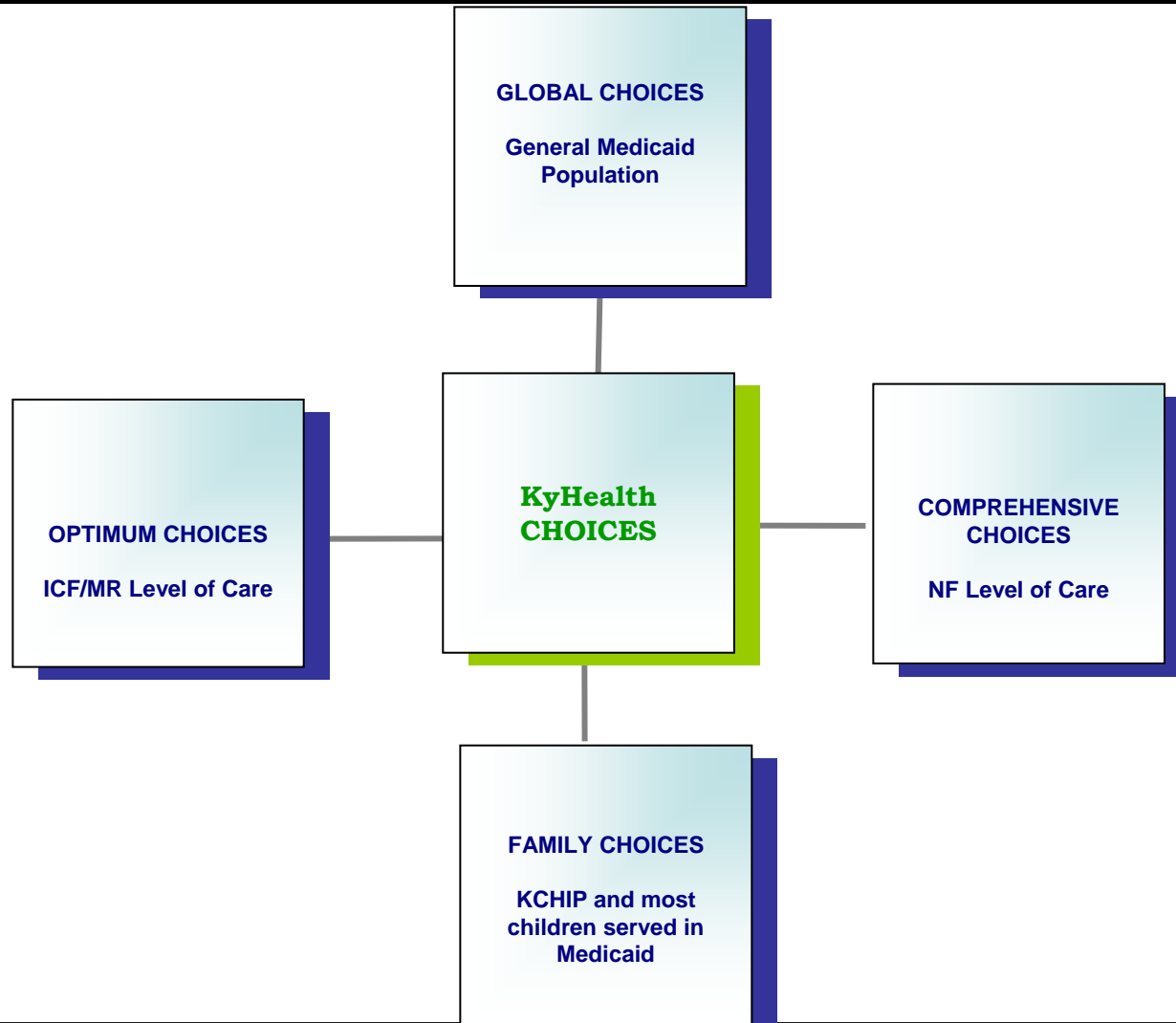
KyHealth Choices Vision

- Improve the health status of those Kentuckians enrolled in the program
- Ensure people receive the right care, in the right setting, at the right time
- Ensure the solvency of Kentucky Medicaid for future generations of Kentuckians
- Transform Kentucky's Medicaid into a 21st Century Health Care System

KyHealth Choices...

- Eliminates the one-size fits all approach to Medicaid
- Utilizes best practices from the commercial health insurance market
- Improves the quality of care delivered to our members
- Empowers members to be active participants in their own healthcare
- Enables the Commonwealth to sustain the Medicaid program through a substantial reduction in the projected rate of growth

Targeted Benefit Plans



Populations By Plan:

- **Global Choices** (235,000 members) will cover the general Medicaid population program including foster children and medically fragile children.
- **Family Choices** (263,000 members) will cover most children including the SCHIP children. *May be bid to the commercial insurance market
- **Optimum Choices** (3,500 members) covers individuals with mental retardation and developmental disabilities in need of long term care.
- **Comprehensive Choices** (27,900 members) covers individuals who are elderly and in need of a nursing facility level of care and also individuals with acquired brain injuries.

Plan Features

Member Involvement - Members will be encouraged to participate in prevention and disease management programs

▪ **Cost Sharing** - Most members enrolled in **KyHealth Choices** will be required to share in the cost of many of the covered services

▪ **Service Limits** - Some services and prescriptions have limits. For example, prescription medicines are limited to a total of four per month.

▪ **Self-Directed Services** - Through Consumer Directed Options (CDO) and our Self-Determination Pilot, Kentucky residents enrolled in our long term care plans will be afforded the option to control and direct Medicaid funds through an individual budget.

▪ **Get Healthy Accounts** - Get Healthy Accounts will be established to provide incentives to Medicaid members for healthy behaviors.

Now....

**What does the DRA mean
for managed care?**

Managed Care's Role

- Clearly the DRA is focused on creating opportunities to improve the health of the Medicaid population while controlling costs
- Managed care models have been very successful in achieving these outcomes, so government is now looking to benefit from those strategies

Opportunities

- Benchmark plans, optional benefit plans, disease and case management programs, and health opportunity accounts are all options for managed care plans to partner with states
- In the long term care arena, the ability to provide HCBW services without a waiver and the provision that allows states to create plans to assist those at-risk of becoming nursing facility level of care are tremendous possibilities for MCO partnership

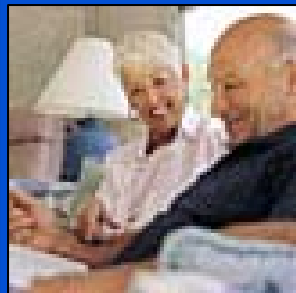
Evaluation

- Overall, the DRA recognizes many of the benefits of a managed care model
- States will have the opportunity to offer many services without the hoops associated with the current waiver process
- In order to maximize these opportunities, states and MCO's must be willing to develop models that move away from the traditional Medicaid service plans
- The focus must be on improved health outcomes; trend and cost reductions will naturally follow

FOR MORE INFORMATION

www.consultingstrategiesteam.com

Presented In Cooperation With
Passport – United Health Care



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