Urgent Issues: Medicaid Transportation

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TABLE 28
Fiscal 2011 Budgetary Actions Aimed at Containing Medicaid Costs

Reducefreeze
Other Strategies
to provide
eliminate
providers
prescription
spending
Region/State
payments
benefits
expansions
drugs
Alabama X
Alaska * X X
Arizona X X XX
Arkansas XX
California X XX
Colorado XX X
Connecticut XX X
Delaware X
Florida
Georgia X
Hawaii X XX X X
Idaho XX X
Illinois X X
Indiana XX
Iowa *
Kansas
Kentucky X
Louisiana * XX XXX X
Maine X X
Maryland* XX X X
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Michigan
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Missouri* XX X X
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Nebraska *
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New Hampshire XX
New Jersey XX XX
New Mexico X XX X X
New York
North Carolina * X XX
North Dakota
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Oregon X XX
Pennsylvania X X
Rhode Island XX
South Carolina XX X
South Dakota X
Tennessee * X X XX
Texas
Utah
Vermont XX XX
Virginia XX X
Washington
West Virginia
Wisconsin X
Wyoming
Puerto Rico X
Total 24156207823

NOTES: *See Notes to Table 28.

SOURCE: National Association of State Budget Officers.

Table 28 continues on next page.
The relationship between the provision of non-emergency medical transportation (NEMT) paid by the states through their Medicaid programs and public and community transportation providers remains an extremely controversial issue. This controversy has recently been centered on the utilization of brokerages as a means of arranging and ordering transportation services within the states. This issue has such a high propensity for conflict that it often seems to be the issue. However, if we think of this controversy more in terms of a natural occurrence, it might be good to frame this discussion differently. The entire brokerage issue is the proverbial tip of the iceberg, masking the real issues and concerns that we often miss within this everyday discussion of the conflict. The real issue is more dramatic and in many respects more difficult.

Perspective

At a meeting on issues affecting Medicaid transportation, David Marsh, General Manager of CARTS in Austin, Texas, once presciently noted, “The problems we have in Medicaid transportation occur when we try to make up for bad public policy by providing transportation.”

Although he may not have had the intent, Mr. Marsh’s statement comes close to the fundamental issues at play in NEMT, and goes to the heart of the larger challenge. The iceberg in this discussion is the larger number of Americans that need non-emergency medical transportation. NEMT — through Medicaid — carries only a small portion of that need. Although the number of Medicaid recipients has grown, Medicaid is not America’s largest public health insurance effort — that’s Medicare. Medicare’s lack of a transportation benefit means that local communities, and often local community, public, human service, or voluntary transportation efforts, are providing these services without cost to Medicare, or with deep discounts often paid by those who participate in our national Medicare insurance program.

An Analogy

Since Medicaid and Medicare are health insurance programs, perhaps there is an analogy in the health care field that fits this situation. We’ve all heard for decades how emergency room care is the most expensive form of health care for patients, health care institutions, and the broader community in which these institutions provide service. In these discussions we’re often told that costs for medical care for everyone rise because people without insurance cannot pay the full costs of their emergency room treatment. This means that losses go into the billing rates and cost reports of all facilities that have unpaid patients. In some cases nonprofit hospitals deeply discount these services but they continue to be actual financial losses. The same would be true for a patient with private insurance coverage—if his insurance company didn’t provide emergency room treatment. These losses would inevitably drive the cost of emergency room care higher for those who can pay. In that respect no health care activity can make it without...
paying its bills, a concept no different from any other business.

The situation with Medicare and its lack of coverage for NEMT isn’t much different from the situation of an insurance policy that doesn’t cover emergency room visits. Simply put, in the transportation environment a local community-based system’s inability to finance mobility services to seniors who have Medicare has to find other ways to finance these important community priorities.

Nonprofit institutions are often in the forefront of attempting to address these needs even when resources are limited. The question becomes: Where and how do local providers find the resources to meet these challenges and provide these trips, since they are similar to the situation with an emergency room trying to find resources for those not being able to pay.

Costs and Cost Allocation

In most medical services, those who can pay are charged and the billings for those who cannot pay are shared between those who can. Many of those who provide NEMT services in local communities are often part of a network of transportation providers using Medicaid, other forms of public assistance, local fund raising, donations, etc., to meet their cost obligations. It’s perfectly reasonable to allocate the costs of unfunded and underfunded trips to others as a means of maintaining operations for the entire community network. However, problems arise when the growing number of un-reimbursed costs begins to exceed the overall resources to pay for them. In the case of Medicaid NEMT, the prices rise because the cost of recovering un-reimbursed services —especially to those insured by Medicare — continue to rise. As our nation grows older demographically, and as outpatient health care services remain in greater demand, that market for demand will continue to grow. The current issues concerning Medicaid cost increases are actually driven by the absence of a Medicare transportation benefit. As Medicare patients continue to exceed Medicaid patients and other traditional resources provided through various special federal and state programs, these services are set on a path that cannot be sustained.

Brokerages in Medicaid

The current push toward brokers is based purely on cost. Clearly, states are under tremendous pressure to hold the line on Medicaid expenditures and toward that end they seek the deepest discounts possible. As reported in a recent article in Managed Care Magazine, Medicaid costs structures are already 30 percent below Medicare rates. Brokerages, because they often focus solely on the lowest cost, can find alternatives in communities by selecting operators without the same value and commitment concerns of those traditionally providing these services in the nonprofit or public sector. Removing this resource from the mix may save the state funds but further depletes the services available for the uninsured.

The Search for Solutions

Though there appear to be a variety of approaches to this vexing issue; there is, as of yet, no one solution. Issues that need to be addressed include:

- Medicare must recognize NEMT as an ancillary medical service and create a sufficient reimbursement rate and methodology for providers.
- States administering Medicaid transportation must include cost measures that address the impact of pushing minimum reimbursement strategies on coordinated community-based mobility solutions and should be based on negotiating a rate that reflects community standards.
- Local community transportation systems should create coordinated networks that provide opportunities for the flexible provision of non-emergency medical transportation services by using a broad-based public private partnership concept that helps support maintaining existing mobility options.
- Local networks must include participation from the medical community.
- Local networks should seek solutions based on the establishment of a continuum of mobility needs that matches patients to the most economical and appropriate forms of
mobility.

- There should be local standards of service developed by local communities in a cooperative effort to enhance safety and customer service.

- Technology is essential for all aspects of coordination and capital investment in community transportation information systems and should be a priority for all insurance-supported transportation.

- Local communities must have working relationships with state insurance exchanges since outpatient services will be an important part of their effort.

- One of the most critical challenges of the Affordable Care Act will also be to extend non-emergency transportation as part of their patient care strategy.

Agents of Change

- Try transit first is an excellent metaphor for the mobility needs of ambulatory patients. Public transit vehicles, buses, vans, and railcars are the most efficient way of providing mobility in health care for those who have no mobility resources of their own.

- In rural communities, local rural transit agencies have been engaged in coordination efforts in transportation and mobility often for decades. These organizations already have major efforts underway and are currently involved in searching for ways to maintain vital services to those who lack any form of subsidized transportation.

- In the same way, public transportation and publicly-funded transportation based in the nonprofit community are seeking to maintain mobility services throughout urbanized communities. They have an important perspective on the long-term needs of mobility in their service areas and can be an important resource in further developing mobility alternatives, especially for seniors.

In summary it’s important to remember the NEMT in Medicaid is only part of the need for mobility in the health care delivery system. That benefit must be available to all who need it — especially seniors and Medicare patients who must also face an increasing utilization of outpatient health care. CT
Medicaid is a means-tested entitlement program financed by the states and the federal government that provides comprehensive and long-term medical care for more than 60 million low-income individuals. Medicaid is estimated to account for about 22 percent of total spending in fiscal 2010, the single largest portion of total state spending. The following sections look at Medicaid spending, enrollment, cost containment proposals, changes to the Children’s Health Insurance Program (CHIP), challenges and options available under the Affordable Care Act (ACA), and state plans for changes to their delivery and payment structures.

Medicaid Growth Rates

Total Medicaid spending increased by 7.9 percent in fiscal 2010 and is estimated to increase by 11.2 percent in fiscal 2011. Increases in total spending growth are primarily a result of increased enrollment due to the economic downturn. Overall, governors’ proposed budgets for fiscal 2012 included a decline in Medicaid spending of 2.9 percent with state funds increasing by 18.6 percent and federal funds decreasing by 13.0 percent. The significant increase in state spending and the significant decrease in federal funding reflect the end of the enhanced Medicaid match rate from the Recovery Act that was in effect from October 2008 and ends June 2011.

Medicaid Enrollment

The economic downturn and high unemployment have resulted in an increase in Medicaid enrollment as individuals lose job-based coverage and incomes decline. Medicaid enrollment increased by 8.1 percent during fiscal 2010 and is estimated to increase by 5.4 percent in fiscal 2011.

In governors’ recommended budgets for fiscal 2012, Medicaid enrollment is projected to increase an additional 3.8 percent. This would represent an 17.3 percent increase in Medicaid enrollment over this three year period. Although Medicaid spending is decelerating for now, the implementation of the Affordable Care Act will greatly increase the number of individuals served in the Medicaid program in 2014 and thereafter.

Medicaid Cost Containment

In governors’ proposed budgets for fiscal 2012, cost containment in Medicaid is a dominant theme. Almost all states are planning to contain Medicaid costs in proposed fiscal 2012 budgets. Proposals for fiscal 2012 include reducing provider rates (33 states) and freezing provider rates (16 states), enhancing program integrity efforts (32 states), limiting spending on prescription drugs (27 states), limiting benefits (25 states), instituting new or higher copayments (21 states), changing the delivery of care (20 states), and expanding managed care (19 states). As a condition of receiving enhanced federal matching funds under the extension of ARRA, states could not restrict eligibility levels or make it more difficult for individuals to apply for coverage. The ACA continued the Medicaid maintenance of eligibility requirements and extended them to CHIP for adults through 2012 and for children through 2019.

The most common strategy for fiscal 2011 is reducing provider payments, which is planned or implemented by 24 states. Fifteen states have frozen or plan to freeze provider payments in fiscal 2011. Other strategies include enhancing program integrity efforts (24 states), limiting spending on prescription drugs (23 states), and limiting benefits (20 states).

With the passage of health care reform,
provider reimbursement rates for certain primary care providers will be raised to match the rate paid to Medicare for 2013 and 2014 with federal funds paying for the increase in only 2013 and 2014. As shown in Tables 28 and 29, the current trend is for provider reimbursement rates to be reduced or frozen due to the current budget constraints in states.

**Additional Resources for Medicaid**

Some states have increased or plan to increase resources for Medicaid mostly from provider taxes or fees. For fiscal 2011, 10 states have raised or plan on raising provider taxes or fees while 12 states have plans to raise provider taxes or fees in governors’ proposed budgets for fiscal 2012. Unlike previous years, no states raised or planned on raising tobacco taxes in fiscal 2011 and 2012 for additional resources for Medicaid.

**Affordable Care Act**

The Affordable Care Act, enacted in March 2010, has a significant impact on states and especially on state Medicaid programs. Beginning on Jan. 1, 2014, state Medicaid programs will be expanded to cover non-pregnant, non-elderly individuals with income up to 133 percent of the federal poverty level. The cost for those newly eligible for coverage will be fully federally funded in calendar years 2014, 2015, and 2016 with federal financing phasing down to 90 percent by 2020. States are required to apply a 5 percent income disregard when determining Medicaid eligibility, effectively bringing the new Medicaid minimum eligibility level to 138 percent of the federal poverty level.

The Affordable Care Act imposes a maintenance of effort (MOE) requirement on eligibility standards, methodologies, and enrollment procedures for adults until an exchange is fully operational (expected to be 2014) and for children in Medicaid and CHIP through 2019. There is a limited exception that allows a state to reduce their eligibility levels for adults over 133 percent of poverty during the period from Jan. 1, 2011 through Dec. 31, 2013 for a state that certifies it has a budget deficit on or after Dec. 31, 2010.

While the major expansions to cover the uninsured will not be taking place until Jan. 1, 2014, other changes under the Affordable Care Act have already taken affect including: the maintenance of effort provisions for Medicaid and CHIP, a new option to cover childless adults in Medicaid using the regular Medicaid match, new long-term care options for community based care, work on establishing and planning for health insurance exchanges, establishment of temporary high risk pools in each state until the exchanges are operational, the early retiree reinsurance program, and changes in the insurance markets in every state.

**Options Under the Affordable Care Act**

States were asked about the likelihood of using various options under the Affordable Care Act or those related to the Act. Such options may range from grants to plan health insurance exchanges, additional funds to move towards home and community based long term care options, or 90 percent matching funds for changes to Medicaid and CHIP eligibility systems. Almost all states have received planning grants to set up the health insurance exchanges and most states plan on applying for the 90 percent match for changes to Medicaid eligibility systems. Connecticut, the District of Columbia, and Minnesota have taken up the option to expand eligibility to adults without dependent children. Additionally, some states are also planning to apply for more limited awards such as behavior modification grants or establishing accountable care organizations for pediatrics. CT
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<th>Eliminate benefits</th>
<th>Limit benefits</th>
<th>Delay expansions</th>
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**NOTES:** *See Notes to Table 28.
**SOURCE:** National Association of State Budget Officers.
### Table 28 (Continued)

#### Fiscal 2011 Budgetary Actions Aimed at Containing Medicaid Costs

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<th>Reform delivery system</th>
<th>Restrict community-based long-term care</th>
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**NOTES:** *See Notes to Table 28.

**SOURCE:** National Association of State Budget Officers.
Stressed States Open Doors to Medicaid Managed Care

By John Carroll, contributing editor, Managed Care Magazine

The following article ran in the March 2011 edition of Managed Care magazine and highlights how the national economic downturn has increased program enrollment and decreased investment — both with significant impacts on the Medicaid program.

This summer California will mark the beginning of a new era for the Medicaid managed care business. After winning a waiver from the federal government last fall, the state’s aged, blind, and disabled beneficiaries — the ABDs, in the parlance of the trade — will be required to join one of California’s Medi-Cal managed care plans.

As a result, about 380,000 high-risk beneficiaries will migrate into a plan, most in dense urban areas like Los Angeles, San Diego, and Sacramento. And based on back-of-the-envelope estimates from Molina Healthcare — one of the country’s largest Medicaid managed care companies — about 27,000 or so will join the 15,000 ABDs who had already voluntarily opted for the plan.

“We think we’re in pretty good shape,” says Richard Bock, MD, the chief medical officer of Molina Healthcare of California. “We’re already taking care of a reasonably-sized population of ABD members, so it’s not like a brand new category of members.” He adds that only those ABDs living in existing managed care counties in California will move into the managed care Medicaid plans.

For California legislators and specialized Medicaid operations like Molina, shifting ABDs to managed care makes sense. High-risk Medicaid beneficiaries need the small army of nurses, providers, and case workers that a plan like Molina deploys to help coordinate care and eliminate ER visits, readmissions, and other costly and avoidable interventions. Even though the state pays plans a higher per-member-per-month capitated fee for the at-risk population than it does for mainstream beneficiaries, California expects to save money compared to keeping them in the fee-for-service program. And right now, saving money on Medicaid has become one of the highest priorities in state governments across the country.

The worst economic downturn since the Depression has saddled a host of states with a staggering budget crisis. With no major revenue relief in sight, many states are lining up right alongside California and turning to managed care to relieve some of their Medicaid cost burden. The changeup is setting the stage for a historic shift that is expected to transform the Medicaid segment of the health insurance industry, positioning MCOs to replace fee-for-service care as the dominant insurance model for low-income Americans.

Steady Growth

Medicaid enrollment has grown steadily over the past decade, from a total of 31.7 million in June 2000 to 46.9 million in June 2009. And the recession has caused Medicaid rolls to spike.
“States are scrambling for every solution they can find, and managed care has a track record of success,” says Jeff Smith, senior vice president and Medicaid managed care adviser at the Lewin Group.

But the tidal market shift isn’t without risk for plans. As more and more states engineer an expansion of Medicaid managed care, they’re also adding new standards requiring plans to demonstrate that they’re actually saving money and delivering care as promised. Plans that fail to live up to these new expectations could find themselves in hot water with state regulators.

**States Shift Medicaid Gears**

Republicans and Democrats alike have determined that shifting beneficiaries into managed care is one effective financial tonic for an indigestible Medicaid bill, which commonly gobbles up from a quarter to a third of a state’s annual budget. And with extra federal support for Medicaid slated to run out July 1, a sense of urgency is giving way to crisis management.

“Difficult economic times make for sound public policy,” Michael Neidorff, CEO of Centene, told analysts in mid-February. “States are now more willing to move from fee-for-service to managed care.”

A survey by the Kaiser Commission on Medicaid and the Uninsured found that 13 states expanded the reach of Medicaid managed care plans in the 2010 fiscal year. With fiscal 2011 set to expire at the end of June, another 20 states had either instituted or were planning fresh expansions, with many of them mandating ABD enrollment in a plan, adding long-term care plans, or making health plan enrollment a requirement for all.

Illinois, with a yawning $15 billion budget hole to plug, is one of the states turning to health plans. Centene and Aetna were picked at the beginning of this year to launch an effort that will see half of the state’s Medicaid population of nearly 3 million shifted into a health plan. In West Virginia, the state mandated that 55,000 recipients with disabilities and mental health problems enroll in managed care plans — which already orchestrate care for half of the state’s Medicaid population — at the beginning of this year. More are joining.

Florida’s new governor, Rick Scott, wants to join states that have decided to move their entire Medicaid population into managed care. Missouri’s Medicaid regulators say they want to join that movement as well. In Texas, the push is on to expand Medicaid managed care beyond cities and suburbs and into the countryside. In New Jersey, state officials are putting long-term care services into managed care.

“The trend is toward putting new people, new geographies [pushing from urban into rural areas] and new services into managed care,” says Meg Murray, CEO of the Association of Community Affiliated Plans, a national organization of not-for-profit Medicaid health plans. Why the attraction?

“Managed care can be held to a much higher standard,” Murray explains. The plans are often expected to earn accreditation, with state regulators demanding Healthcare Effectiveness Data and Information Set (HEDIS) scores on quality and patient satisfaction surveys to track the response of beneficiaries. Plans are also required to provide fully fleshed out provider networks to ensure access — all things that can’t be done in traditional fee-for-service programs.

“They have more sustained-care managers who work with the families and beneficiaries to keep them out of the hospital,” says Murray.

**Fast Food**

By way of an example, Murray relates how one not-for-profit plan recently highlighted the case of a Medicaid beneficiary whose parents had died. Not knowing how to cook, she ate at fast food restaurants and her weight ballooned as her health deteriorated. The plan stepped in to teach her basic cooking skills and offered an attendant to help with housekeeping so she could stay in her home rather than transfer to a nursing home. That’s something that wouldn’t happen in fee-for-service Medicaid, and it saved taxpayers money because housekeeping help is far cheaper than the cost of a nursing home.

The current crop of ambitious state contracts comes as the Patient Protection and Affordable Care Act promises to remold Medicaid into a broader safety net, a move that the Congressional Budget Office has estimated will add 16 million Medicaid members.
“Most of those new beneficiaries will wind up in Medicaid managed care,” says Vernon Smith, a principal and Medicaid consultant at Health Management Associates.

Some health plans, though, are bracing for an even bigger windfall of new members.

WellPoint Chief Financial Officer Wayne Devoid recently told analysts that he believes market forces are in play that will expand Medicaid by 20 million people by 2015. And he intends for WellPoint to be prepared to gain its share.

Wall Street hasn’t overlooked what’s going on here, either. For Molina, the sudden change of fortunes is commanding the close attention of market analysts. Looking ahead for the rest of the year and through 2012, Molina forecasts that it will have $4.5 billion in revenue this year and then see that figure swell to as much as $6 billion in 2012 as Medicaid rosters become larger.

That growth, though, comes at a time that state Medicaid programs have had to deal with intense budget problems, which in turn may create problems for the plans. Medicaid traditionally has had some of the lowest provider payment rates in the country. Molina notes that on average, Medicaid pays providers 72 percent of the Medicare rate, though that number varies by region.

Despite the gap, some states, including California, are proposing a unilateral 10 percent cut in fee-for-service payment rates for providers. For states, the fastest and most effective method for cutting Medicaid costs is a swift cut in provider rates, Vernon Smith explains. And even though Medicaid health plans are free to negotiate rates to make sure they have the networks needed to provide ready access to care, no state is being accused of being overly generous. That can create headwinds for managed care organizations in the low-income insurance sector.

“We have to live within a budget,” says Michael Siegel, MD, vice president and medical director at Molina. “With health care costs going up significantly, the states aren’t increasingly challenged to match these increases. This translates into Molina paying providers less than what commercial plans are paying.”

Making an Impact

Molina, though, isn’t sitting idly by to see which beneficiaries come its way and whether it will have the physicians it will need in its network to provide care for the growing population. California has already supplied a list of the most frequently visited Medicaid providers in the five counties Molina serves, so it can try to coax them into the network.

“We’re hoping that as they see their patient base erode and move to managed care, they will be interested in following,” says Bock.

States are attracted to managed care groups because they’re required to assemble sufficient networks of providers to ensure access, with regular patient satisfaction surveys to track how they’re doing, Vernon Smith notes. Better care coordination can cut costs, he says, because a small group of ailing Medicaid patients always consumes the lion’s share of the services.

“In general if you look at the Medicaid population, 75 percent of the beneficiaries generate about 25 percent of the cost,” says Siegel. “The other 25 percent generate 75 percent of the cost. And in that group there’s a smaller percentage that generate a much larger percentage than their given numbers. States are finally acknowledging that they need to improve their management of this high-risk population, and they’re now looking at ways to include these populations — which have not to a great extent been in managed care — into managed care.”

It makes a lot of sense, says Joel Menges, a vice president at the Lewin Group. “The traditional Medicaid population of mothers and children cycles on and off the program, creating short-term savings opportunities but offering little chance for plans to achieve favorable long-term impacts for these individuals.”

These new beneficiaries include a large concentration of disabled people with multiple comorbidities (multiple life-threatening conditions) who will stay in the system, giving care coordinators a chance to have a big effect on their utilization of care.

In some cases, states are demanding that health plans make the necessary effort to get a handle on each new member.

“The basis of what the state spends on managed care is the fixed rate they pay us,” says Bock. “The state’s savings are built in;
we need to manage care within the budget.” And to make the shift to managed care politically palatable in some states, legislators added safeguards, some still being put into place through new regulations.

“We’re required to do risk stratification of every new ABD member so as to identify those at high risk,” says Bock. “Within a limited time frame, we’ll need to do a health risk assessment — interview the patient, develop a care management plan. That plan is our way of coordinating care between medical services, behavioral health, and social services. It’s definitely a challenging population. They have a higher medical need, higher behavioral health needs, and they are undoubtedly some of the most socially and economically and medically underserved people in our community. There’s no question they will be a challenge.”

That’s not surprising, says Lewin’s Jeff Smith. “There’s an expectation that the HMOs will need to step up care coordination, especially for ABDs,” says the consultant. “There will be standards and consequences for not delivering.”

While the move toward more capitated contracts with MCOs is growing fast, not all states have been taking the same path. In Connecticut, Gov. Dan Malloy decided in February to drop the state’s capitated pacts with three managed care companies — Aetna, United Health, and the not-for-profit Community Health Network of Connecticut — and to become self-insured, asking the plans to come back and bid to become administrators for the state program.

“Connecticut is a little bit of an outlier,” says Ellen Andrews, executive director of the Connecticut Health Policy Project and a member of the state’s Medicaid care oversight council. Connecticut officials think that they’ve learned enough from an earlier experiment with self-insurance to make it work this time.

Three health plans were needed to fill state contracts, says Andrews, and only three turned out, spurring complaints that the state was overpaying for Medicaid managed care.

Paid $50 Million Too Much

“The state didn’t specify rates [it had a range that was extremely generous], so the state basically had to pay whatever the plans wanted,” says Andrews. “We overpaid by at least $50 million a year, based on an independent audit by Milliman for the Office of State Comptroller.”

While managed care companies handled the care of 400,000 of the state’s 600,000 beneficiaries, the managed care contracts didn’t include aged, blind, and disabled beneficiaries. Under the new administrative services organization model, the state expects
to be able to orchestrate better control of the entire population, including ABDs, with primary care case management that coordinates care through patient-centered medical homes.

“The state paid the $18.18 per member per month during the self-insured phase [because there was no time to negotiate or rebid] and when it went back to capitation auditors, they reported that the plans spent only $13 and change on the same administrative functions — when they were spending their own money,” says Andrews adding that this amounted to a saving of $86 million a year.

In Arizona, the budget crisis has become so perilous that the Republican-dominated legislature pushed to get a federal waiver that will let it simply cut 280,000 adult beneficiaries out of the program. And that’s after the state triggered a national hullabaloo over its decision to stop covering the cost of certain transplants.

“We understand the states are walking a tightrope,” says Murray. “But before states take drastic measures, they should look at the savings they could get from managed care, such as moving more dual-eligibles and drugs into managed care. There’s still a lot of money on the table in terms of savings from managed care.”

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Medicaid Brokerage: The Opportunities and Challenges for Community Transit

By Steve Fittante

Steve Fittante has significant experience in the community and public transit industry, and shares his more recent experience with non-emergency Medicaid transportation and brokerages in this insightful article. Flexibility and a willingness to adapt to change, as readers will see, are Steve’s advice as the community and public transportation industry moves into a new era of Medicaid transportation.

The advent of statewide Medicaid brokerage has been a development which has worried many community transit operators whose small vehicle operations may have been direct providers of Medicaid funded non-emergency transportation. For many community transit operators, Medicaid has been one of the key sources of operating funds for their advance reservation, small vehicle services. For these operators, the arrival of a statewide broker whose livelihood is predicated on contracting with the lowest cost (responsible) provider, the capitated broker payment model has threatened the status quo, especially if the community transit provider had been performing the broker function.

The purpose of this article is to encourage transit operators to view the opportunities for competing in the non-emergency medical transportation market and to utilize their existing vehicle operations to generate additional revenues through greater efficiency.

It is understandable that this shift in paradigm (one which in some ways may be less efficient than a more broad based broker model that incorporate all human service funding sources) would be threatening to community transit providers who have been providing Medicaid service under direct contract with Medicaid or its assigned state government agencies.

For many community transit providers who are contemplating participation as a new provider under a state sanctioned Medicaid broker, the issue of a higher average trip or per mile cost than private livery or taxi services is at first glance the same as the community transit provider who has been a Medicaid provider. There is, however, some inherent cost advantages which the community transit provider may have over their private livery competitors.

Many governmental and non-profit providers began their service providing non-emergency, non-Medicaid medical transportation on an advance reservation, subscription basis to medical destinations including but not limited to dialysis centers, cancer therapy centers and mental health clinics. In many cases, these coordinated human service transportation providers used vans and minibuses with seating capacities exceeding what was needed for the medical transportation portion of their coordinated service.

While the average cost per trip for these...
Medical Transportation

services may be higher than what a small private livery company cost structure per trip would be, the marginal cost of adding Medicaid passengers to these runs would be considerably less and the average cost would decrease based on the economies of scale (more passenger trips per operating hour).

The win-win opportunity is for the community transit operator to focus on its subscription trips which can be offered at a lower marginal cost than trips which might have to be placed on exclusive trip or lower productivity runs. Many of the competing taxi and livery companies can offer lower costs for single trips but transit agencies who are already providing non-Medicaid group trips or transit runs to hospitals, mental health clinics and dialysis centers can offer these trips at the marginal (additional) cost that it takes to add another pickup to the run or trip.

In New Jersey, the statewide Medicaid broker has recognized this as a win-win opportunity and has negotiated contracts with community transit providers on a flat rate that is higher than a typical fare but considerably less than the standard base rate plus mileage rate being offered to taxi and livery companies. These rates have enabled the community transit providers to increase their productivity per hour and generate new revenues with minimal additional cost. In one example, a county system added 15 additional passengers to three existing vehicle runs while still meeting its maximum ride time standard for the first boarding passenger. The broker reduced its cost by more than 50 percent of what the reimbursement would have been under the existing livery reimbursement contract.

• Developing an effective contract between a community transit operator and a statewide or regional Medicaid broker involves an examination of a number of issues which differ from the traditional private livery provider: Recognition of existing FTA training, vehicle specification, insurance and drug and alcohol testing regulations which may have different parameters than the standard broker requirements for providers (highly regulated provider exceptions). Medicaid brokers can reduce the barriers of unnecessary separate drug and alcohol standards and additional insurance riders that drive cost for transit operators and reduce the win-win opportunities for the broker and transit provider.

• Recognition of community transit provider shared riding provisions with non-Medicaid passengers. One of the strengths of community transit is the ability to combine a range of passengers going from multiple origins to multiple destinations both on fixed route transit and human service subscription trips. It is in the mutual interest of the broker to reduce cost and the transit provider to tap these economies of scale to provide new revenues with minimal added cost. While many Medicaid trips could be provided more economically by the lower cost livery provider, many trips to congregate locations would be better served by community transit operators.

• Recognition that public fares charged on other elements of the community transit provider’s service do not account for the full operating marginal cost of providing Medicaid trips. There is a need for a hybrid approach that recognizes that fares do not recover the marginal cost of additional trips on community transit subscription runs and that fare box recovery on most systems is considerably less than 50 percent of operating costs. This hybrid will provide the broker with more opportunities to place riders at a lower rate of reimbursement and fairly compensates the community transit provider for the true marginal cost of their operation for these trips.

A broker recognizing these distinctions will have the opportunity to reduce their provider costs for the trips which community transit providers can do most efficiently. Similarly, by looking to provide Medicaid trips that they can provide more efficiently than livery providers contracted strictly for Medicaid, community transit can expand its revenue and reduce its cost per trip through volume contracting.

While the ideal brokerage model would
be one that includes a broader set of human service funding sources than solely Medicaid, the reality is that states are implementing Medicaid brokerages and community transit agencies need to get in the game. Medicaid brokerage needs to encompass a hybrid model that enables brokers to reduce costs and transit operators to be able to compete for the type of volume trips that take advantage of their efficiencies. It’s a win-win whose time has come.

Steve Fittante is a founding member of CTAA and has developed and managed community transit systems as both a private and public sector administrator. He is currently the Director of the Middlesex County (NJ) Department of Transportation and teaches at the Bloustein School of Urban Planning and Policy at Rutgers University. Steve also recently testified before a U.S. Senate Banking Committee hearing on promoting broader access to public transit for America’s older adults and people with disabilities. His full testimony is available here.

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The Affordable Care Act: Answers to Frequently Asked Questions...and Answers

The following is our first installment in what promises to be a popular regular feature of DigitalCT — the Manager’s Corner. In this department, we will share practical, tested tips and practices, as well as provide basic information about oft-confused and confusing topics. Our first Manager’s Corner focuses on the Affordable Care Act and seeks to answer the basic question: How will it impact my organization? Have any topics you’d like to see us tackle in the Manager’s Corner. Please let us know at cteditor@ctaa.org. These frequently asked questions (FAQs) come from CTAA’s Insurance Store partners, Gallagher Benefit Services. For additional information please click here.

The Affordable Care Act: Answers to Frequently Asked Questions

The Community Transportation Association of America’s Insurance Store partners, Gallagher Benefit Services, has compiled a thorough list of frequently asked questions and answers, all of which are available to CTAA members. In this article, we provide some of the most pressing FAQs that connect most directly with the community and public transit industry.

Is there anything we have to do immediately?

Although the Act was effective on the date the President signed it, most of its provisions are not effective immediately. For example, certain coverage mandates don’t take effect until the first plan year starting on or after Sept. 23, 2010. Other provisions are phased in between 2011 and 2018.

Do I only have to “offer” the coverage, or do I also have to pay for the coverage to avoid the “free rider” penalty? If so, how much do I have to contribute?

Not necessarily. You are not required to offer coverage nor pay any part of the coverage if you offer it. However, employers with at least 50 full-time employees who don’t offer coverage or whose employee contributions exceed a certain percentage of the employee’s income could be subject to a penalty starting in 2014, if any full time employee receives a premium tax credit towards purchasing their own coverage through an exchange.

Our plan is self-funded. Will we have to do anything as a result of this new law?

Self-funded plans are generally treated the same as fully-insured plans under the Act. You should be analyzing the coming changes for the impact they will have on your self-funded plan.

We are a governmental entity. Do we have to comply with this legislation?

Yes. There are no exceptions for non-federal governmental plans so you should be analyzing the coming changes for the impact they will have on your plan.

Will I be required to offer health insurance coverage to my employees?

No. However, if you have at least 50 full-time employees, and you don’t offer coverage, you will owe a penalty starting in 2014 if any full time employee is eligible for and purchases subsidized coverage through an exchange. This penalty is called the “free rider” penalty.

Our plan is self-funded. Will we have to do anything as a result of this new law?

Self-funded plans are generally treated the same as fully-insured plans under the Act. You should be analyzing the coming changes for the impact they will have on your self-funded plan.

If you have at least 50 full time employees and you do not offer coverage, and at least one full time employee receives a premium tax credit, you would have to pay an annual fee of $2,000 per full time employee (excluding the first 30 employees). Employees
eligible for a premium tax credit are those whose household income is less than 400 percent of the federal poverty level.

If you have at least 50 full time employees and you offer coverage, but at least one employee receives a premium tax credit for purchasing coverage in the exchange, you would be assessed the lesser of an annual $3,000 penalty for each full-time employee who declines your coverage and instead purchases subsidized individual coverage through an exchange, or $2,000 per full-time employee. An employee who is offered coverage will only be eligible for subsidized coverage if the employee’s contribution exceeds 9.5 percent of the employee's household income or if the plan’s share of the total allowed cost of benefits is less than 60 percent and the employee’s household income is less than 400 percent of the federal poverty level.

**I have heard we may have to provide “vouchers” which the employee can use to buy insurance through an exchange. Is that true?**

No. A “free choice voucher” requirement was included in PPACA but that requirement was repealed upon passage of the Fiscal Year 2011 Federal Budget on April 17, 2011.

**Do I have to “offer” and pay for dependent coverage also? What if the dependent (spouse or children) are covered by another employer’s plan?**

The Act does not require you to offer or pay for health coverage that includes spouses and dependent children.

**Will we have to report anything to the government regarding our plan’s coverage or contributions?**

Yes. Large employers that employed an average of at least 50 full time employees or any employer that requires any employee to pay more than 8 percent of wages for coverage must file an annual return with the IRS starting in 2014. You must report whether you offer full time employees the opportunity to enroll in coverage and provide certain other information including:

- The employer’s name, the date, and the employer’s EIN;
- A certification that you offer full time employees the opportunity to enroll in “minimum essential coverage;”
- The number of full time employees you had for each month of the calendar year;
- The name, address, and taxpayer ID of each full time employee employed during the year and the months during which the employee and dependents were covered under your group health plan;
- The months coverage was available under the plan;
- The monthly premium for the lowest cost option in each enrollment category;
- Your share of total allowed costs of benefits provided under the plan
- The length of your plan’s waiting period
- The plan option for which you pay the largest portion of the cost and the portion of the cost you paid for each enrollment category under that option.

If your plan is insured, you are permitted to enter into an agreement with your insurer to provide the above information in the return they are required to file. A written statement will also have to be provided to each full time employee named in the return that includes the name, address and contact information of the entity that filed the return and the information in the return pertaining to that individual.

**I’ve been hearing about “exchanges.” Can you describe what they are?**

Exchanges are arrangements through which private and non-profit insurers offer small employers (up to 100 employees) and individuals the ability to purchase health insurance. The Act requires each state to set up an exchange for the purchase of health insurance coverage. Coverage can be purchased through the exchanges starting in 2014. States have the option to allow large employers (more than 100 employees) to begin purchasing coverage through the exchanges starting in 2017.

Regional or national exchanges could also be
established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the exchange.

It is expected that each exchange will offer four categories of plans plus a catastrophic plan including:

- **Bronze plan** – Essential health benefits covering 60 percent of the plan benefit costs, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010);

- **Silver plan** – Essential health benefits covering 70 percent of the plan benefit costs, with HSA out-of-pocket limits;

- **Gold plan** – Essential health benefits covering 80 percent of the plan benefit costs, with HSA out-of-pocket limits;

- **Platinum plan** – Essential health benefits covering 90 percent of the plan benefit costs, with HSA out-of-pocket limits;

- **Catastrophic plan** – Available to individuals up to age 30, or to those who are exempt from the mandate to purchase coverage. Provides catastrophic coverage only, with the coverage level set at the current High Deductible Health Plan levels except that preventive benefits and coverage for three primary care visits would be exempt from the deductible.

**Will I have to buy health insurance for my employees through one of the new exchanges? Starting when?**

No. Employers will not be required to purchase coverage through an exchange though it will initially be an option for small employers starting in 2014.

**Am I considered a small employer for purposes of buying insurance through the exchanges?**

A small employer for purposes of buying coverage through an exchange is defined as an employer with 100 or less full time equivalent employees. Prior to 2016, states can limit purchases through an exchange to businesses with 50 or fewer workers. Starting in 2017, states can allow businesses with more than 100 employees to purchase coverage through an exchange.

**How do I determine how many full time employees I have?**

Full time employees are defined as those employees who work on average 30 hours per week.

**Are there any exclusions for seasonal and part time workers?**

The health reform package does not require employers to provide coverage for employees working on average less than 30 hours per week (“part-time”). The hours worked by part time employees are counted to determine full-time equivalents for purposes of determining if the employer is subject to the employer mandate. This is done by taking the total number of monthly hours worked by part time employees and dividing by 120 to get the number of “full time equivalent” employees. Hours worked by part time employees are also counted to determine if the employer is eligible for the small business premium tax credit.

The health care reform package does not require employers to provide coverage for seasonal employees. Seasonal employees are workers who perform labor or services on a seasonal basis (no more than 120 days during the taxable year and retail workers employed exclusively during holiday seasons). They can be excluded from the threshold count to determine whether an employer has over 50 employees to be subject to the employer mandate. They are also excluded when determining if the employer has less than 25 full time equivalent employees for purposes of the small business premium tax credit and from the calculation of the employer’s annual wage level for purposes of the credit.