OBAMA-BIDEN TRANSITION PROJECT

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Transition Paper
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

AFSCME, and our 1.6 million members, are acutely aware of the missed opportunities of the past eight years and the potential for positive change within the Centers for Medicare and Medicaid Services (CMS). Our members care for the elderly, disabled and sick in health care facilities and in their homes, and determine eligibility for Medicaid and the State Children's Health Insurance Program (SCHIP). Our working and retiree members who are 65 years old and older rely on Medicare for their basic health care. We offer these recommendations on their behalf and the millions of Americans they serve.

Restoring a Robust Partnership for Medicaid

At some point during 2007, Medicaid provided health care coverage for about one in every five persons in the United States. AFSCME members are connected to Medicaid through the work we do to determine eligibility and to provide quality care for these patients night and day as nurses, aides, dieticians and food service workers, custodians, technicians, physician assistants, therapists, doctors, pharmacists and administrative staff.

Besides being an important safety net for low-income individuals who otherwise would be uninsured, Medicaid is the backbone of our nation's health care sector; nearly one-fifth of our national expenditures on health services and supplies are through Medicaid. It is the major component of state budgets, accounting for 22% of state budgets, on average. Medicaid, like Medicare, is a public foundation upon which to build a guarantee of quality, affordable health care for all. With respect to Medicaid, the primary goal of the new administration should be to revitalize and reinvigorate the federal-state partnership to expand access to quality care. This will require a fiscal and visionary investment. It demands the appointment of leaders who value and are committed to Medicaid as a first-class health care program. For eight years the Bush administration denigrated and sought to dismantle fiscal and public support for Medicaid. Change is welcome and quick intervention is needed. We urge the following:

- On day one, sign into law an economic recovery plan that increases the federal medical assistance percentage (FMAP) and provide states with flexible grants. The deepening recession and multi-year loss of revenues are creating ever-widening state budget gaps – which will combine over this year, next and 2011 to be in the range of $250 billion. The size of budget holes has led economists to call for 24 months of state aid in the range of at least $100-150 billion, part in increased Medicaid funding and part in grants.

- On day one, direct the Acting CMS Administrator to issue a notice of revision of the Bush administration regulations which shifted Medicaid costs onto states, providers or beneficiaries. The seven regulations combined will reduce federal payments to the states by $50 billion over the next five years. The proposed (and one enacted) regulations would not save costs, but would merely result in cost-shifting to state and local government and strain the safety net provider system. A thorough description of the background and effect of the regulations (including a state-by-state analysis of the fiscal impact) prepared by Rep. Waxman's Oversight and Reform Committee majority staff can be found at: http://oversight.house.gov/documents/20080303111450.pdf. A moratorium on six of the adverse regulations expires April 1, 2009.

- Policy and legislation to strengthen and invest in public hospitals and clinics.

American Federation of State, County and Municipal Employees, AFL-CIO

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- Propose a supplemental budget that provides for an extension of the Transitional Medical Assistance Program, funding for which expires June 30, 2009, that puts the program on a more secure and regular funding cycle.

- Launch policy, regulatory and funding initiatives to strengthen staffing in intermediate care facilities for the mentally retarded, hospitals and home and community-based care to ensure the retention of a stable and well-trained workforce essential to the delivery of quality care.

- Set a course for improving the quality of care in nursing homes, which should include implementing minimum nurse staffing standards based on Department of Health and Human Services (HHS) research linking insufficient staffing and poor quality in nursing homes.

- Propose legislation that gives the Secretary clear authority and criteria by which to trigger a temporary increase in the FMAP rate for a state or states in case of natural disaster (such as hurricane, flood, pandemic influenza) or economic crisis.

- In conjunction with the Department of Labor, the Centers for Disease Control and HHS's Office of Public Health Preparedness and Emergency Planning, require states to submit a Medicaid state plan amendment to ensure the adequate protection of health care workers in the event of a pandemic.

Protect Public Accountability in Medicaid

Section 1115 Medicaid waivers give states the opportunity to depart significantly from federal standards. They can have a significant adverse impact on beneficiaries, and set a precedent for future waivers. For example, Rhode Island is asking CMS for permission to convert its current Medicaid program from an entitlement to a block grant – in large part due to its budgetary crisis – and is seeking complete and unprecedented flexibility to make changes in eligibility and services for many beneficiaries without any federal oversight. Louisiana's governor has proposed to enroll beneficiaries in managed care plans. Florida's waiver project has resulted in reduced access to health care for beneficiaries, reduced provider participation, and additional administrative costs. A recent letter from the Government Accountability Office (GAO) states that HHS has not been following its own written policies and procedures for waiver review that require public input and transparency. Instead, negotiations surrounding these vital changes are often conducted behind closed doors. CMS must implement a process to ensure that waiver proposals are subject to a thorough and transparent review process that includes the input of stakeholders at both the state and federal level.

Moreover, the Medicaid law requires that civil service employees perform the duties involved in determining eligibility for the program. The statute provides that "the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan" – that is, by public employees.

During the eight years of the Bush administration, CMS allowed several states to undertake controversial and expensive privatization initiatives. Texas' project was a complete failure. It caused substantial harm to hundreds of thousands of poor families and wasted substantial sums of taxpayer dollars. Indiana's project continues to operate, but problems similar to the Texas initiative have emerged. In particular, seniors and the disabled are having an especially difficult time accessing Medicaid and food stamp benefits. The problems in Indiana, where the caseworker model has been eliminated and replaced with what is essentially a data processing model, have

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grown widespread enough that the state has halted expansion of the project temporarily and there is considerable sentiment in the state legislature to stop further expansion.

In both cases, the CMS allowed the states to separate most of the intake of information from the interview and final determination of eligibility. The entire application and intake process involves the exercise of judgment and discretion, and it should not be subject to private companies' obligation to maximize profits.

Additionally, CMS has not required New York to submit a waiver request for its statewide Medicaid call center for which a "request for proposal" (RFP) has been issued. These privatized call centers would screen eligibility for Medicaid and SCHIP, process eligibility renewals and applications for presumptive eligibility, and determine good cause exceptions. The private call center model has failed in Indiana and Texas, and should not be established in New York.

We urge the following specific actions:

- CMS must implement a process to ensure that state Medicaid waiver proposals are subject to a thorough and transparent review process that includes the input of stakeholders at both the state and federal level. This should be applied to Rhode Island, Louisiana, and all other pending waiver petitions. CMS should also review existing waivers to determine whether they are meeting the objectives of the Medicaid statute.

- CMS should reject any state request to waive the Medicaid law's requirement that public employees perform all aspects of eligibility determinations. CMS and states should interpret the merit staffing provisions as including the eligibility determination process, not just the final determination.

- We urge the new administration to prohibit further expansion of the Indiana project, to undertake a full evaluation of the impact on applicants, and to require the state to reinstitute the casework model by transferring state caseworkers from the private contractor back to the state agency.

Medicare Advantage Plans

AFSCME agrees with MedPAC that overpayments to Medicare Advantage (MA) private insurance plans should be rolled back to produce a level playing field with the original Medicare program and to improve Medicare's long-range solvency. Currently, the overpayments are enriching insurance companies at Medicare's expense. Insurers find them particularly helpful in attracting large employers. Employers are promised lower costs for retiree health care if they remove their retirees from Medicare and supplemental coverage and instead opt for Medicare Advantage. The trend is not only expensive for Medicare, but also destabilizing for retiree coverage. Retirees in MA plans are totally dependent on private insurers, which have a long history of unreliable service to seniors. The MA program has proved to be a bonanza to the private insurance companies who, according to GAO (http://www.gao.gov/new.items/d09132r.pdf) obtained $1.1 billion more in profits than projected in 2005 and $1.3 billion more in profits than projected in 2006 from the MA program. In sum, MA plans earned $3.4 billion in profits in 2006 which is over $600 in profit per MA enrollee.

- In the short term, CMS should eliminate the Medicare Advantage waiver program for the employer market. Customized products – permitted by the waivers – help attract employers to MA. At the very least, a moratorium should be placed on the granting of these waivers while the process is reviewed.

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- We recommend CMS action in the area of actuarial equivalency. MA plans are supposed to be actuarially equivalent to regular Medicare, but CMS has been lax in its review of plans. Better oversight is needed to ensure that the plans provide the benefits that seniors need and are not earning windfall profits at the expense of seniors and the Medicare program.

- In the longer term, we support President-elect Obama's campaign promise to push for federal legislation to eliminate Medicare's overpayments to private Medicare Advantage plans.

Medicare's Premium Support Demonstration Project

The "comparative cost adjustment demonstration project," also known as the "premium support" demonstration, was established by the Medicare Modernization Act (MMA). Starting in 2010 in six metro areas, the original Medicare program will be competing directly with subsidized private plans based on cost. Medicare's actuaries have projected dramatic changes in premiums from one area to another, with wide cost differences even for seniors living in neighboring counties. The demonstration project essentially voucherizes Medicare – converting it from a defined benefit to a defined contribution program. AFSCME believes that this radical change will rob seniors and the disabled of guaranteed benefits and promised protections and, in short order, will destroy the Medicare program itself. That's why we believe the 2010 premium support demonstration should be stopped before it begins.

- We urge support for administrative action or legislation to rescind the premium support demonstration project of the MMA.

Medicare Prescription Drug Program

MMA and its implementing regulations provided needed drug coverage to millions of beneficiaries, yet also contained provisions that harm consumers, employers and government which are still in force and should be changed or repealed.

The MMA radically altered the federal-state fiscal relationship by requiring states to provide significant financing for the Medicare drug benefit through a "clawback" provision, also called a "phased-down State contribution." Each state must pay the federal government for outpatient prescription drugs for beneficiaries who are dually enrolled in both Medicare and Medicaid. The Congressional Budget Office projects that states will pay $35 billion from FY 2009-2012. The clawback constitutes the largest source of state payments to the federal government. Proponents claimed the MMA would ease state Medicaid programs of their responsibility to pay for "dual-eligibles." However, flaws in the payment calculation can cause states to spend more than they would have without the law.

In addition, the MMA prohibits Medicare from negotiating lower prices with drug companies, and does not include a drug benefit in traditional Medicare, forgoing the enormous buying power of its 40 million beneficiaries. Private insurers negotiate separately on behalf of subsets of beneficiaries – a much less effective means of containing costs. Beneficiaries can only enroll in a privatized program served by a confusing menu of private companies that often also promote private Medicare plans.

Other important issues in the MMA law and regulations affect the health of beneficiaries, employers and public finances. Each must be examined carefully as Part D is fixed. These include, but are not limited to, the inadequate amount of the Retiree Drug Subsidy given to assist

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many public and private employers to continue coverage for the 30% of beneficiaries with employer-sponsored drug benefits, the coverage gap or "donut hole", and the calculations and definitions of items in regulation, such as benchmark plans, true out of pocket costs, prescription drug prices, and actuarial equivalence.

- In the short term, establish a process for states to appeal determinations of the clawback payment calculation and revise how the baseline calculation is inflated to more accurately reflect program growth and state costs that would have been spent on dual eligibles. Examine the way other items are calculated and defined in the MMA law and regulations to protect beneficiaries, employers and governments from coverage gaps and loss of comprehensive benefits.

- In the medium term, as President Obama seeks legislation to allow the federal government to negotiate for lower prescription drug prices for the Medicare program, we urge an elimination of the required state payments. Create a prescription drug benefit option in the traditional Medicare program.

AFSCME
December 2008

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