

# Medicaid: A Safety Net in Need of a Patch

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Seizing the opportunity in a changing health care marketplace



# Objectives

- Increase understanding of Medicaid's:
  - Background
  - Financing
  - Interaction with the “Recovery Act” (ARRA 2009)
  - Use of Managed Care
  - Recent Trends
  - Role in Larger Health Reform

# PART 1. POLICY

“It is not sufficient for us simply to add more people to Medicare or Medicaid to increase the rolls, to increase coverage in the absence of cost controls and reform...Another way of putting it is we can't simply put more people into a broken system that doesn't work.”

*President Obama in letter to Congress dated 06/03/2009*

# Federal/State Partnership

- Federally authorized, State administered
- Federal requirements, State options
- Service delivery arrangements
- States buy health care in the marketplace
- “If you’ve seen one Medicaid program, you’ve seen one Medicaid program”

# Federal Requirements

- States must submit a Medicaid State Plan to the Centers for Medicare and Medicaid Services (CMS).
- State Plan must cover all mandatory eligibility groups and services must be covered.
- Services in the State Plan have to be available statewide for all beneficiaries in the same amount, duration and scope (DRA 2005 created some exceptions).

# Eligibility (Mandatory)

- Families and Children:
  - children <6 with family incomes below 133% FPL
  - children 6-19 with family incomes < 100% FPL
  - pregnant women with incomes below 133% FPL
  - children in foster care or adoption assistance
- Elderly and Disabled:
  - SSI and qualified severely impaired individuals
- Low-income Medicare Beneficiaries:
  - QMBs, SLMBs, QIs, and QDWIs

# Services (Mandatory)

- Certain basic services must be provided to the categorically eligible population, including:
  - inpatient and outpatient hospital services
  - physician services
  - med/surg dental services
  - nursing facility & home health services (21 & older)
  - family planning services and supplies
  - health clinic services
  - lab and x-ray services
  - pediatric and family nurse practitioner services
  - nurse-midwife services
  - EPSDT (younger than 21)

# Waivers

- Research and Demonstration Projects (Section 1115 of the Social Security Act).
  - broad in scope, including more than just Medicaid
  - typically statewide
  - cover an estimated 8 million enrollees
  - occur in 17 states and account for about one-fifth of Medicaid spending
  - required to be “budget-neutral”
  - allow coverage expansion

# Waivers (continued)

- Program Waivers (Section 1915 of the SSA)
  - specific to Medicaid
  - required to be “cost-neutral”
  - do not allow coverage expansion
  - Section 1915(b) “Freedom of Choice” waivers permit states to implement models, such as mandatory enrollment in managed care, that restrict choice.
  - Section 1915(c) “Home and Community Based Services (HCBS)” waivers allow states to provide HCBS alternatives to institutional care.

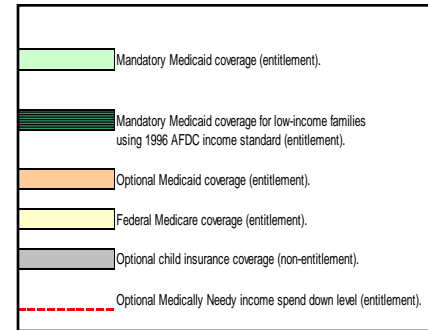
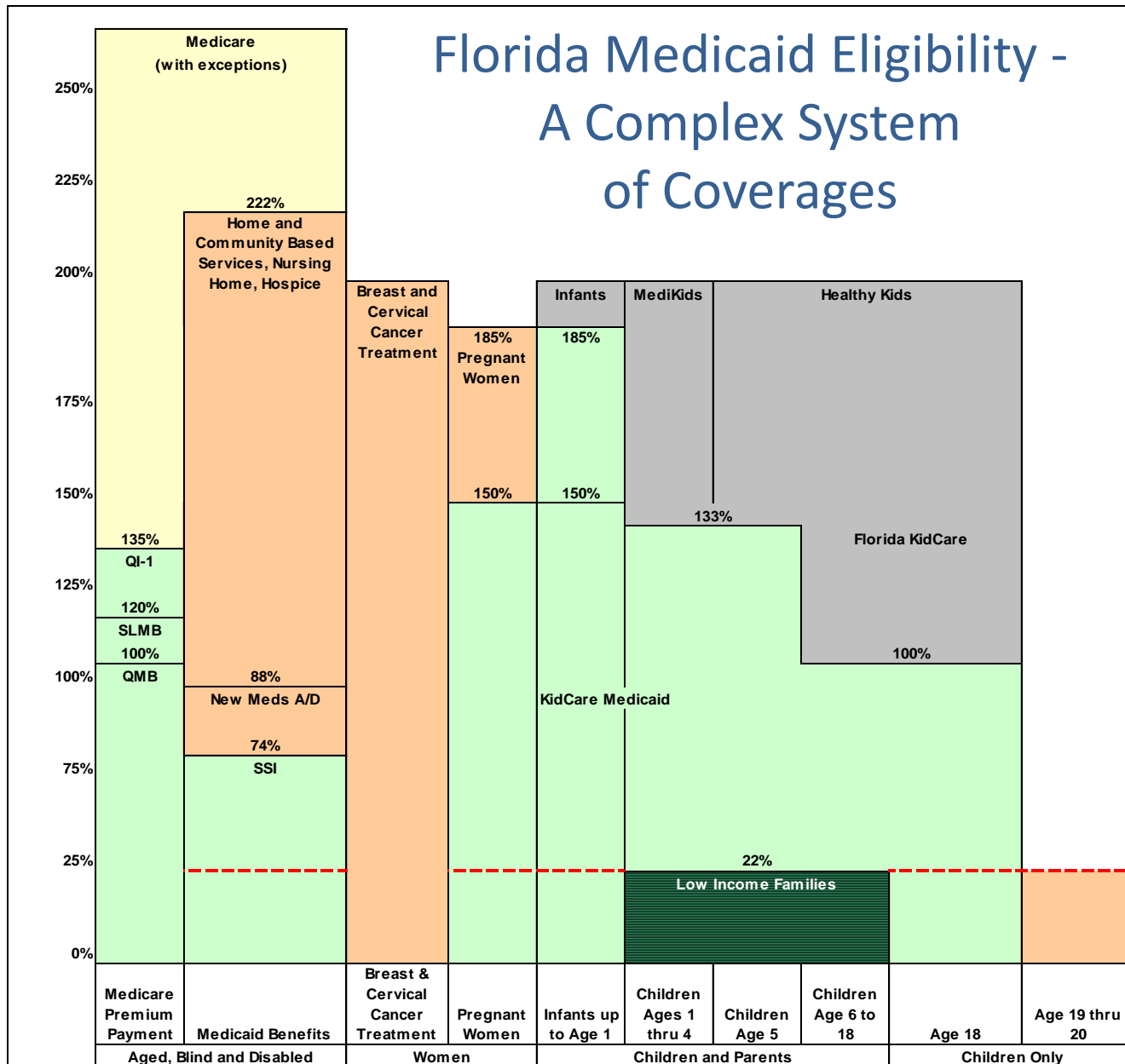
# ...and then along came DRA (2005)

- Premiums and cost-sharing have traditionally been prohibited under traditional Medicaid for most eligibility groups but after the Deficit Reduction Act of 2005, states may now require certain beneficiaries to share in the cost of Medicaid services.
- Allows states to incorporate in their State Plan what used to require a waiver.

...and this all leads to?



# Florida Medicaid Eligibility - A Complex System of Coverages



Family Size	**Monthly Income
1	\$850
2	\$1,140
3	\$1,430
4	\$1,720
5	\$2,010
6	\$2,300
7	\$2,590
8	\$2,880
Each Additional	\$290

\*Coverage for infants up to 185% Federal Poverty Level is required in order for states to receive Title XXI funding.

\*\*Federal Poverty Level as of January 2007

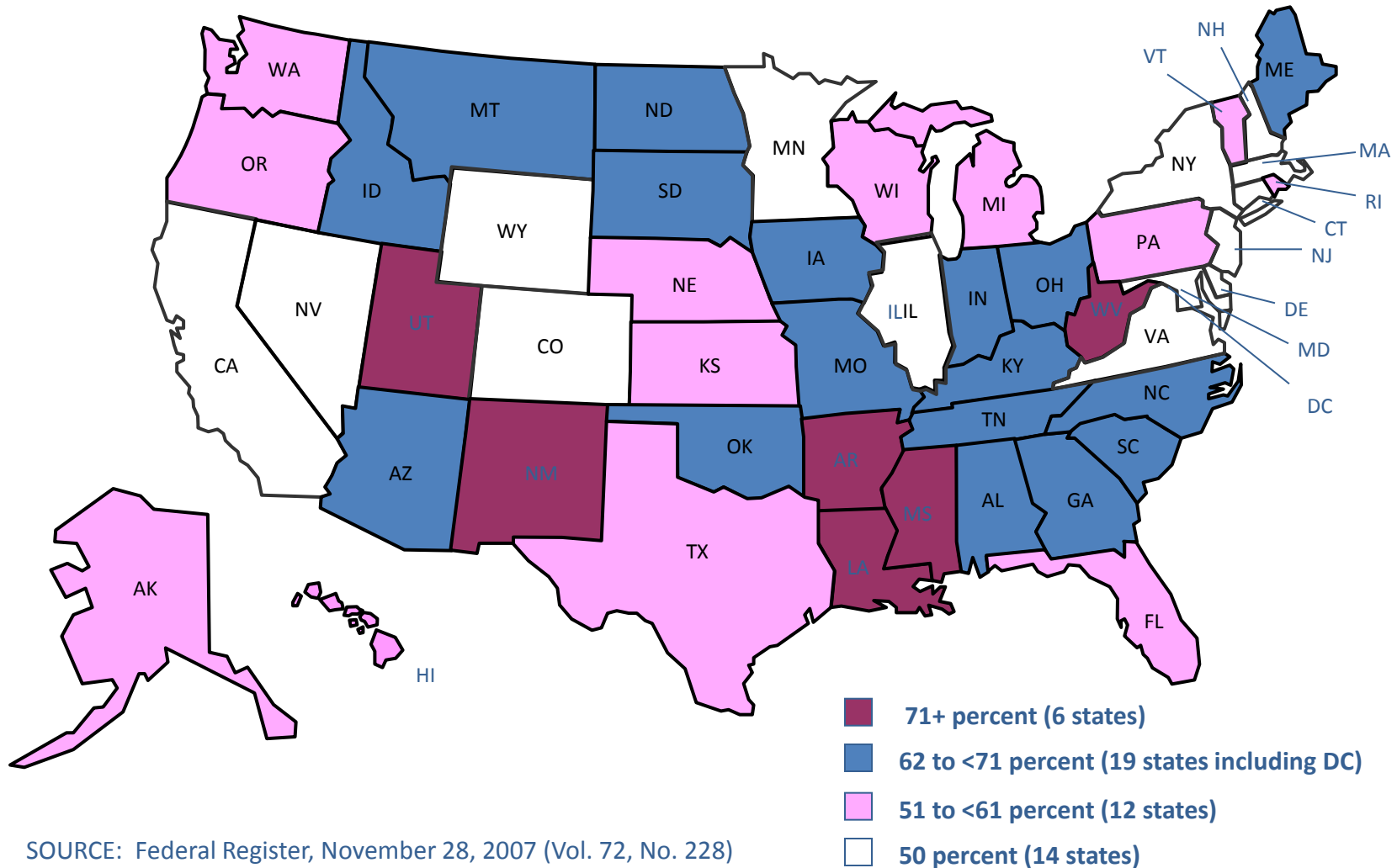
## PART 2. FINANCE

“This projected trend in Medicare and Medicaid spending obviously has implications for government budgets. For a given path of revenue and non-health spending, the projected behavior of Medicare and Medicaid in the absence of reform implies an unsustainable rise in the Federal deficit. Since state governments pay for a large fraction of health care for low-income populations, particularly through Medicaid, rising health care costs also have serious implications for state budgets. And, because states must balance their budgets each year, the budgetary pressures are felt more quickly at the state level. ” *President’s Council of Economic Advisors on 06/02/2009*

# Federal Financing

- States pay up-front for services and are reimbursed by the Federal Government for a percentage of their expenditures.
- This percentage is referred to as the Federal Medical Assistance Percentage (FMAP), which varies based on relationship of state's per capita income to national per capita income and ranges from 50% to 76%\*
- FMAP adjusted annually using lagged data
- Federal Government also reimburses for a percentage of administrative costs (usually a flat 50 percent) and IT systems (usually a flat 90 percent)
- Medicaid accounts for over 40 percent of all Federal funds flowing to states

# Federal Medical Assistance Percentages, FY 2009

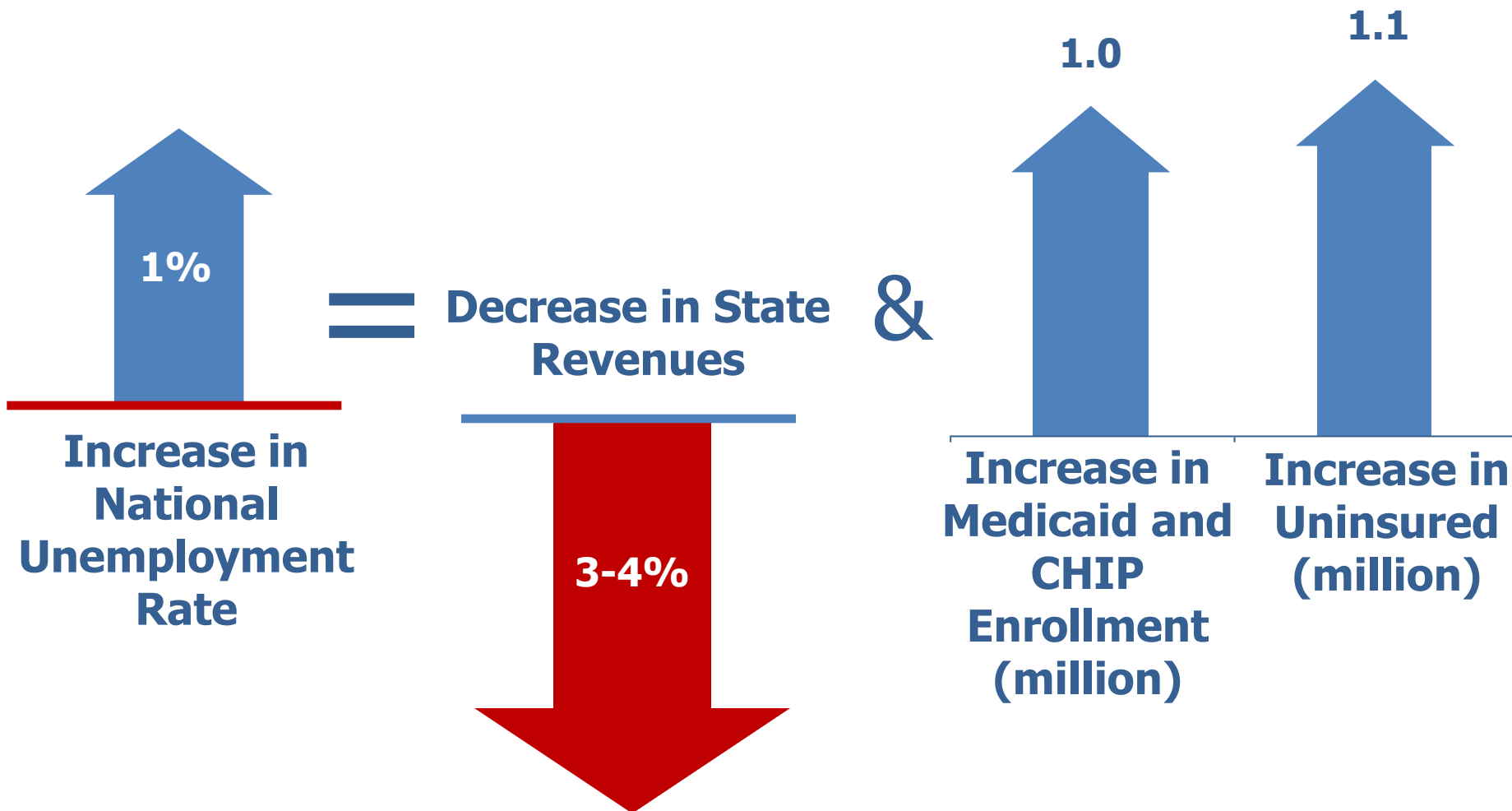


SOURCE: Federal Register, November 28, 2007 (Vol. 72, No. 228) and Friday, December 7, 2007 (Vol. 72, No. 235)

# State Financing

- State and/or local general fund revenues appropriated to Medicaid
- “Permissible” health care-related taxes and “bona fide” provider-related donations
- Inter-Governmental Transfers (IGTs) and Certified Public Expenditures (CPEs)
- Medicaid is 2nd highest expenditure (about 20% and growing) in state budgets after education
- Medicaid is “counter-cyclical”
- Requirement for balanced budgets

# Impact of a 1% Point Increase in Unemployment on State Revenues, Medicaid, CHIP & Uninsured



Source: J Holahan and B Garrett, [Rising Unemployment, Medicaid, and the Uninsured](#), prepared for the Kaiser Commission on Medicaid and the Uninsured, January 2009.

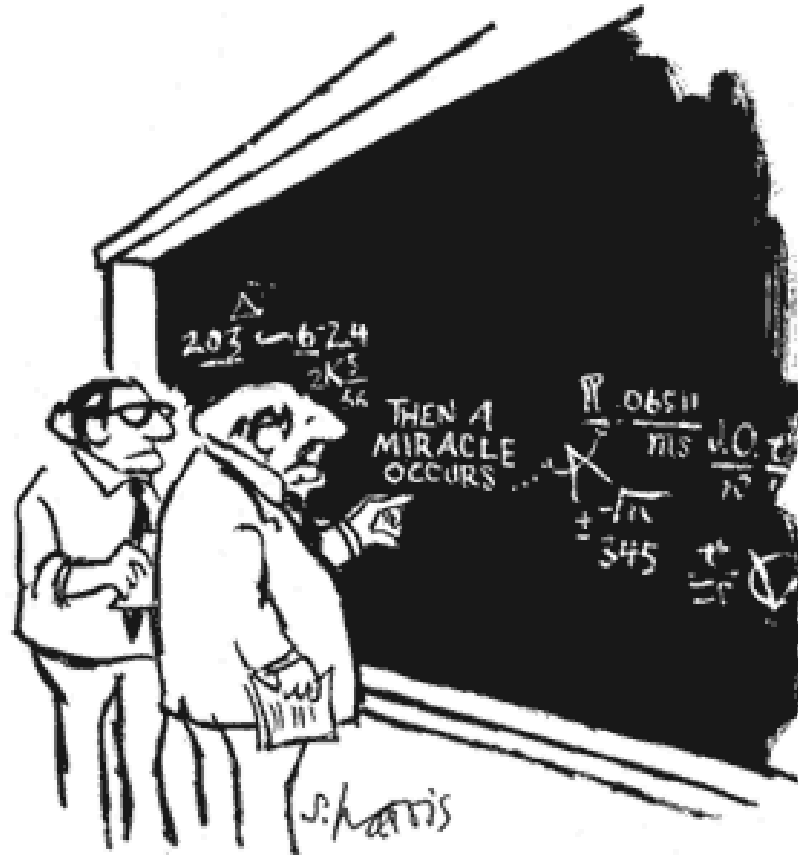
# Wishful Thinking

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**“This part of the plan will be funded with all the unused money we must have laying around someplace.”**

# Budget "Alchemy"



"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."

# Impact on State Budgets

- So far, 42 states were forced to reduce enacted budgets in fiscal 2009 by \$31.6 billion compared to 13 states in FY08.
- 35 states assume negative budget growth for fiscal 2010 governors' recommended general fund budgets, while 30 states are estimating negative growth budgets for fiscal 2009.
- State fiscal conditions historically lag behind any national economic recovery, which indicates state fiscal conditions will remain weak into fiscal years 2011 and 2012.

Source: National Governor's Association. Fiscal Survey of States (2009). <http://www.nga.org/Files/pdf/FSS0906.PDF>

# Cost Containment

- The “usual suspects”
  - Strategy 1: Medicaid Maximization
  - Strategy 2: Low-Match to High-Match
  - Strategy 3: Intergovernmental Transfers
  - Strategy 4: Private Sector Cost Sharing
  - Strategy 5: Reconfiguring the LTC Delivery System
  - Strategy 6: Pharmacy Cost Containment Strategies
  - Strategy 7: Rate Adjustment
  - Strategy 8: Managing Health Care Better
  - Strategy 9: Expanding Managed Care
  - Strategy 10: Selective Contracting

Source: National Conference of State Legislatures. *Medicaid Cost Containment – A Legislator’s Toolkit* (2002).

## ...But

- Since the economy worsened so quickly and deeply, states were forced to make difficult decisions about
  - eligibility
  - benefits/cost-sharing
  - reimbursement

# Impact on Beneficiaries



# PART 3. PAYMENT

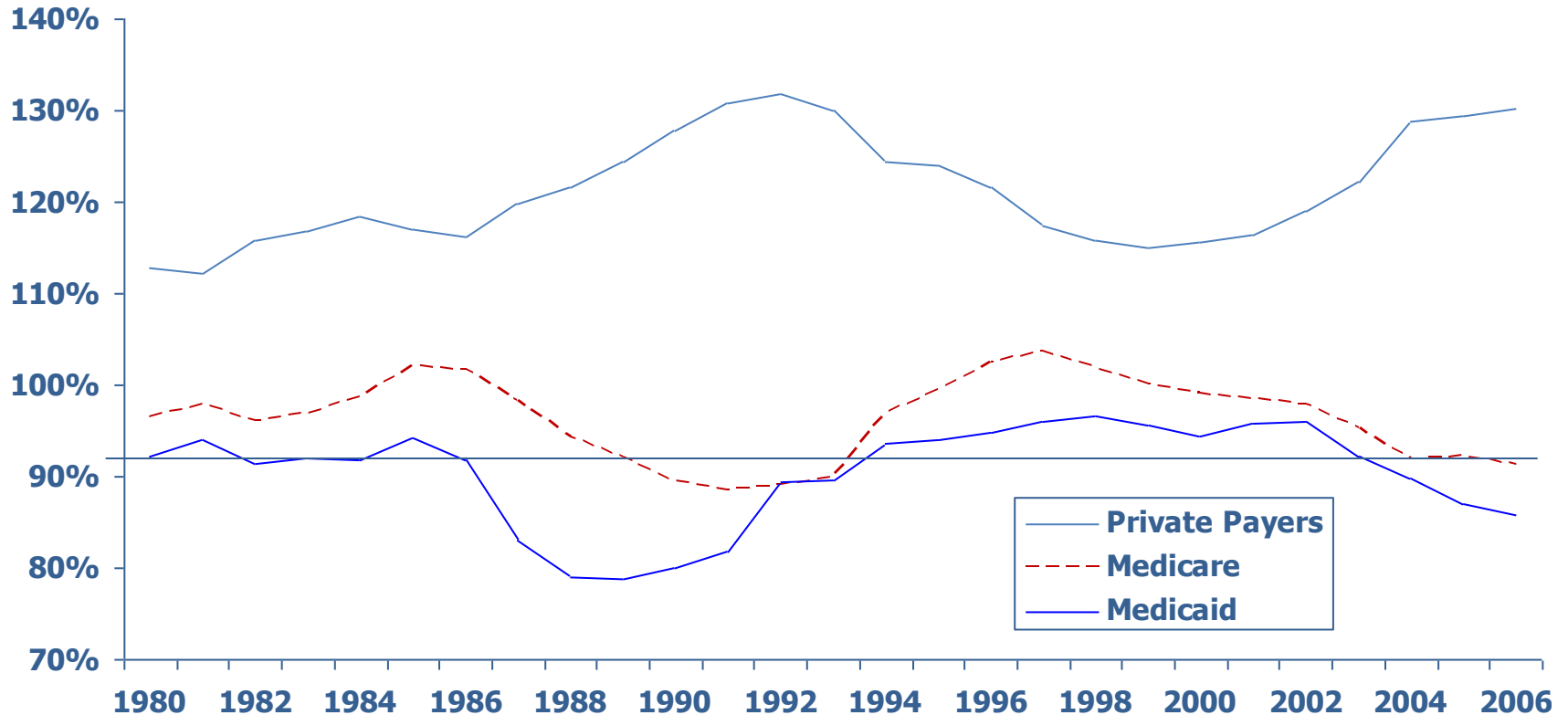
“Low and slow.”

*Anonymous doctor responding to the question “What do you think of Medicaid payment?”*

“Our nation has a clear history of reducing health care program budgets through across-the-board cuts to health care professionals, and the impact on patients is reduced access to care ... Public safety-net programs like Medicaid and Medicare need to be properly financed so that they work for patients and physicians.”

*Joseph Heyman, chairman of the AMA in the USA Today on 06/03/2009*

# Community Hospital Payment-to-Cost Ratios, by Source of Revenue, 1980-2006



Source: American Hospital Association and Avalere Health, Avalere Health analysis of 2006 American Hospital Association Annual Survey data, for community hospitals, *Trendwatch Chartbook 2008, Trends Affecting Hospitals and Health Systems*, April 2008, Table 4.4, p. A-35, at <http://www.aha.org/aha/trendwatch/chartbook/2008/08appendix4.pdf>.

# Physician Payment

- Medicaid physician fees grew by more than 15 percent from 2003 to 2008, but fell in real terms because the gains did not keep pace with inflation.
- Medicaid fees did grow faster than Medicare fees during that period, however, rising from 69 percent of Medicare in 2003 to 72 percent by 2008.

Source: Stephen Zuckerman, Aimee Williams, and Karen Stockley. **Trends In Medicaid Physician Fees, 2003-2008.** *Health Affairs* Web Exclusive, April 28, 2009

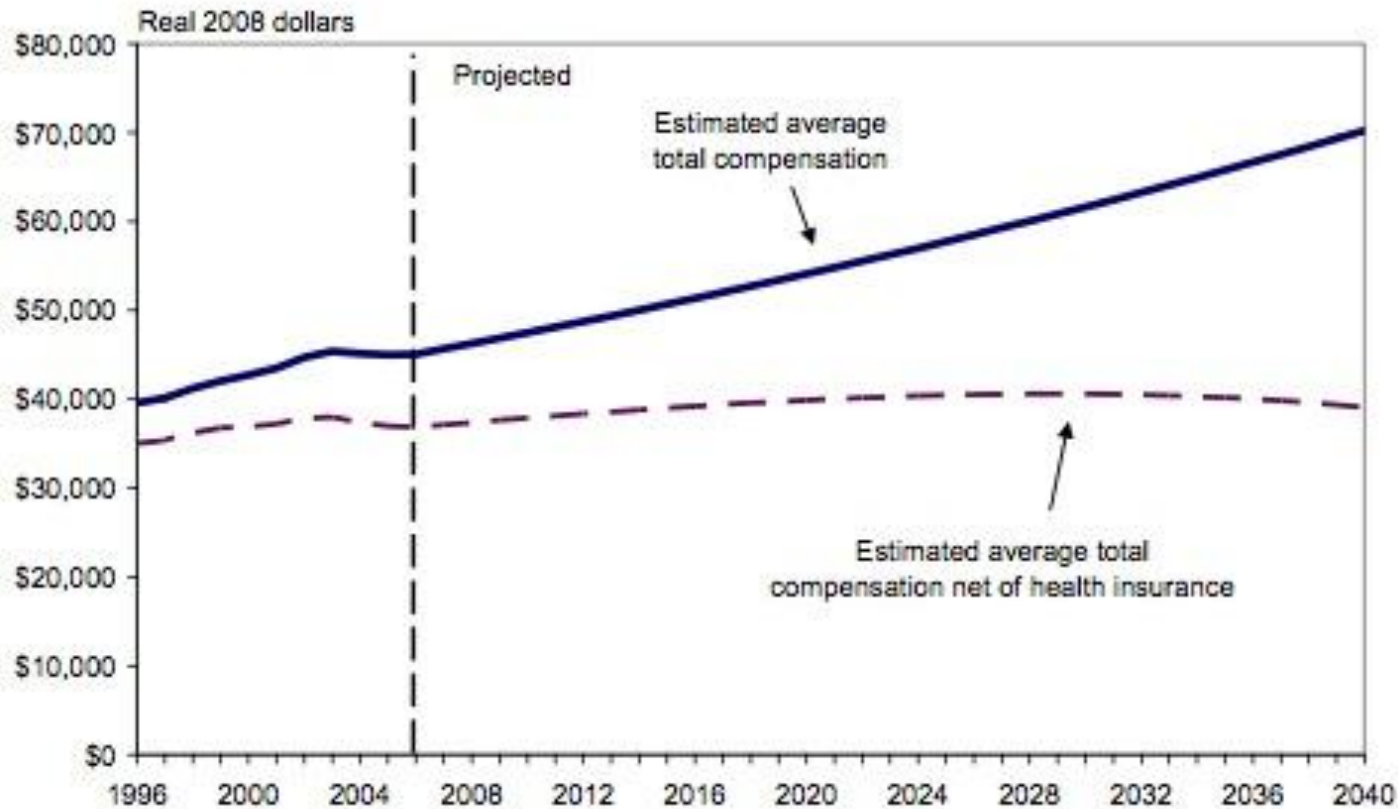
# Access



“Is there a Doctor who accepts Medicaid in the house?”

# Where Does this Cost Shift Go?

**Figure 3: Projected Annual Total Compensation and Compensation Net of Health Insurance Premiums**



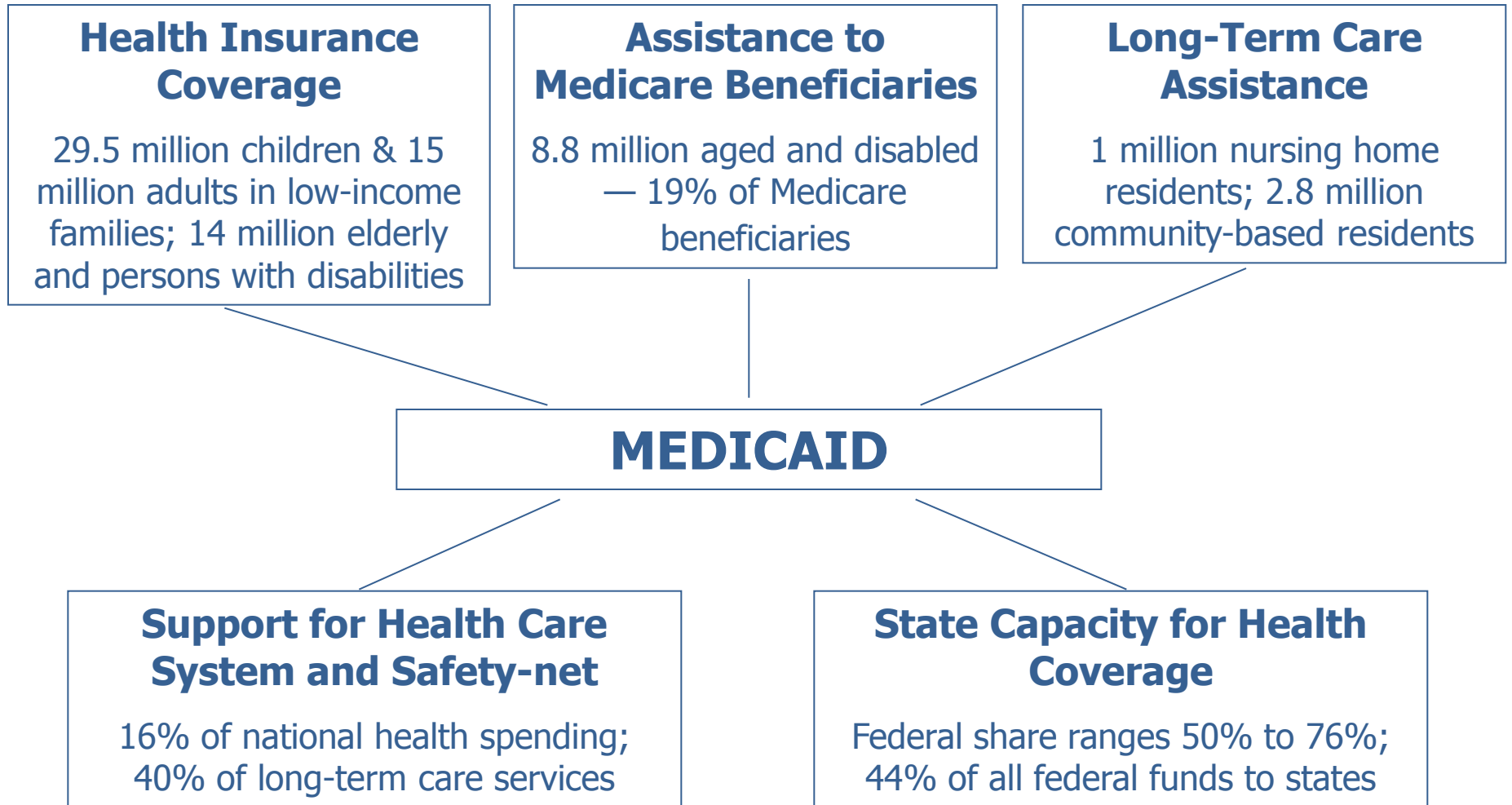
Source: CEA calculations.

# PART 4. IMPACT

“What's Medicaid? I know I hear it ... I really don't know what it is. I know that's a big shock to everyone in the audience, Okay?”

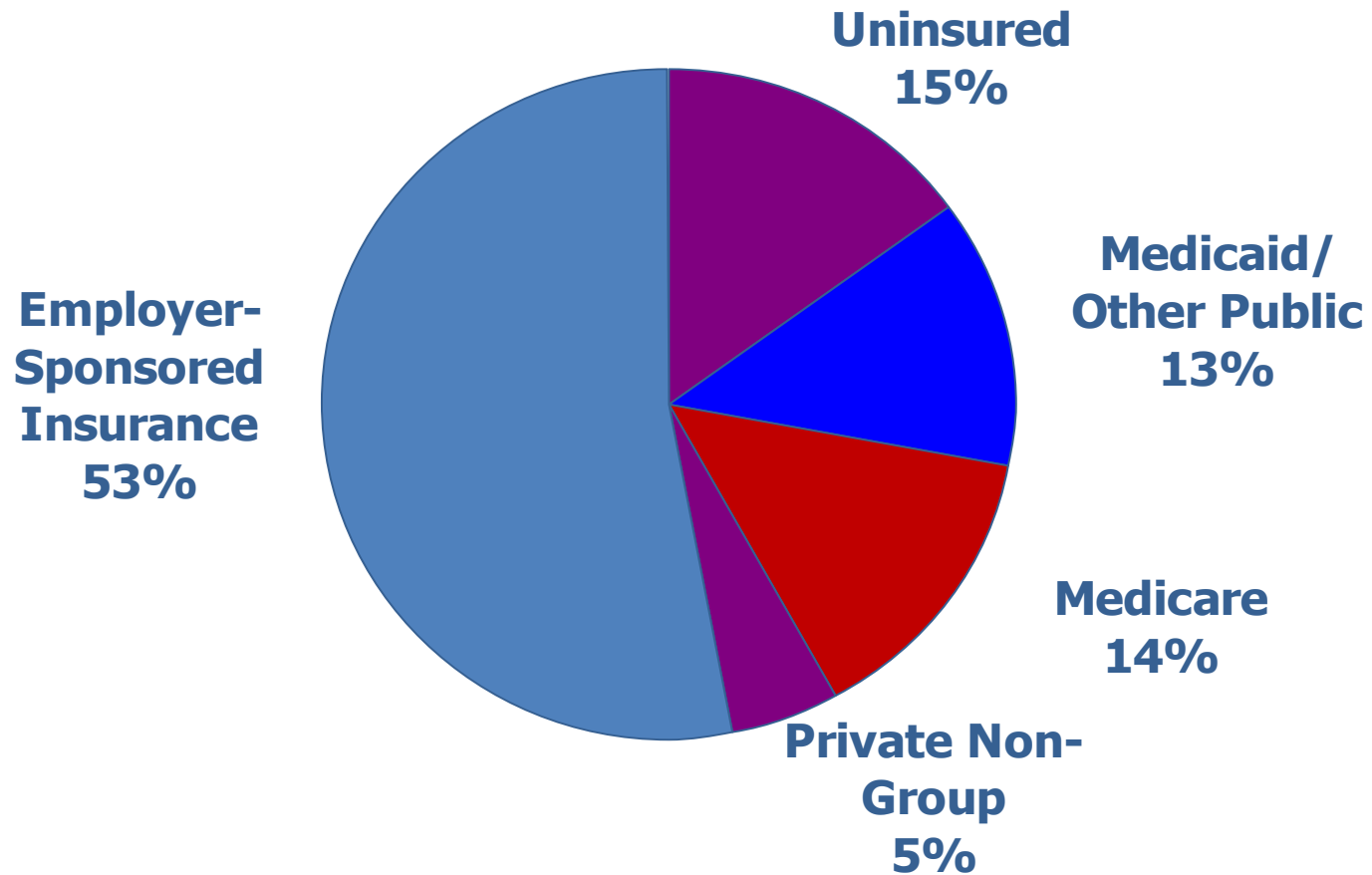
*Gary Elkins, an eight-term member of the Texas House of Representatives and member of the Health and Human Services Committee, at a meeting on 03/24/2009*

# Medicaid Today



SOURCE: Kaiser Commission on Medicaid and the Uninsured, 2009

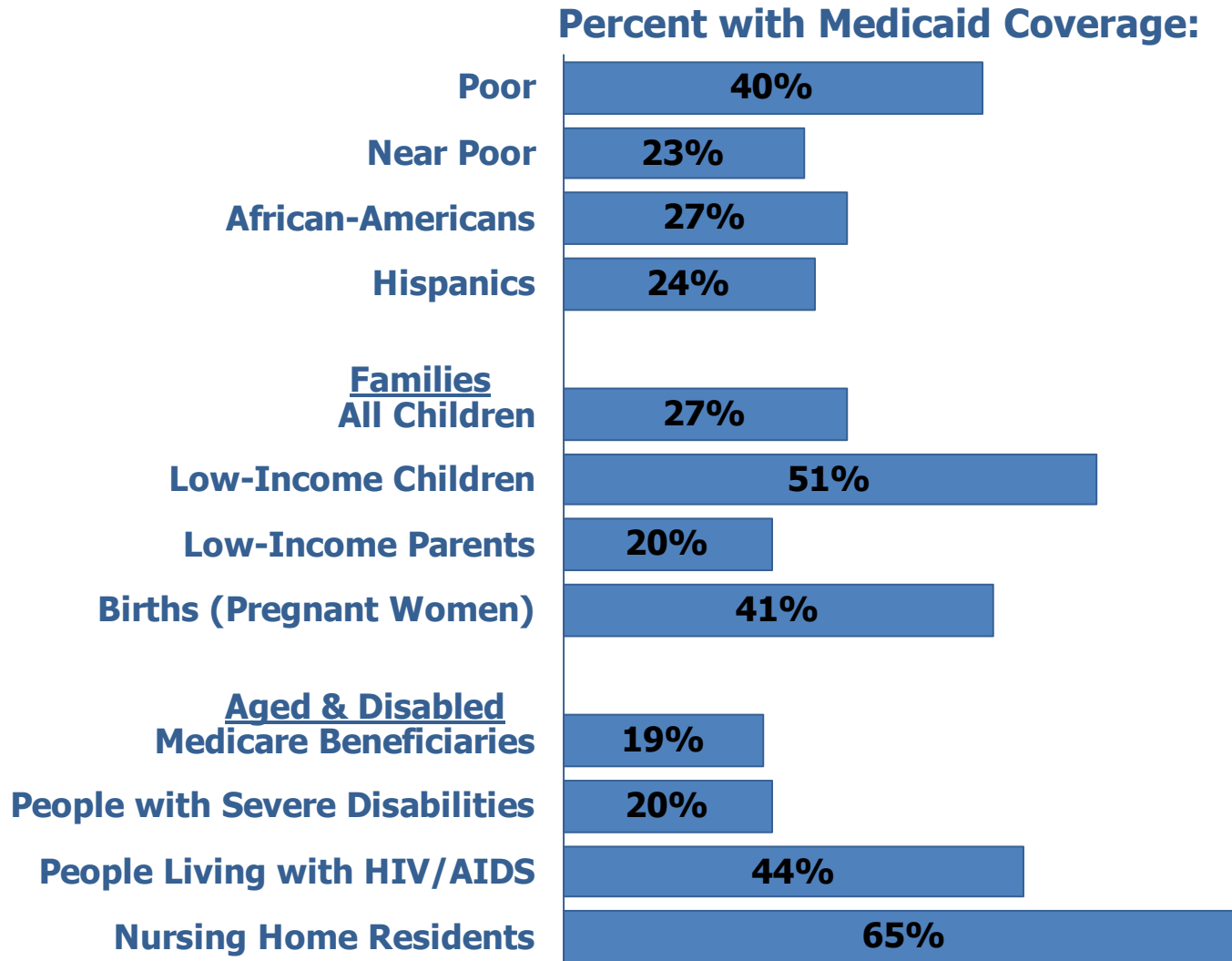
# Health Insurance Coverage in the U.S., 2007



**Total = 298.2 million**

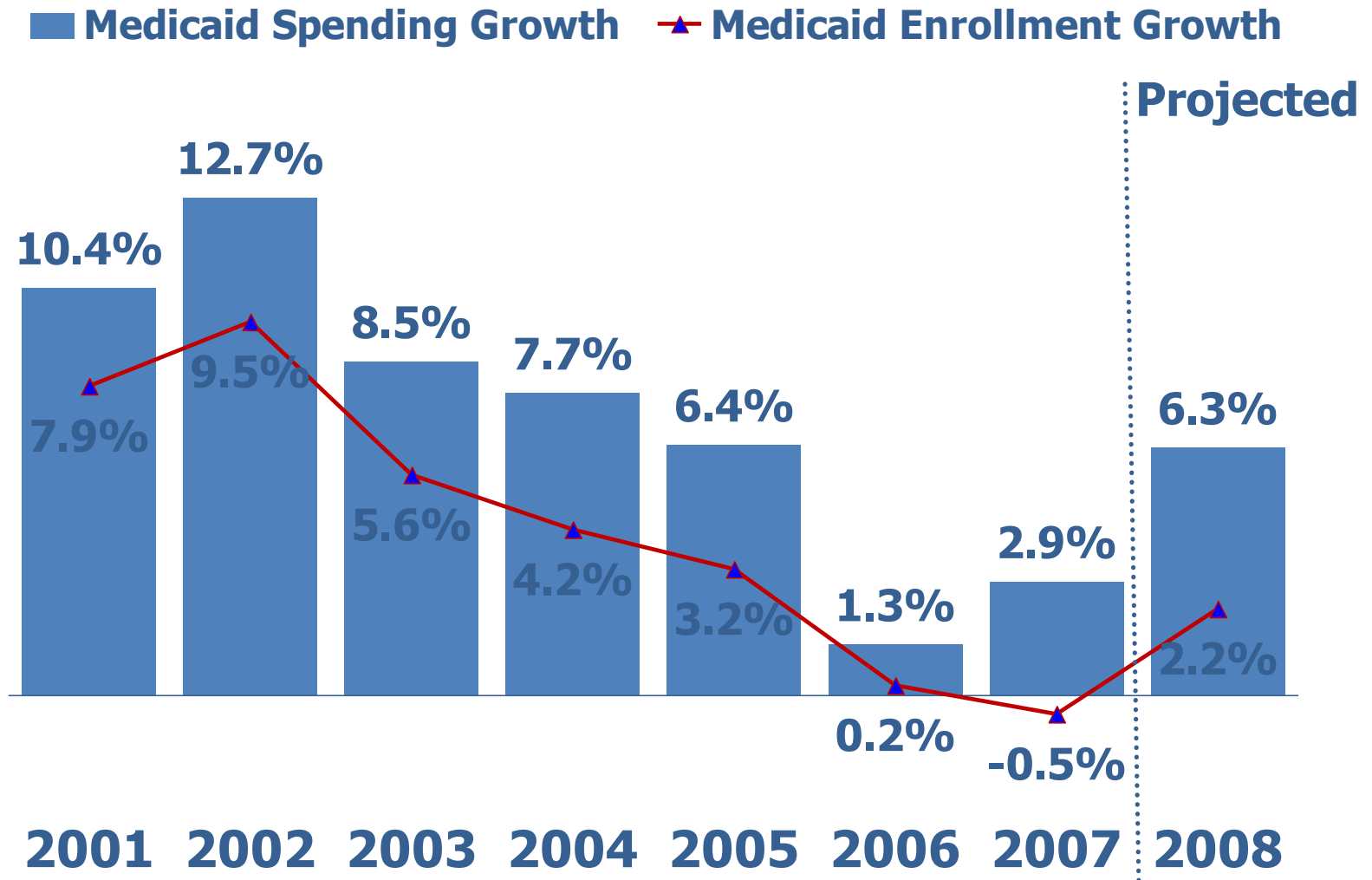
SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of March 2008 CPS

# Medicaid's Role for Selected Populations



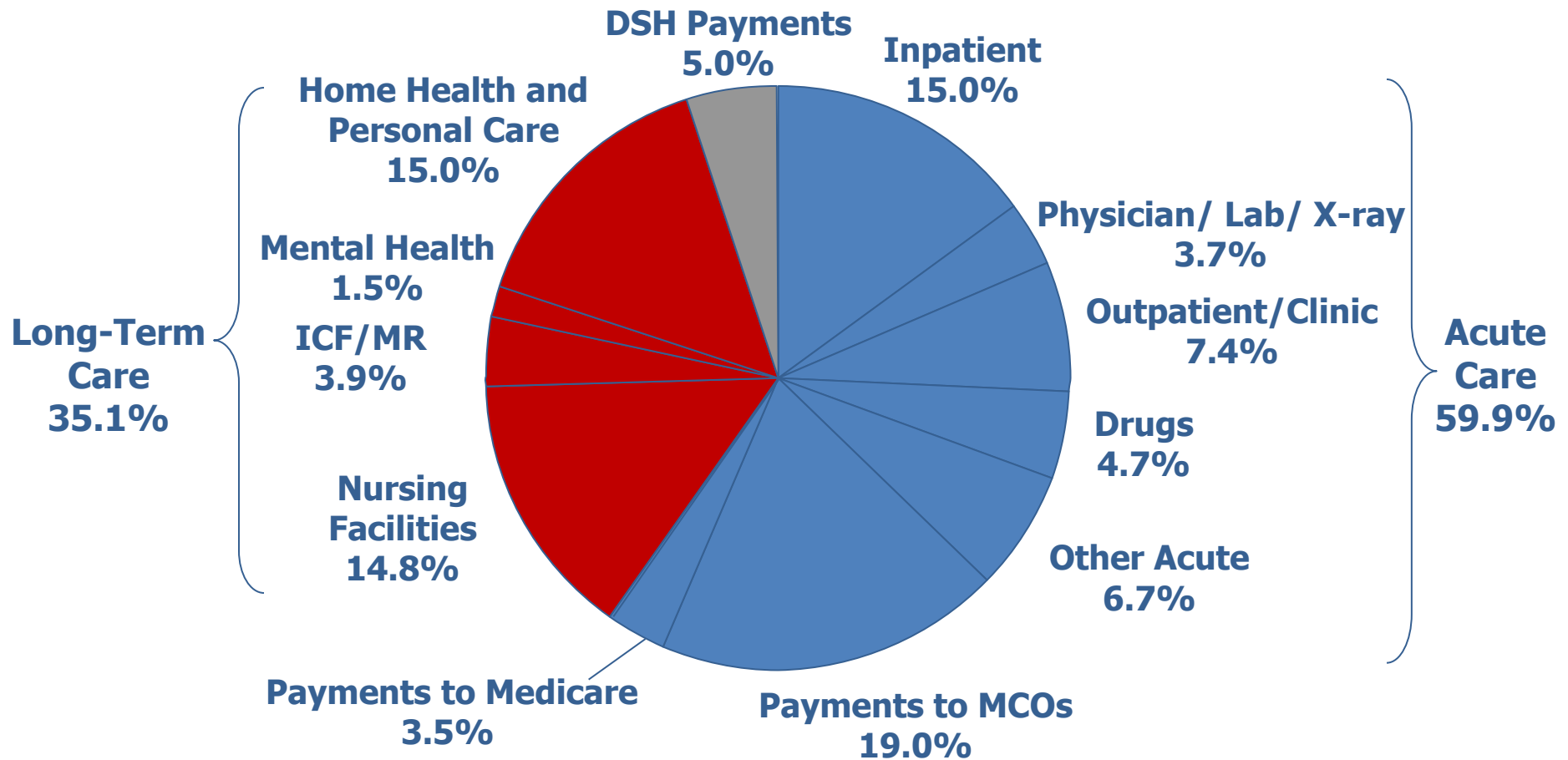
SOURCE: KCMU, KFF, and Urban Institute estimates; Birth data: NGA, MCH Update.

# Percent Change in Medicaid Spending and Enrollment, FY 2001-2008



Source: KCMU survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2007.

# Medicaid Expenditures by Service, 2007

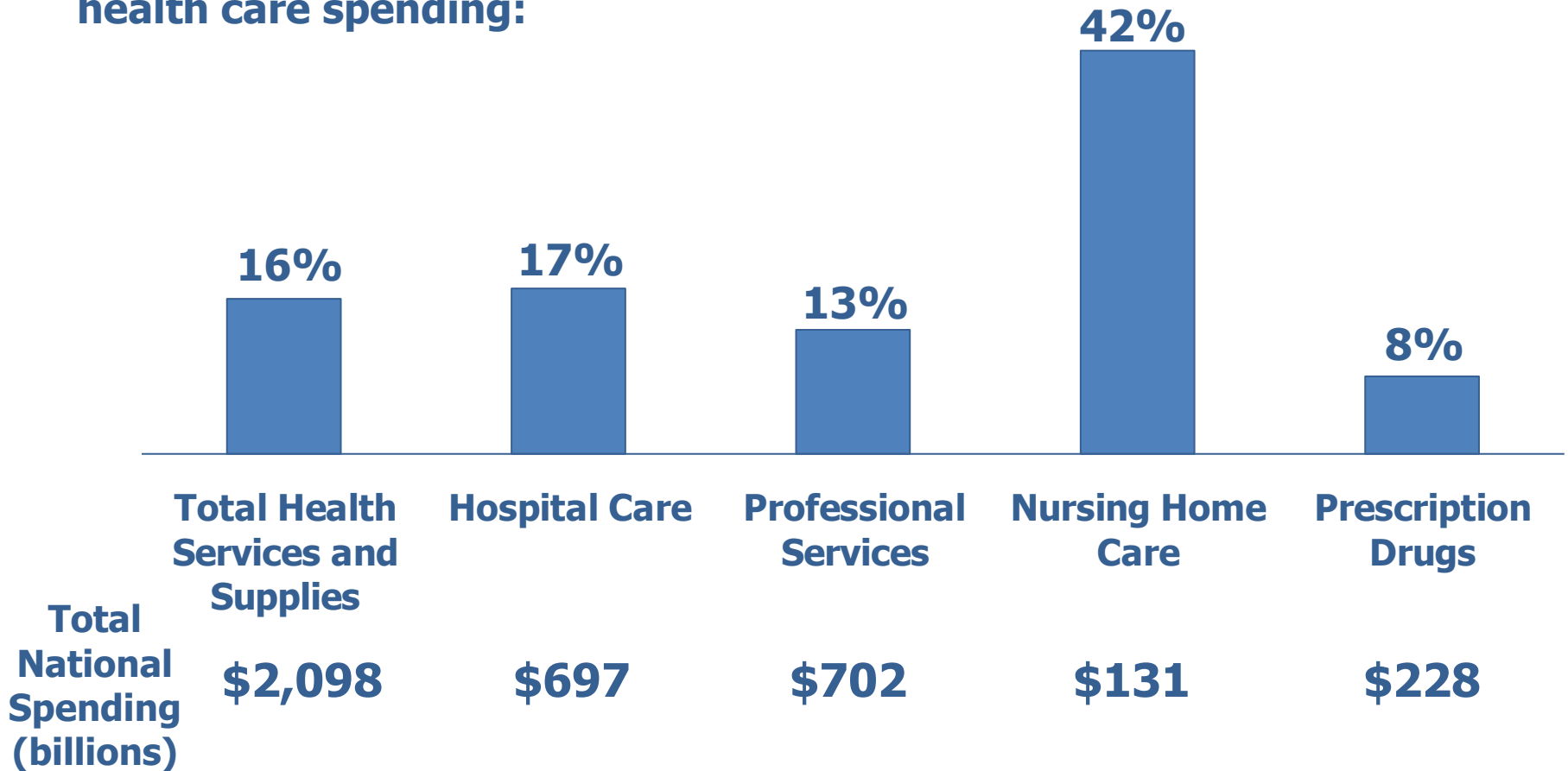


**Total = \$319.7 billion**

SOURCE: Urban Institute estimates from data on CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured.

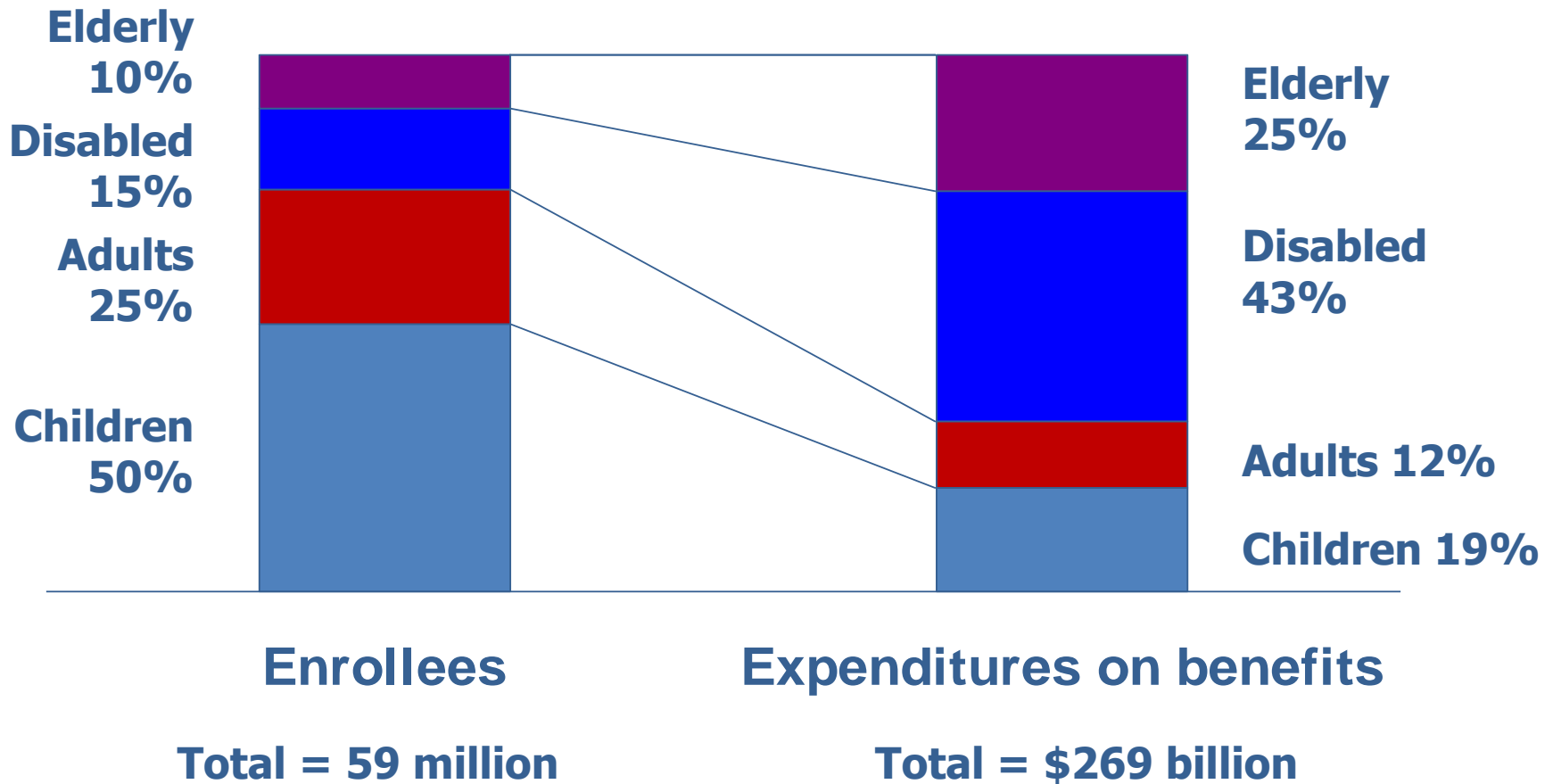
# Medicaid in the Health System, 2007

**Medicaid as a share of national health care spending:**



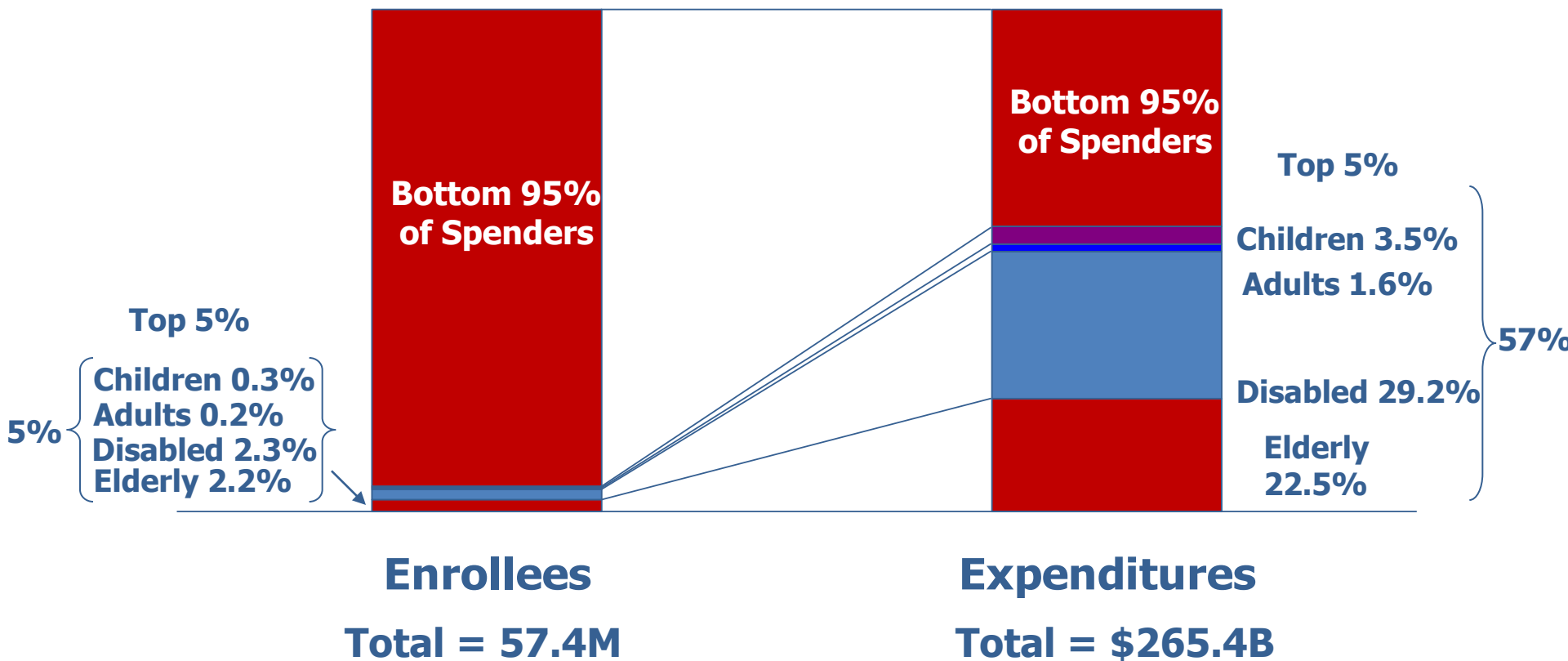
SOURCE: CMS , Office of the Actuary, National Health Statistics Group, *National Health Expenditure Accounts*, January 2009.

# Medicaid Enrollees and Expenditures by Enrollment Group, 2006



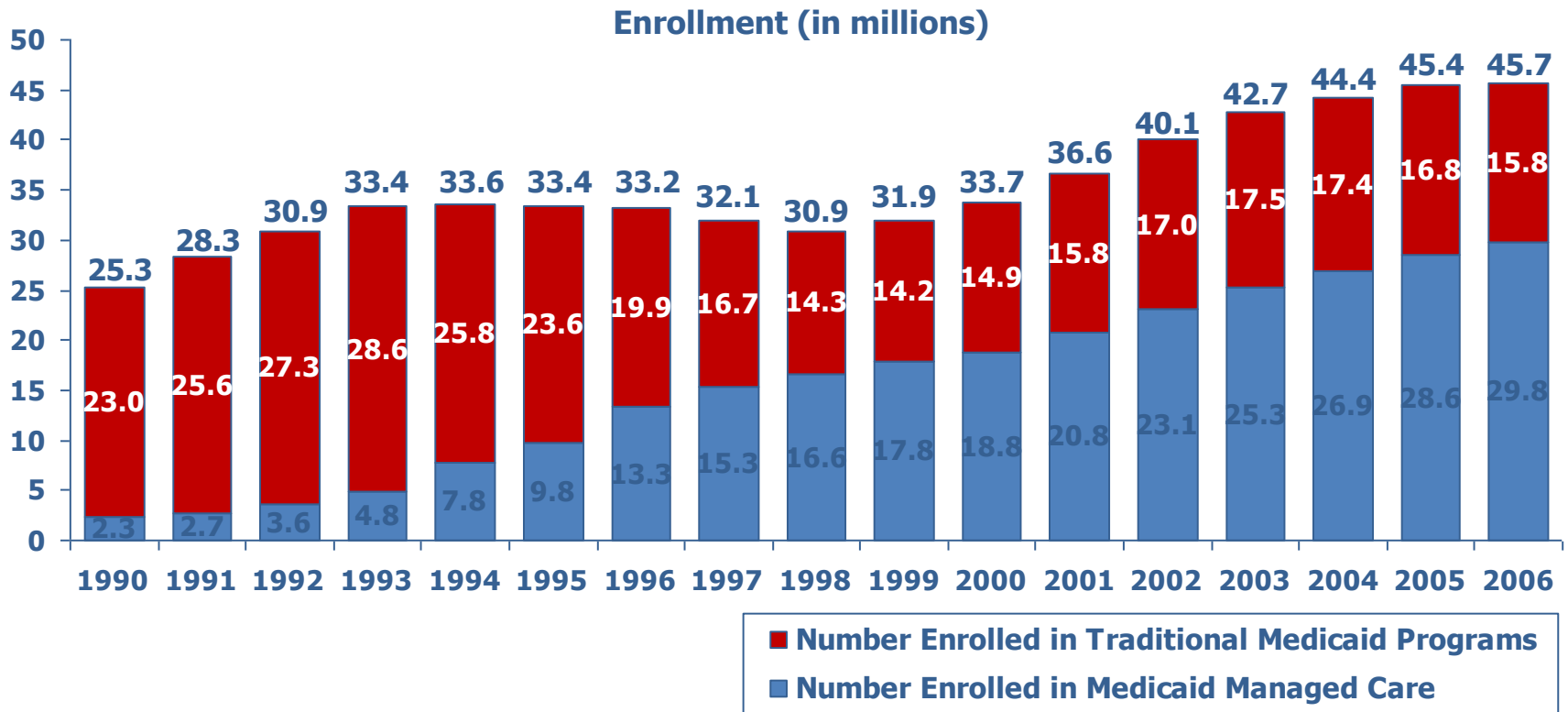
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2006 MSIS data.

# Top 5% of Enrollees Accounted for More than Half of Medicaid Spending in 2004



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on MSIS 2004.

# Medicaid Managed Care and Traditional Enrollment, 1990-2006



Source: Kaiser Family Foundation, Trends and Indicators in the Changing Health Care Marketplace, 2002, May 2002, Exhibit 2.8, p.23, at <http://www.kff.org/insurance/3161-index.cfm>, using and updated with data from the Centers for Medicare and Medicaid Services, at [http://new.cms.hhs.gov/MedicaidDataSourcesGenInfo/06\\_MdManCrEnrllRep.asp](http://new.cms.hhs.gov/MedicaidDataSourcesGenInfo/06_MdManCrEnrllRep.asp).



# PART 5. REFORM

“All great leaders have had one characteristic in common: it was the willingness to confront unequivocally the major anxiety of their people in their time. This, and not much else, is the essence of leadership.”

*John Kenneth Galbraith , Economist*

# State-Based Reform

- Delivery system reforms – HIT, disease management, medical homes, pay for performance, service integration, centers of excellence
- Coverage reforms – prevention/primary care, comparative effectiveness, Medicare/Medicaid coordination, community LTC
- Consumer behavior, community wellness focus
- Increased rates of private coverage through “connectors”

# National Reform

- Medicaid buys in the health care marketplace
- Expect Medicaid to have a large role in any national reform efforts
- Public Plan?

# Some States of Note

- New York
- Florida
- North Carolina
- Oklahoma
- Indiana
- Tennessee
- Louisiana
- Vermont
- Arizona
- Massachusetts

# Summary

Medicaid is an integral part of the public safety net but it needs a major retooling if it is going to play a major role in national health reform.

It will need to transform itself from a passive payor to an active player in each state's public health system and a purchaser of higher quality, more efficient health care.

This will necessitate funds, faith, and sacrifice, but it will ultimately align the interests of stakeholders and increase value.

# Thank You

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