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Making Medicaid Work: Protect the Vulnerable, Offer Individualized Care, and Reduce Costs

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MAKING MEDICAID WORK

*PROTECT THE VULNERABLE, OFFER INDIVIDUALIZED CARE,
AND REDUCE COSTS*



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Committee

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EXECUTIVE SUMMARY: MAKING MEDICAID WORK

PROTECT THE VULNERABLE, OFFER INDIVIDUALIZED CARE, AND REDUCE COSTS

Medicaid, a state-federal partnership program created in 1965, was designed as a safety net for the most vulnerable Americans. While the program covered just four million people in its first year, today, there are approximately 68 million Medicaid enrollees¹ - more recipients than any other government health care program, including Medicare. That is nearly one out of every four Americans. The data show that the size and costs of today's Medicaid are compromising the program's mission. Unequivocally, if Medicaid is to continue fulfilling its safety net mission to the country's most vulnerable, the program must be fixed.

One of the most successful, bipartisan repairs to an American safety net program was the Personal Responsibility and Work Opportunity Reconciliation Act of the 1990s - more commonly known as welfare reform. Solutions for sustainable welfare reform came from the states - not one-size-fits-all social engineering from Washington - and the same model of federalism will work to fix Medicaid. This joint congressional committee blueprint, *Making Medicaid Work*, is based on careful analysis of the extensive feedback from the states, input from providers and patients, and the reality of the country's fiscal condition. It seeks to modernize the Medicaid program in two primary ways: (1) equipping states to implement patient-centered reforms; and, (2) imposing fiscal discipline in the program.

First and foremost, Medicaid reform should be about improving the quality of care offered to enrollees. While politicians promise care and benefits, the antiquated Medicaid program does not deliver the level of quality patients deserve. *Making Medicaid Work* offers states new tools to implement innovative, patient-centered reforms. States could design individualized benefit packages based on proven, successful models like value-based insurance design or the benefit package offered to Members of Congress. The blueprint would also encourage states to reform their health care delivery systems through increased provider transparency and value-based purchasing. States choosing to expand coordinated care would also be able to expand more quickly than under current law and do so free from current statutory barriers. Under the blueprint, the federal government would prioritize responding to bold ideas from forward-thinking states to improve the quality of care in their Medicaid programs.

¹ Congressional Budget Office (CBO). The 2012 Long-Term Budget Outlook. June 2012. Available online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term_Budget_Outlook_2.pdf

Currently, federal taxpayers are required by law to match whatever state politicians spend on Medicaid. This open ended liability is a significant risk to the program's future financial soundness. The federal share of Medicaid spending as a share of the economy is set to grow by 25 percent over the next 10 years,² with total federal spending during that time reaching nearly \$5 trillion.³ Meanwhile, Medicaid represents the single largest portion of state budgets crowding out other important investments such as education.⁴ In response to these challenges, this blueprint proposes the adoption of per capita caps, a proposal that has been advocated by politicians across the ideological spectrum from President Bill Clinton to former Senator Phil Gramm, to implement desperately needed fiscal discipline in Medicaid while preserving access to care for beneficiaries.

² Office of Management & Budget. "Summary Tables for Fiscal Year 2014." Available online at <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/tables.pdf>

³ CBO. Medicaid, February 2013 Baseline. Available online at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43885-Medicaid.pdf>

⁴ Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (OACT). 2012 Actuarial Report on the Financial Outlook for Medicaid. Available online at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf>

MAKING MEDICAID WORK

PROTECT THE VULNERABLE, OFFER INDIVIDUALIZED CARE, AND REDUCE COSTS

Medicaid, a state-federal partnership program created in 1965, was designed as a safety net to secure care for low-income Americans, primarily pregnant women, dependent children, the blind, and the disabled. While the program covered just four million people in its first year, today, there are approximately 68 million Americans enrolled in Medicaid⁵ - more enrollees than any other government health care program, including Medicare. With the implementation of the Patient Protection and Affordable Care Act (PPACA), enrollment could grow by nearly 26 million—resulting in the largest expansion of the program in history.⁶ The data show that the size and costs of today's Medicaid are compromising the program's safety net mission for those in need.

Under today's program, the country's most vulnerable citizens have difficulty in accessing quality healthcare. A recent analysis published in *Health Affairs* found that only 69.4 percent of physicians accept Medicaid patients compared to more than 80 percent of physicians accepting privately insured patients.⁷ According to the Government Accountability Office (GAO), nearly half of children currently enrolled in Medicaid and the Children's Health Insurance Program (CHIP) are not receiving basic preventive care – even though the program requires those benefits. GAO went on to say, “Two nationally representative surveys from 2007 suggest that many children in Medicaid and CHIP needing care coordination did not receive it, and many needing access to networks of care had a problem with accessing the needed services....”⁸ The lack of preventive care often leads to more significant chronic care needs and higher mortality. Another study from the University of Virginia found, “that surgical patients on Medicaid are 13 percent more likely to die than those with no insurance at all, and 97 percent more likely to die than those with private insurance.”⁹ Now that the program has expanded beyond its original mission, its resources are spread too thinly to provide quality care to those who need it. Without serious reform, the quality of the safety net will only worsen.

Unfortunately, the quality issues plaguing the Medicaid program are not surprising given the constant interference from politicians, bureaucrats, and lobbyists in Washington. Innovative states are routinely stopped from improving patient care thanks to bureaucratic hurdles and

⁵ Congressional Budget Office (CBO). The 2012 Long-Term Budget Outlook. June 2012. Available online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term_Budget_Outlook_2.pdf

⁶ Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (OACT). 2011 Actuarial Report on the Financial Outlook for Medicaid. Available online at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2011.pdf>

⁷ Decker, Sandra L. "In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help." *Health Affairs* 31.8 (2012): 1673-1679. Available online at <http://content.healthaffairs.org/content/31/8/1673.full.pdf+html>

⁸ Government Accountability Office (GAO). Medicaid and CHIP: Reports for Monitoring Children's Health Care Services Need Improvement. GAO-11-293R. April 5, 2011. Available online at <http://www.gao.gov/new.items/d11293r.pdf>

⁹ Roy, Avik. Why Medicaid is a Humanitarian Catastrophe. *Forbes*. March 2, 2011. Available online at <http://www.forbes.com/sites/aroy/2011/03/02/why-medicaid-is-a-humanitarian-catastrophe/>

special interests. For example, Oklahoma recently learned that federal political officials would terminate the state's long-standing and successful premium assistance program known as Insure Oklahoma, which last year provided private coverage for more than 20,000 adults in the state because CMS believed the program's purpose had expired in light of PPACA implementation.

Medicaid, a program run by bureaucrats at multiple levels of government, has been on the GAO's high risk program list for years. The program wastes more than \$30 billion per year on improper payments draining scarce resources from patient care.¹⁰ Given the program's shared funding structure, patient care improvements get lost in the tug-of-war between federal bureaucrats and state politicians.

Not only is Medicaid failing patients, the program's financial troubles threaten economic opportunity. Federal Medicaid spending alone will reach nearly \$5 trillion over the next decade¹¹ – a significant driver of the compounding debt burden facing the next generation of Americans considering the nearly \$17 trillion debt that Americans currently live under.¹² The financial challenges are not just a federal debt-driver, but a state taxpayer liability as well.

But the financial sword of Damocles is not just future federal spending; states will spend an additional \$2.5 trillion on Medicaid over the next 10 years as well.¹³ According to the National Governors Association, "Medicaid represents the single largest portion of total state spending...."¹⁴ To fund Medicaid, states cut critical investments in education, which threatens the nation's ability to compete in the global economy.

Moreover, Medicaid's open-ended funding structure sets up the wrong set of incentives. Instead of a structure that drives innovation, the status quo is full of incentives for state politicians to maximize the share of Medicaid funded by federal taxpayers. In order to drive innovation that benefits patients and lowers costs, reforms are needed to financially align payments to states.

Unequivocally, if Medicaid is to continue fulfilling its safety net mission to the country's most vulnerable, the program must be fixed.

¹⁰ GAO. "The Medicaid Program (Information as it appears in the 2013 High Risk Report). Available online at http://www.gao.gov/highrisk/medicaid_program#t=1

¹¹ CBO. Medicaid, February 2013 Baseline. Available online at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43885-Medicaid.pdf>

¹² TreasuryDirect. The Debt to the Penny and Who Holds It. April 18, 2013. Available online at <http://www.treasurydirect.gov/NP/BPDLogin?application=np>

¹³ CMS, OACT. 2012 Actuarial Report on the Financial Outlook for Medicaid. Available online at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf>

¹⁴ National Governors Association (NGA). The Fiscal Survey of the States. Spring 2012. Available online at <http://www.nga.org/files/live/sites/NGA/files/pdf/FSS1206.PDF>

One of the most successful, bipartisan repairs to an American safety net was the Personal Responsibility and Work Opportunity Reconciliation Act of the 1990s. Solutions for sustainable welfare reform came from the states – not one-size-fits-all social engineering from Washington – and the same model of federalism will work to fix Medicaid. To that end, in May 2011, Representative Fred Upton, the Chairman of the House Energy and Commerce Committee and Senator Orrin Hatch, the Ranking Member of the Senate Finance Committee, wrote to the governors of all 50 states and the U.S. territories:

“Our goal is to empower the states to design and implement innovative Medicaid solutions that work for their states. Medicaid must be reformed to better serve its beneficiaries and to better use taxpayer dollars, and “We” ask you to join us in a comprehensive effort. You have run Medicaid programs and are in the best position to tell Washington how to fix Medicaid.”¹⁵

Many states have pioneered Medicaid reforms – such as West Virginia’s personal responsibility emphasis, New York’s efforts to better coordinate care for dual eligible beneficiaries, Pennsylvania’s initiative to care for individuals with mental health conditions, and Florida’s patient choice improvements – and national reforms should build on these successes.

In response to those requests, the majority of the nation’s governors outlined seven principles for true innovation and results in the Medicaid program. The governors said, “We must reassess and focus our efforts on reshaping how healthcare is delivered through innovation, creativity and responsibility – all demonstrated capabilities of states. We must bring the antiquated Medicaid program into the 21st century and secure the program’s long-term integrity.” The governors also published a landmark report, *A New Medicaid: A Flexible, Innovative and Accountable Future*, with 31 solutions to, “develop a better and more efficient Medicaid system, one that gives states greater flexibility, spurs delivery innovation, encourages greater accountability, and reduces the cost of the program to states and the federal government alike.”¹⁶

This joint congressional committee blueprint, *Making Medicaid Work*, is based on careful analysis of the extensive feedback from the states, input from providers and patients, and the facts about the country’s fiscal condition. It seeks to modernize the Medicaid program in two primary ways: 1) equipping states to implement patient-centered reforms and 2) implementing fiscal discipline in the program.

We must improve the quality of care for our nation’s most vulnerable citizens by providing states new tools to implement innovative, patient-centered reforms based on models with proven

¹⁵ Committee on Energy and Commerce and Senate Finance Committee. Congressional Leaders Seek Governors’ Feedback to Improve Medicaid.” May 23, 2011. Copy of letter available online at <http://energycommerce.house.gov/press-release/congressional-leaders-seek-governors-feedback-improve-medicaid>

¹⁶ Republican Governors Association (RGA), Public Policy Committee. “A New Medicaid: A Flexible, Innovative and Accountable Future.” August 30, 2011. Available online at http://www.scribd.com/fullscreen/63596104?access_key=key-16dzhu6py6idfkjmi8it

success and in a way that fosters future innovation. There are many ways to implement fiscal discipline in the Medicaid program, such as block grants that cap the amount of spending the federal government sends to states and proposals that limit the amount of federal dollars spent for each Medicaid beneficiary (per capita caps). This blueprint proposes a bipartisan solution similar to a proposal put forward by President Bill Clinton in 1995 and one that has had the support of conservatives such as former Senators including Phil Gramm (R-TX) and the late Jesse Helms (R-NC). Putting the Medicaid program on a sustainable budget with per capita caps will establish transparent funding streams for states to meet the individual health care needs of distinct Medicaid population categories.

GOAL 1: EMPOWER STATES TO IMPLEMENT INNOVATIVE, PATIENT-CENTERED REFORMS

First and foremost, Medicaid reform should be about improving the quality of care offered to benefit recipients. The antiquated Medicaid program does not deliver the level of quality patients deserve. We must begin by identifying which regulatory barriers prohibit states from designing benefits to address the healthcare challenges of each distinct Medicaid population and then offer states new tools to implement innovative, patient-centered reforms.

Encourage Individualized Benefit Designs

In identifying the healthcare needs of each Medicaid population group, states need the flexibility to design appropriate benefit structures to meet the needs of their enrollees in a quality-driven, cost-effective, and efficient manner. Recognizing that one solution will not work for every state nor every Medicaid population, this blueprint offers states a menu of options from which to design benefits.

- ✓ Additional Benchmark Benefit Design Options: Under CHIP, states have long been permitted to choose from several “benchmark plans” in designing coverage options: the state’s largest non-Medicaid or private coverage HMO, the state’s employee health plan, the BlueCross BlueShield plan offered to Members of Congress and federal employees, or an innovative plan approved by the Secretary of Health and Human Services (HHS). Building upon the intent of the reforms in the Deficit Reduction Act of 2005 (DRA), this proposal would ensure states have the same set of plan design options for Medicaid beneficiaries as they historically have had for CHIP recipients. Specifically, the benchmark plans under Section 1937 of the Social Security Act would work independently of additional federal regulatory requirements and new mandates imposed by PPACA.
- ✓ Value-Based Insurance Design: Many private employers and insurers have successfully lowered health care costs and improved patient outcomes through value-based insurance design (V-BID). According to a recent policy paper from the University of Michigan’s Center for Value-Based Insurance Design, “The basic V-BID premise is to align patients’ out-of-pocket costs, such as copayments and deductibles, with the value—not the cost—of health services. Thus, the more beneficial the service, the lower the patients’ out-of-pocket cost. By reducing barriers to high-value services (through lower costs to patients) and discouraging low-value

services (through higher costs to patients), V-BID plans can achieve better health outcomes at any level of health care expenditure.”¹⁷ This policy proposal would allow states to offer V-BID plans to Medicaid beneficiaries as a way of structuring patient incentives around high-value providers.

- ✓ **Assistance to Enroll in Private Coverage:** The Medicaid statute has long included provisions to allow states to offer premium assistance to beneficiaries, but the bureaucratic hurdles to implementation have prevented the vast majority of states from offering the promise of private coverage to Medicaid recipients. This proposal would allow states to offer premium assistance programs that provide recipients the opportunity to receive benefits equivalent to private coverage (without additional federal restrictions) offered in the individual market or by an employer. States would be able to enroll all eligible family members in a premium assistance plan to enhance care coordination and provider continuity among family members.
- ✓ **Specialty Plans:** In many states, the majority of Medicaid spending goes toward a small number of high-cost, complex-need individuals. In fact, according to one study, four percent of Medicaid enrollees accounted for 48 percent of the costs.¹⁸ Based on feedback from governors and the success of models such as Special Needs Plans (SNPs) in Medicare, this proposal would allow states to invest in unique care-coordination and benefit design approaches for recipients with high costs and complex care needs. States would be able to passively enroll these beneficiaries in these specialty plans and design benefit packages to coordinate their complex health care needs.
- ✓ **Basic Primary Care Benefits:** Rather than being confined to a one-size-fits-all benefit package that can be cost-prohibitive, this proposal would give states the ability to offer limited benefit packages to address population health care needs specific to their state. Under a 2002 Section 1115 waiver, the state of Utah obtained the ability to offer primary care benefits in order to address specific population health care needs.
- ✓ **Enhanced Coordination for Mental Health Conditions:** Medicaid is the single largest payer of behavioral and mental health services, and many states have led the way in designing innovative approaches to improve this care. One state-led initiative in Pennsylvania sought to better align physical and behavioral care services, and the early results have demonstrated reductions in hospitalizations, hospital readmissions, and emergency room visits.¹⁹ This proposal would build on the success of the Pennsylvania pilot program by giving states the

¹⁷V-BID Center Brief. “The Evidence for V-BID: Validating an Intuitive Concept.” November 2012. Available online at <http://www.sph.umich.edu/vbidcenter/publications/pdfs/V-BID%20brief%20Evidence%20Nov2012.pdf>

¹⁸ Kaiser Family Foundation. “Profile of Medicaid’s High Cost Populations.” December 2006. Available online at <http://www.kff.org/medicaid/upload/7565.pdf>

¹⁹ Center for Health Care Strategies. “Medicaid Pilot Program Demonstrates Decrease in Emergency Department Visits and Hospitalizations for Patients with Serious Mental Illness.” October 1, 2012. Available online at http://www.chcs.org/info-url3969/info-url_show.htm?doc_id=1261430

tools to better integrate physical and behavioral care services (through aligning provider payments) and allowing provider data sharing (by aligning existing regulations regarding the exchange of treatment and care coordination information with the Health Insurance Portability and Accountability Act Privacy Rule).

- ✓ **Healthy Behavior Framework:** Studies have consistently shown Medicaid enrollees utilize less efficient settings to receive health care services. Despite efforts to expand primary care programs, a recent study published in the *Journal of the American Medical Association* found that costly emergency department (ED), “visit rates have increased from 1997 to 2007 and that EDs are increasingly serving as the safety net for medically underserved patients, particularly adults with Medicaid.²⁰” In an effort to improve care, improve patient safety, and reduce costs, governors have asked for more flexibility to ensure services and health care settings are being used to optimize public health outcomes.
 - *Enhanced Benefit Accounts:* States should be granted the ability to implement incentive-based models that reward beneficiaries for healthy behaviors and practices that improve their care and reduce the overall costs to the program. States should be granted greater flexibility to implement “value-added” services or financial incentives for individuals to make healthy decisions, such as selecting a low-cost plan or following treatment regimens. States should be able to build on successful models such as the Florida Enhanced Benefit Accounts, where enrollees receive incentive payments through program adherence to be used by enrollees for additional services, products and cost-sharing expenses. In West Virginia, added plan benefits are incentives for enrollees agreeing to adhere to certain healthy behaviors; and, in Idaho, studies have shown that financial incentives have worked in, “improving the proportion of children with up-to-date well-child visits.”²¹
 - *Appropriate Cost-Sharing:* Under current law, Medicaid cost-sharing is allowable with significant limitations. This blueprint would allow states maximum flexibility in designing a cost-sharing framework across all health care services and incomes. When carefully designed, cost-sharing can be an important tool to encourage patients to follow treatment regimens, receive primary care services instead of unnecessary emergency room utilization, and seek higher value health care services. States would have the ability to develop and test enforcement mechanisms to ensure program effectiveness.

²⁰Tang, Ning. “Trends and Characteristics of US Emergency Department Visits, 1997-2007. The Journal of the American Medical Association (JAMA). August 11, 2010. Available online at <http://jama.jamanetwork.com/article.aspx?articleid=186383>

²¹ Blumenthal KJ. “Medicaid incentive programs to encourage healthy behavior show mixed results to date and should be studied and improved.” *Health Affairs*. March 2013. Available online at <http://www.ncbi.nlm.nih.gov/pubmed/23459728>

- *Shared Responsibility*: States should be allowed to impose premiums on enrollees to ensure patients' shared ownership in health care decisions. Even under PPACA, low-income individuals will be responsible for at least two percent of the costs of their health care benefits through the new insurance Exchanges, and this proposal would allow states to use the same tool for certain Medicaid populations. Under this policy, states would be allowed to charge premiums, as appropriate, and develop incentive-based benefit packages that, for example, could encourage healthy behaviors such as enrollment in certain wellness programs by decreasing premiums or nullifying them all together. The decision as to how premiums should be applied, if at all, will be left to the states.
- ✓ **Consumer-Driven Options**: States like Indiana have implemented benefit models that provide higher deductible plans along with a pre-funded account to cover out-of-pocket medical expenses. While beneficiaries' accounts contain resources to ensure they receive the care they need, the approach introduces consumer incentives into the delivery of care under this model. Indiana's plan was implemented through a Section 1115 demonstration waiver with significant limitations; this policy would statutorily authorize this model without existing barriers restricting enrollment and participation. Under this option, states would have greater flexibility to promote patient choice and raise cost awareness for appropriate enrollees.

Reform the Delivery System through Increased Provider Transparency and Value-Based Purchasing

- ✓ **Promote Health Care Transparency**: Patients in America have more access to information about the quality and prices of cars than they do about their health care providers. With so little transparency in the health care system, it is not surprising that health care costs outpace any other sector of the American economy and that patients routinely miss out on value for the dollars they spend. As recently noted in Steven Brill's article in *TIME*²² and a March 2013 *JAMA* study²³, there is significant pricing variation among similar products and services not directly attributed to quality differences. This proposal would encourage health care providers to make pricing data more widely available to health care consumers. Additionally, building on efforts to release Medicare claims data, this proposal would require states to release Medicaid claims data to certified entities for the purposes of increasing transparency about provider quality throughout the health care system. Strict protections would be in place to protect patient privacy and proprietary information. Non-government entities would be able to use this information to establish robust data sets, which may be aggregated with clinical information to the extent feasible, to evaluate provider quality and outcomes.

²² Brill, Steven. "Bitter Pill: Why Medical Bills Are Killing Us." *TIME*. March 4, 2013. Available online at <http://www.time.com/time/magazine/article/0,9171,2136864,00.html>

²³ Rosenthal, Jaime. "Availability of Consumer Prices From US Hospitals for a Common Surgical Procedure." *JAMA*. March 25, 2013. Available online at <http://archinte.jamanetwork.com/article.aspx?articleid=1569848#AuthorInformation>

- ✓ Align Provider Incentives: Under traditional Medicaid fee-for-service, states separate Medicaid payments to providers for each of the individual services they furnish to beneficiaries for a single illness or course of treatment. This approach can result in fragmented care with minimal coordination across providers and health care settings. This outdated payment model rewards the quantity of services offered by providers rather than the quality of care provided. Research has shown that certain value-based payment methods can align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners – allowing them to work closely together across all specialties and settings. For example, Arkansas’ Medicaid Payment Improvement Initiative provides incentives to improve care quality and efficiency and reduce Medicaid costs through episode-based payments for medical conditions including upper respiratory infections, congestive heart failure and total joint replacement. This policy would go beyond the payment demonstration authorities allowed under PPACA and allow states to implement these innovative payment approaches in appropriate geographic regions and partner with specific providers. This would foster payment arrangements with providers that include financial and performance accountability measures for episodes of care that will lead to, “higher quality, more coordinated care at a lower cost to the Medicaid program.”²⁴
- ✓ State Ability to Set Provider Rates: The experience of federal price-setting that was put in place with the Boren amendment,²⁵ which was repealed by a bipartisan effort in the 1990s, illustrated the importance of allowing states to determine the most appropriate rates and methodologies for provider payments. States need the ability to pay providers in methods consistent with local practice patterns and budget needs. This proposal would make it clear that states have the exclusive authority to establish provider rates and preclude federal regulations that may infringe upon that right.

Improve Access to Coordinated Care

The use of managed care in Medicaid has grown steadily over the years as both states and managed care plans grow more experienced in caring for vulnerable populations. For example, between 1997 and 2009, Medicaid managed care enrollment grew from just eight million to nearly

²⁴ Center for Medicare & Medicaid Innovation (CMMI). “Bundled Payments for Care Improvement (BPCI) Initiative: General Information.” Available online at <http://innovation.cms.gov/initiatives/bundled-payments/>

²⁵ Summary of the Boren Amendment: “From 1980 to 1997, federal law directly linked Medicaid nursing home rates with minimum federal and state quality of care standards. As part of the Omnibus Reconciliation Act of 1980, the “Boren amendment” required that Medicaid nursing home rates be “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards” (Section 1902(a)(13) of the Social Security Act). State Medicaid officials overwhelmingly came to oppose the amendment as impossible to operationalize, believing that they were forced by the courts to spend too much on nursing homes at the expense of other services. The federal Balanced Budget Act of 1997 repealed the Boren amendment, giving states far greater freedom in setting nursing home payment rates.” Summary of the Boren Amendment from the Urban Institute, available online at <http://www.urban.org/UploadedPDF/anf30.pdf>

50 million.²⁶ And nearly half of Medicaid enrollees are now in comprehensive risk-based managed care plans where the plan assumes full responsibility for patient quality and costs. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), “interest continues to grow in expanding managed care to additional enrollees, especially high cost, high need populations.”²⁷ This proposal would increase access to the coordinated care offered under managed care plans in several ways.

- ✓ Offer Managed Care to More Beneficiaries: This proposal would allow states to passively enroll additional beneficiary populations, such as foster children and high cost, high need individuals, without receiving a special waiver from the federal government.
- ✓ Align Payer Incentives: The evolution of the Medicaid payment system has resulted in many unintended consequences that defy common sense. For example, some states have historically carved out inpatient services from managed care contracts simply to preserve additional federal funds offered under hospital upper payment limits (UPL). This proposal would rectify these systemic inefficiencies by requiring the Centers for Medicare and Medicaid Services (CMS) to establish model waivers for states to receive defined, budget-neutral funding streams, based on their current supplemental payments, which could be aligned with per capita payments to managed care plans. A similar concept was recently approved by CMS for the state of Texas in order to facilitate the expansion of managed care.
- ✓ Improve Managed Care Payment Determination: The blueprint would direct the GAO to study and report on state Medicaid program “best practices” regarding managed care payment determination and quality measurement. The report would include evaluation of the effectiveness of actuarial soundness requirements, competitive bidding approaches, and payments based on historic cost trends. The report would also evaluate various quality measurement approaches and metrics, such as measures accredited by the Utilization Review Accreditation Commission and the National Committee for Quality Assurance.
- ✓ Preserve State Regulatory Authority: Many states have implemented their own approaches to monitoring care utilization and costs under managed care arrangements, and federal efforts to impose additional Medical Loss Ratios (MLR) may complicate those state-led efforts. This proposal would preclude the federal government from imposing a one-size-fits-all MLR upon state contracts with managed care plans.

²⁶ (MACPAC) Report to the Congress on Medicaid and CHIP. March 2011. Available online at <https://docs.google.com/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWwYWN8Z3g6NTZmYjU1ZDcwMTQzMDc0MA>

²⁷ Ibid.

Reduce Federal Administrative Barriers that Deter Innovation

While the flexibilities outlined above offer states an array of options to modernize Medicaid, it would be impossible to include every innovative idea in federal statute. This proposal would reform the Section 1115 waiver process to make it more responsive to forward-thinking states with bold ideas to improve their Medicaid programs. As suggested by a report from the Republican Governors Association (RGA), the waiver process would be improved to offer broad, outcomes-based Program Operating Agreements (POA) between the federal government and individual states. States would publicly and routinely report on defined outcomes instead of the status quo, which micromanages states with a laundry list of regulations. States would be held accountable on “recognized measures of quality, cost, access and customer satisfaction that reflects the states’ priorities and permits an assessment of program performance over time.”²⁸ To that end, the existing Section 1115 waiver process would be reformed as follows:

- ✓ **1115 Waiver Clock**: Once a state submits a waiver request to the federal government, CMS would be required to send the state a final round of questions regarding the request within 60 days and then give a final answer to the requesting state within 120 days. If productive discussions are in process, a state may offer an extension of the deadline to CMS in 30 day increments.
- ✓ **Waiver Reciprocity**: The Secretary of HHS would be required to approve a state waiver request if a similar waiver has previously been approved for another state, if such waiver would not increase federal costs. This would accelerate the adoption of innovative ideas among the states, and it would reduce the influence of political ideology in HHS decisions about waiver requests.
- ✓ **Waiver Integrity Improvements**: While waivers are intended to allow testing and implementation of innovative ideas in the Medicaid program, too often they have been abused to tap the federal Treasury through loopholes in “budget neutrality” rules. This proposal would require the CMS Office of the Actuary to review and approve the budget neutrality assumptions under waivers before approval.
- ✓ **Innovative Practices Compendium**: States often raise concerns that there are few resources that appropriately catalog and update Medicaid directors on innovations and active state demonstrations. As such, this policy would promote information sharing among states and identify an appropriate set of resources to regularly update states on pending waiver applications, existing demonstrations, and analyses of any long-standing waivers that have proven to improve quality and reduce federal and state Medicaid expenditures.

²⁸ See footnote 12.

Increase the Efficiency and Effectiveness of Eligibility Determinations and Review

- ✓ Repeal of the Maintenance of Effort (MOE) Mandate: States should have the ability to better define their eligibility groups and ensure the integrity of the Medicaid program with a repeal of the burdensome MOE provision originally included in the president's stimulus bill and later expanded in PPACA. The MOE has been a significant burden on states interested in managing their enrollment levels, implementing key cost-containment strategies, and developing new program integrity measures. Instead, the federal mandate forces governors to make deeper reductions in other key areas such as provider rates and optional benefits.
- ✓ Encourage Proper Recipient Identification: This policy would allow states greater flexibility to verify recipient identity, citizenship, and eligibility to ensure the Medicaid program remains protected for those truly eligible and most in need.

Build upon Existing Efforts to Coordinate Care for Dually-Eligible Enrollees

- ✓ Our respective committees continue to monitor the demonstration projects currently in progress through the federal Center for Medicare and Medicaid Innovation (CMMI) and throughout a broad number of states. These demonstrations are testing initiatives related to benefit structure, enrollment mechanisms, and payment alignment. We are hopeful these models will increase access to quality care and reduce costs. We support the goal of better coordinated benefits and services for the dually-eligible populations and will work to build on any success these efforts achieve.

Promote Transparent Funding Allotments for Long-Term Care Services and Supports

- ✓ With the rise in long-term care spending and the greater demand for individuals to remain in their communities, states have experimented with various approaches to reforming long term care services and supports. For example, there was bipartisan support for the Bush administration's "Money Follows the Person" demonstration programs that help states transition beneficiaries from institutions to the community.²⁹ Similarly, the state of Tennessee recently implemented its CHOICES proposal to offer beneficiaries with long-term care needs the option of receiving vital services in their homes.³⁰ This proposal would allow states to choose a defined funding allotment with enhanced state flexibility to continue building upon these successes.

²⁹ Kaiser Family Foundation. "Money Follows The Person: A 2011 Survey of Transitions, Services and Costs." December 2011. Available online at <http://www.kff.org/medicaid/upload/8142-02-2.pdf>

³⁰ TennCare: Background on CHOICES program. "Long-Term Services & Supports Gives CHOICES." Available online at http://www.tn.gov/tenncare/long_choices.shtml

Protect Benefits for Disabled Populations Currently Eligible for Medicaid

- ✓ The purpose of this proposal is to improve the quality of care offered under the Medicaid program and lower systemic costs – not to strip critical benefits away from the program’s most vulnerable beneficiaries. This proposal includes a guaranteed protection of current law benefits upon which individuals with disabilities rely. Nothing in this proposal would change the longstanding entitlement to benefits for individuals with disabilities.

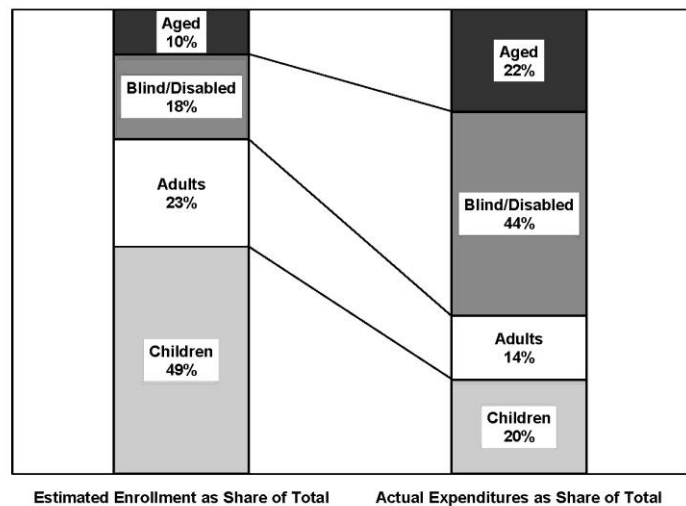
GOAL 2: DEFINE TRANSPARENT FUNDING STREAMS TO STATES TO MEET THE INDIVIDUAL HEALTH CARE NEEDS OF DISCRETE MEDICAID POPULATIONS.

Medicaid should not be viewed as a monolithic health care program. Today, Medicaid comprises over 50 different programs nationwide and the nearly 68 million Americans currently enrolled represent discrete population categories ranging from healthy, low-income children to poor, disabled adults, and seniors with long-term care needs.

Medicaid spending is as complex as the populations served. Figure 1 illustrates that the size of a population category does not directly relate to the expenditure levels for such categories. The more costly Medicaid populations – specifically, the aged, blind, and disabled – require more complex health care services and are higher utilizers of care. Their health care needs, just like the distinct needs of healthy children, should be customized and targeted appropriately to improve care and reduce costs.

The federal share of Medicaid spending as a share of the economy is set to grow by 25 percent over the next 10 years,³¹ with total federal spending during that time reaching nearly \$5 trillion.³² According to the CMS Office of the Actuary, the Medicaid program is the federal government’s “largest source of general revenue-based spending on health services... a larger source of such Federal expenditures than Medicare.” Currently, federal taxpayers have an open-ended liability to match state Medicaid spending, which is a significant factor in Medicaid’s budgetary challenges.

Figure 1—Medicaid Enrollment and Expenditures, by Enrollment Group, as Share of Total,¹ FY 2009



³¹ Office of Management & Budget. “Summary Tables for Fiscal Year 2014.” Available online at <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/tables.pdf>

³² See footnote 7.

Medicaid also represents the single largest portion of state budgets (estimated at an average 23.6 percent in FY2011).³³ An April 2013 GAO report regarding state fiscal challenges notes:

In the long term, the decline in the sector's operating balance is primarily driven by the rising health-related costs of state and local expenditures on Medicaid and the cost of health care compensation for state and local government employees and retirees. Since most state and local governments are required to balance their operating budgets, the declining fiscal conditions shown in our simulations continue to suggest that the sector would need to make substantial policy changes to avoid growing fiscal imbalances in the future. That is, absent any intervention or policy changes, state and local governments would face an increasing gap between receipts and expenditures in the coming years.³⁴

Bipartisan per capita cap reforms would insert desperately needed fiscal discipline in Medicaid while preserving access to care for beneficiaries. In testimony before the Senate Finance Committee in 1997, former Clinton administration official and HHS Secretary Donna Shalala noted, "there are absolutely no incentives for states to deny coverage to a needy individual, or to a family.... It is a sensible way to make sure that people who need Medicaid are able to receive it."³⁵

While the fiscal health of the Medicaid program is dire, studies have also consistently shown that access to care and the quality of services provided in the program are below average. Whether it is the initial challenge of finding a primary care physician who will accept them or one who will help with follow-up care, Medicaid beneficiaries are at an unfair disadvantage when compared with other coverage groups. That lack of preventive care often leads to more significant chronic care needs and higher mortality. We believe in a Medicaid program that better serves our nation's poorest and sickest Americans by modernizing the program to set financial incentives in a way that fosters innovation and quality care.

We can ensure the financial alignment of medical assistance payments for the needs of discrete Medicaid population categories through a per capita financial framework – one that provides budget predictability for federal and state taxpayers while protecting the investment in each Medicaid enrollee.

A per capita cap is a reasonable approach for reform that received widespread support from congressional Democrats when proposed by the Clinton administration in 1995 and

³³ See footnote 9.

³⁴ GAO. "State and Local Governments' Fiscal Outlook: April 2013 Update." GAO-13-546SP. April 30, 2013. Available online at: <http://www.gao.gov/assets/660/654255.pdf>

³⁵ Shalala, Hon. Donna E., Ph.D. Testimony before the Senate Finance Committee regarding President's FY 1998 Budget Proposal for Medicare, Medicaid & Welfare. February 13, 1997. Available online at http://congressional.proquest.com/congressional/result/pgpresultpage.gispdfhitspanel.pdf?link=http%3A%2F%2Fprod.cosmos.dc4.bowker-dmz.com%2Fapp-bin%2Fgis-hearing%2F%2F3%2F7%2Fb%2Fhrg-1997-fns-0015_from_1_to_393.pdf?entitlementkeys=1234

promoted as, “providing states with sufficient funds to maintain coverage,” while addressing the “top concerns of governors,” around state flexibility. At the time, all 46 members of the Democratic Caucus of the Senate signed a letter to President Clinton expressing their “strong support for the Medicaid per-capita cap structure” including several currently serving Senators and then-Senator Joe Biden (D-DE). More recently, in October 2012, former Senate Majority Leader Tom Daschle (D-SD) expressed his support for Medicaid per capita caps as a way of “guaranteeing benefits on the Medicaid program.” Additionally, conservatives such as former Senators Phil Gramm (R-TX) and the late Jesse Helms (R-NC) have proposed similar legislation.³⁶

How a Per Capita Cap Model Would Work

Similar to the reforms proposed in the 1990s, federal per capita caps would be placed on the four major beneficiary groups outlined by the Congressional Budget Office (CBO): aged, blind and disabled, children, and adults. The overall federal per capita allotment would be based on the product of the state’s number of enrollees in each of the four population category and the per capita amount for each population category.

- ✓ **State Base Year Per Capita Calculations:** The individual per capita calculation by population category would be based on the most recently available expenditure data and would be state-specific.³⁷ Base year federal cap amounts would be determined by each state’s average medical assistance and non-benefit expenditures per full-year-equivalent enrollee. After the base year amount, caps would grow by a realistic exogenous and appropriate growth factor for each state. In an effort to correctly implement the exogenous growth factor, the Secretary would, every five years, rebase state specific per capita payments if average per capita costs have grown annually at a rate slower than the targeted growth rate.
- ✓ **Geographic Spending Variation:** There is significant variation in Medicaid programs across states. As such, the exogenous growth factor for states whose average per capita spending is in the top quartile of states would grow at a slower growth rate, and states whose average per capita spending is in the bottom quartile would grow at faster growth rate in an attempt to normalize per capita spending across states. The committees have worked extensively with GAO on modeling to study factors influencing spending variation by state, including historical pricing phenomena and geographic practice variation. The goal is to consider any recommendations that appropriately adjust payments in order to attempt to normalize spending across states over time.

³⁶ S.1802. “Comprehensive Family Health Access and Savings Act.” January 27, 1994. Available online at <http://www.gpo.gov/fdsys/pkg/BILLS-103s1807pcs/pdf/BILLS-103s1807pcs.pdf>

³⁷ Most recently available expenditure data for such calculation would be dependent on enactment of such model in statute.

- ✓ Continued State Investment and Data Integrity: Under this model, current federal medical assistance percentages (FMAP) rules apply and states would not be eligible for federal funds without continued state investment. CMS would project aggregate federal Medicaid expenditures for each state on a quarterly basis, and once the amount was drawn down, no additional federal funds would be available unless the state can demonstrate that actual enrollment had been higher than projected. On an annual basis, CMS would administer post facto adjustments for overpayments or underpayments to appropriately reflect enrollment levels, and states would be subject to audits and penalties for over-reporting actual enrollment data. Much like how the program works today, if a state chooses to spend above their federal per capita targets, they may use state-only dollars to fund additional Medicaid expenses.
- ✓ Risk Corridors for Disabled Per Capita Amounts: One of the goals of a federal per capita model is to ensure greater efficiency in the use of Medicaid funds. As such, states that achieve greater efficiency in the use of funds could draw down additional federal dollars up to the state's overall cap and use such funds across population categories, especially in years where new models are being implemented in certain populations and costs may be higher than average for such groups. A shared-savings and risk corridor model would be established to allow states incentive to achieve efficiencies and maintain savings from the model as well determine how to protect vulnerable populations such as the disabled from unpredictable spending above the state's cap.
- ✓ Excluded Per Capita Payments: Certain payment categories would be excluded from the caps and would be calculated through a separate funding stream, including: (1) federal payments made to states on behalf of certain dual-eligibles whose Medicaid expenses are limited to cost-sharing and premiums; (2) federal payments made to disproportionate share hospitals; (3) Graduate Medical Education payments; (4) federal payments made under the Children's Health Insurance Program (CHIP); (5) federal payments made on behalf of Indian Health Service (IHS) enrollees; (6) other partial Medicaid benefit enrollees; and, (7) other appropriate exclusions.
- ✓ Special Provisions for 1115 Waivers: Moreover, the Secretary would establish special provisions for states operating Medicaid programs under waivers in a manner consistent with improved budget neutrality requirements as discussed previously.
- ✓ Targeted State-Determined Spending Levels: States would be allowed to cap enrollment for high income recipients if state Medicaid spending exceeded state-determined budget targets. States like New York have voluntarily imposed similar enrollment restrictions today, and this proposal would give states additional options to meet their own goals.

Rewarding Quality Improvement and Cost Effectiveness Success

The goal of the proposed per capita model is to ensure greater flexibility for states while improving budget predictability and fiscal discipline for the federal budget. While the increased flexibility is critical for states, we should ensure there is a framework in place that holds states accountable and improves the quality of care for enrollees. As such, states would be required to

report on transparent achievement measures on access to care, patient outcomes, patient experience, and health care costs.

Reporting requirements would work in tandem with financial incentives for states. States that achieve certain benchmarks on cost reduction, access, and quality would be awarded bonus funding from a defined pool of federal dollars. These award funds could be used for innovative public health initiatives in the state to reduce overall health care costs, lower the incidence of chronic disease, or achieve other state health care goals.

Program Integrity Enhancements

- ✓ **Lower Provider Tax Threshold:** States are able to use revenues from health care provider taxes to help finance the state share of Medicaid expenditures. This effectively reduces the level of state commitment to the Medicaid program at the expense of federal taxpayers. Under current law, states are limited to a provider tax threshold of no higher than 6 percent of the net patient service revenues. Until October 1, 2011, the threshold was 5.5 percent. The president’s Fiscal Year (FY) 2013 budget proposal would have phased-down the threshold to 3.5 percent. While it would not eliminate state provider taxes altogether, this proposal would adjust the provider tax threshold back to its previous 5.5 percent level.
- ✓ **Increase Transparency for Medicaid Supplemental Payments:** According to the GAO, “States reported \$32 billion in Medicaid supplemental payments during fiscal year 2010, but the exact amount of supplemental payments is unknown because state reporting was incomplete.”³⁸ Additionally, GAO reports have found that some non-disproportionate share hospital (DSH) supplemental payments are not even being used for Medicaid purposes.³⁹ This proposal would strengthen reporting requirements for DSH payment audits. Additionally, to address serious concerns raised by GAO, this proposal would impose reporting requirements on non-DSH supplemental payments, clarify payment policies for non-DSH supplemental funding, and require annual independent audits of states’ non-DSH provider payments.⁴⁰

³⁸ GAO. “Medicaid: States Reported Billions More In Supplemental Payments in Recent Years.” GAO-12-694. July 20, 2012. Available online at <http://www.gao.gov/assets/600/592784.pdf>

³⁹ GAO. “Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed.” GAO-13-48. November 2012. Available online at <http://www.gao.gov/assets/660/650322.pdf>

⁴⁰ Ibid.

CONCLUSION

Congress and the nation's governors can — and will — enact comprehensive and sustainable Medicaid reform. It is time to fix the Medicaid program. We owe it to taxpayers and to the millions of vulnerable Americans that depend on the program. Governors need the flexibility to deal with the quality and spending challenges posed by Medicaid costs and the American taxpayers need a reliable safety-net program.

This blueprint is a product of significant input from the states and policy experts from a wide range of ideological positions. The committees look forward to receiving additional feedback from interested parties on how the blueprint could be improved to ensure greater innovation in the Medicaid program, increased quality of care, and reduced overall costs.