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The Medicaid Check Up: Reasons for Reform

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U.S. HOUSE OF REPRESENTATIVES
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The Policy Paper Series

Transforming Ideas Into Solutions

The Medicaid Check Up: Reasons for Reform



Prepared by the Energy and Commerce Committee, Majority Staff

INTRODUCTION

Medicaid, a shared state-federal program created in 1965, was originally designed as a safety net for low-income Americans, primarily dependent children, the blind and disabled. Surprising to most, Medicaid today covers more Americans than any other government-run health care program, including Medicare. While the program covered approximately four million people in its first year, today, there are nearly 60 million Americans enrolled in Medicaid.¹

It is important to understand the state of the program today, so that Congress can make the improvements necessary to sustain Medicaid for the nation's most vulnerable. Before the annual cost of Medicaid doubles over the next 10 years, state governments and federal policymakers should have a clear picture of how the program serves its current enrollees.

This paper reviews critical Medicaid program components to provide a better understanding of the program's original purpose and analyzes Medicaid's strengths and weaknesses in serving the nation's most vulnerable citizens. The goals of this review are to assess whether Medicaid beneficiaries get the appropriate, high-quality care their privately insured counterparts receive and what a dramatic expansion of Medicaid means for the program. The review puts Medicaid through a series of "check-ups" to evaluate the program against financial, bureaucratic, access, quality and program integrity criteria. The conclusion: the Medicaid program is in serious jeopardy and this country's most vulnerable citizens deserve better health care options.

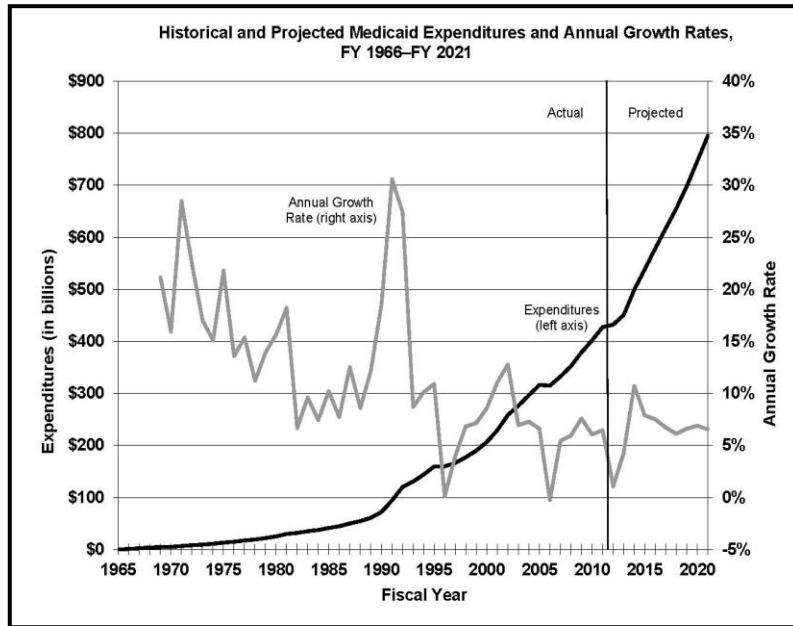
A REVIEW OF MEDICAID'S ORIGINAL INTENT AND A FINANCIAL CHECK-UP

According to the Congressional Budget Office (CBO), the federal government will spend nearly \$5 trillion on Medicaid over the next 10 years - a substantial contributor to the growing national debt.² And at the state level, Medicaid spending now consumes nearly one-quarter of most state expenditures - a significant driver of state budget crises.³

¹ Office of the Actuary, CMS. "2012 Actuarial Report on the Financial Outlook for Medicaid." March 2012. Available online at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf>.

² Congressional Budget Office. Medicaid- 2013 baseline. Available online at <http://cbo.gov/sites/default/files/cbofiles/attachments/43885-Medicaid.pdf>.

³ National Association of State Budget Officers (NASBO). NASBO State Expenditure Report. December 20, 2012. Available online at http://www.nasbo.org/sites/default/files/Summary%20-%20State%20Expenditure%20Report_0.pdf.



In a March 2012 report, the Centers for Medicare and Medicaid Services (CMS) Chief Actuary projected that states would spend an approximate \$2.5 trillion over the next 10 years to fund their Medicaid programs. As the CMS chart on the left shows, total annual Medicaid spending grew to over \$400 billion by its 45th year in operation (1965-2010). CMS further estimates that in the next ten years, the implementation of the

president’s stimulus package in 2010 and the president’s Patient Protection and Affordable Care Act (PPACA) will require a doubling in annual Medicaid spending -- from approximately \$400 billion in 2010 to approximately \$800 billion by 2021.⁴

When fully implemented, the president’s health care law will result in the single largest expansion in the program’s history as one American in four becomes a Medicaid recipient over the next 10 years. As a result of PPACA, this sudden expansion jeopardizes the program’s initial purpose as a safety-net program for the most vulnerable.

Rather than creating affordable health care coverage choices for the uninsured, the president’s health care law could force nearly 26 million adults and other newly eligible Americans into the already strained safety net program.⁵ Historically, eligibility for Medicaid has been limited mainly to specific categories, including children in poor families, the poorest seniors, low-income pregnant women, and the blind and disabled. Federal Medicaid rules to date generally prohibit use of federal Medicaid dollars to cover adults without dependent children (with some exceptions through special waivers or other eligibility circumstances). With the addition of the newly eligible PPACA adults, the program’s demographics will change dramatically.

The expanded Medicaid population is expected to include relatively healthy beneficiaries as well as a significant number of individuals with multiple chronic health

⁴ Office of the Actuary, CMS. “2012 Actuarial Report on the Financial Outlook for Medicaid.” March 2012. Available online at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf>,

⁵ Ibid.

care needs. Researchers have concluded that the health care needs of the new populations are unknown but could certainly be costly and include individuals with significant mental health/substance abuse problems.⁶ According to an August 2010 policy brief by the Center for Health Care Strategies, “there is reason to believe that the criminal justice system may become an active source of Medicaid enrollment post-expansion, particularly for the subset of offenders with charges related to substance abuse... many of these offenders may become newly eligible for Medicaid in 2014 once they leave the criminal justice system.”⁷

The projected enrollment and expenditures associated with the expansion populations are staggering. Another important unknown lies with the impact such an expansion might have on the quality of care provided to current beneficiaries and those categories of individuals the program was originally intended to serve.

According to CBO’s February 2013 estimates, federal taxpayers could spend as much as \$638 billion over 10 years to fund the president’s expansion of the Medicaid program.⁸ Recent estimates from the CMS Chief Actuary note that states collectively could spend \$60 billion, on top of what they already spend, over the same period to cover the cost of the expansion population.⁹

States are already facing significant budget deficits. Especially for those that are required to balance their budgets, the decision to expand the Medicaid program is not a choice states can make based only on the possibility of acquiring billions of dollars in new federal funding over the next 10 years.

As the graphic on the following page illustrates, Medicaid surpassed K-12 education in total Fiscal Year (FY) 2010 state spending.¹⁰ State budgets are under significant pressure and according to recent reports, more than a quarter of states were forced to cut Medicaid

⁶ Verdier, James M. “Extending Medicaid Coverage to Low-Income Childless Adults.” Mathematica Policy Research. July 15, 2011. Available online at: http://www.mathematica-mpr.com/publications/PDFs/health/childless_adults_verdier_%20071511.pdf

⁷ Somers, Stephen A. “Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States.” Center for Health Care Strategies. August 2010. Available online at: http://www.chcs.org/usr_doc/Medicaid_Expansion_Brief.pdf.

⁸ Congressional Budget Office. “Estimate of the Budgetary Effects of the Insurance Coverage Provisions in the Affordable Care Act,” February 2013. Available online at http://cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf

⁹ Office of the Actuary, CMS. “2012 Actuarial Report on the Financial Outlook for Medicaid.” March 2012. Available online at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf>

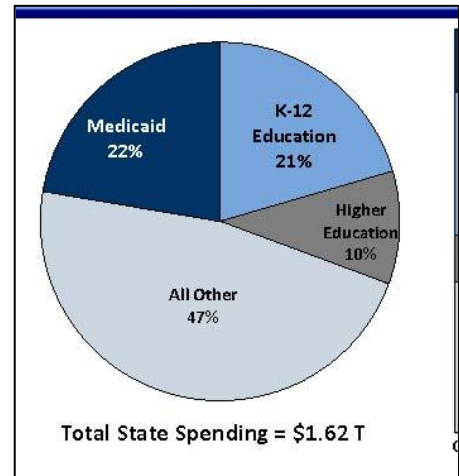
¹⁰ Kaiser Family Foundation. “State Fiscal Conditions and Medicaid.” February 2012. Available online at: <http://www.kff.org/medicaid/upload/7580-08.pdf>

funding to balance their budgets; they see no relief in sight.¹¹ In fact, a 2010 study by the Deloitte Center for Health Solutions predicted that by 2030, Medicaid will account for up to 35 percent of spending in some states.¹²

Paradoxically, as spending for education is squeezed, the health status of the population is expected to decline because research indicates that less educated people are less aware of health issues. According to a Robert Wood Johnson Foundation Issues Brief examining the social determinants of health, “A

large body of evidence links education with health, even when other factors like income are taken into account.”¹³ Expanding health care may subsequently worsen the health of the nation’s most needy. With states facing billions in tax shortfalls due to a poor economic recovery, the shocking cost projections for the next expansion of Medicaid are looming over future health care.

Looking ahead, states will have to weigh any decision to expand their Medicaid programs against the existing financial pressure to serve the program’s current and eligible beneficiaries. Cost estimates of expanding services for the new populations must take into account the added market effects that could bring millions of previously-eligible, but not enrolled Americans into the program – adding potentially billions more to a state’s tab.¹⁴ Governors and legislatures must recognize that every Medicaid dollar spent on an able-bodied, childless adult in the expansion population is potentially a future dollar diverted from the poorest and sickest children and seniors enrolled currently.



A BUREAUCRACY CHECK-UP: REVISITING THE FEDERAL-STATE PARTNERSHIP

Since its creation, the Medicaid program has been a federal-state partnership based on the financial understanding that at least a portion of every state dollar would be matched by federal funds in exchange for the state’s agreement to operate and manage its

¹¹ Galewitz, Phil. “13 States Cut Medicaid to Balance Budgets” July 24, 2012. Available online at: <http://www.kaiserhealthnews.org/Stories/2012/July/25/medicaid-cuts.aspx>.

¹² Deloitte. “Issue Brief: Medicaid Long-Term Care: The Ticking Time Bomb.” June 2010. Available online at: http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_2010LTCinMedicaid_062110.pdf

¹³ Robert Wood Johnson Foundation. “Education Matters for Health.” Issue Brief Series: Exploring the Social Determinants of Health. Available online at: <http://www.rwjf.org/content/dam/web-assets/2011/05/education-matters-for-health>.

¹⁴ The woodwork effect occurs when individuals who were previously eligible for Medicaid (before PPACA), but who had not enrolled, would be drawn to enroll with the increased publicity to enroll newly eligible poor childless adults.

own program under certain federal rules and criteria. Over time, however, the level of flexibility afforded to the states has been restricted, thereby reducing the ability of states to adjust their programs in the face of societal and economic changes.

The limited flexibility afforded to states has given state officials little choice but to watch, almost from the sidelines, as Medicaid has consumed more and more of their state resources. Instead of allowing state and local officials the flexibility to best administer Medicaid, the federal government has created an extensive “one-size fits-all” maze of federal mandates and administrative requirements. This is neither fair nor efficient to those most in need.

A strong indicator of such overreach was the inclusion of the federal mandate on all states to expand their Medicaid programs in the president’s health care law, struck down by the Supreme Court in 2012. There is a laundry list of other state mandates– making it more difficult for governors and states to operate their programs to best protect enrollees. For example, the Maintenance of Effort (MOE) mandate hampers states trying to streamline their eligibility review processes to curb misuse in the programs. Additionally, the Obama administration has attempted to dictate how states now pay providers, and under the president’s health care law, benefits for the new expansion populations will be directly tied to federal mandates, which could cost states significantly. Those mandates - on top of the long-standing mandatory guidelines for benefits, eligibility, and financing -- have only intensified the governors’ calls for relief through comprehensive Medicaid reform.

In 2011, the Republican Governors Association (RGA) released a set of Medicaid reform principles. In their challenge to the federal government, the governors (representing 29 states) called on their federal partners to acknowledge that, “no issue is more important to fixing our nation’s healthcare system than improving Medicaid...Governors must be given the flexibility to craft solutions based on their states’ specific needs without constantly needing to ask the federal government for permission.”¹⁵

“This practice must stop if Governors are to contain costs and provide a safety net for our citizens; we know their needs far better than the federal government. We cannot do the jobs we were elected to do while continuing to be hampered by a federal program that stifles innovation and handcuffs state flexibility.”

- *Governors Perry of Texas, McDonnell of Virginia, and Christie of New Jersey*

Many states have sought to take advantage of one of the only forms of relief available to them: waivers granted by the federal government. Moreover, faced with the

¹⁵ Republican Governors Association. Letter to Chairman Upton and Senator Hatch. “GOP Govs Unveil Medicaid Reform Principles.” June 13, 2011. Available online at <http://www.rga.org/homepage/gop-govs-unveil-medicaid-reform-principles/>.

bureaucratic complexity and escalating costs of the Medicaid program, states sought to make more efficient use of Medicaid dollars by such means as managed care. While any relief from the Medicaid program's restrictions is appreciated by the states, the waiver process itself is a source of great dissatisfaction and is often complex, costly and extremely lengthy. The program's centralized micromanagement, complex bureaucratic requirements, and outdated service delivery are often cited by the states as impeding their ability to provide the quality health coverage, patient responsiveness, and efficient administration common in the private sector. As a result, states have long sought enhanced operational flexibility so that they can better meet the health care needs of their most vulnerable residents.

The call from states for greater flexibility has been reiterated by Republican and Democrat governors alike for nearly 20 years.¹⁶ Washington rejects such requests at its own peril.

**AN ACCESS CHECK UP:
MEDICAID ENROLLEES ALREADY FACE CHALLENGES IN ACCESSING CARE**

While states are increasingly concerned with the growing cost of the Medicaid program, beneficiaries and providers alike are concerned that the dramatic expansion of the program could further weaken an already-strained network of providers willing to accept Medicaid patients. The problem is two-fold: providers are increasingly unwilling to accept Medicaid beneficiaries as patients and Medicaid beneficiaries are less likely to receive primary care in an appropriate setting—both examples of why this broken system needs to be changed.

In a recent analysis, economist Sandra Decker found that only 70 percent of physicians would accept Medicaid patients in 2011. According to reports, "That number was significantly lower than those accepting privately-insured subscribers (81 percent) or Medicare patients (83 percent), indicating that this wasn't just about doctors being overbooked – it was specific to the Medicaid program."¹⁷ Additional studies also show that Medicaid beneficiaries face more difficulties scheduling adequate and timely follow-up care after initial treatment for an illness than those with private insurance.¹⁸ Whether it is the

¹⁶ National Governors Association, "Restructuring Medicaid: Concepts, Issues, and Alternatives." Staff Paper. July 24, 1995. Available online at: <http://www.clintonlibrary.gov/assets/storage/Research%20-%20Digital%20Library/jenningssubject/Box%20008/647860-flexibility-medicaid-managed-care-3.pdf>

¹⁷ Kliff, Sarah. "Study: One-third of doctors wouldn't take new Medicaid patients last year." Washington Post. August 6, 2012. Available online at <http://www.washingtonpost.com/blogs/wonkblog/wp/2012/08/06/study-one-third-of-doctors-wouldnt-take-new-medicaid-patients-last-year/>

¹⁸ Lindsey Tanner, "Study Says Uninsured Lack Follow-Up Care," Associated Press, September 13, 2005. Available online at: www.washingtonpost.com/wp-dyn/content/article/2005/09/13/AR2005091301221_2.html.

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.

Exacerbating these problems is the web of bureaucratic restrictions placed on states, including the MOE provision included in the president’s health care law. In a February 3, 2011, letter to states, U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius noted the PPACA limitations and instead directed states to consider reducing “what benefits are covered, how providers are paid, and how care is delivered.”¹⁹ As a result, states facing balanced budget challenges have been forced to either eliminate or reduce optional benefits or cut provider reimbursement rates. According to the Kaiser Family Foundation, in FY2012, at least 45 states made changes to their provider payments (see figure below).²⁰ As provider willingness to accept Medicaid declines, patients find themselves receiving care in more costly and inefficient health care settings, such as emergency rooms.

	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Copays	Changes to Application and Renewal	LTC
United States	45+DC Yes	38 Yes	17+DC Yes	3 Yes	14 Yes	1 Yes	11 Yes

A recent study found that current Medicaid enrollees are twice as likely to report difficulty in accessing primary care services than those with private insurance. Researchers have noted: “The shortage of primary care providers in the U.S. seems to affect Medicaid patients disproportionately and more harshly.”²¹ That same study found that Medicaid patients are twice as likely to visit the emergency room as those with private health insurance – a finding reinforced by the now famous Oregon Health Insurance Experiment, where researchers found Medicaid coverage did not result in a “significant change in emergency room utilization.”²² With nearly 26 million more Americans joining the ranks of the Medicaid program over the next 10 years, where will these individuals go

¹⁹ HHS Letter to states, “Sebelius outlines state flexibility and federal support available for Medicaid-Full Letter.” HHS Press Release. February 3, 2011. Available online at: <http://www.hhs.gov/news/press/2011pres/01/20110203c.html>.

²⁰ Kaiser Family Foundation. “Medicaid Cost Containment Actions Taken by States, FY2012.” Available online at <http://www.statehealthfacts.org/comparetable.jsp?ind=188&cat=4>

²¹ Annals of Emergency Medicine. “Medicaid Patients Struggle to Get Primary Care, Visit ERs More.” March 14, 2012. Available online at: <http://www.acep.org/Content.aspx?id=84318>.

²² Baicker, Katherine. “The Effects of Medicaid Coverage-Learning from the Oregon Experiment.” July 20, 2011. Available online at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3321578/>.

for care? And is it fair to subject even more Americans to a system that isn't working as well as many private insurance plans?

A QUALITY CHECK-UP: PAY MORE, GET LESS

Despite the nearly half trillion dollars spent on Medicaid each year, its enrollees face limited access to care. Researchers have also found that the Medicaid program provides relatively poor quality of care and inadequate follow-up care to its nearly 60 million current enrollees. The studies provide an often dismal review, concluding that Medicaid recipients don't receive the care they need before chronic disease onset and such lack of primary care often results in higher mortality and costlier care.

In fact, a 2008 study in the Archives of Internal Medicine found that only half of the Medicaid enrollees studied actually received adequate screening procedures for colorectal, breast, or cervical cancer.²³ A more recent study by the University of Virginia (UVA) 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."²⁴ As the UVA study found and numerous subsequent studies confirmed, delay in access to care and late diagnosis leads to higher mortality rates causing "[p]atients enrolled in Medicaid [to] have worse survival rates than those with private insurance or even no insurance at all."²⁵

Medicaid patients are also less likely to receive the benefit of high-quality innovative therapies. For example, "patients with non-ST segment elevation acute coronary syndromes (NSTSE ACS), a form of heart attack, benefit significantly from innovative therapeutic approaches, including early invasive management strategies. These measures have now been incorporated into the guidelines of the American College of Cardiology and the American Heart Association. According to a study in the Annals of Internal Medicine, however, Medicaid patients with NSTSE ACS were less likely to receive evidence-based therapies and had worse outcomes (including increased mortality rates) than patients who

²³ Preidt, Robert. "Cancer Screenings for Medicaid Patients Miss Targets." ABC News. October 15, 2008. Available online at: http://abcnews.go.com/Health/Healthday/story?id=6033191&page=1#.UGDG_I0ia5I.

²⁴ Roy, Avik. "UVA Study: Surgical Patients on Medicaid are 13% More Likely to Die Than Those Without Insurance." July 27, 2010. Available online at <http://www.nationalreview.com/critical-condition/231147/uva-study-surgical-patients-medicaid-are-13-more-likely-die-those-without->.

²⁵ Artz, Kenneth. "Study: For Patients Battling Cancer, Medicaid is Worse Than Being Uninsured." Heartland Institute. March 20, 2012. Available online at: <http://news.heartland.org/newspaper-article/2012/03/20/study-patients-battling-cancer-medicaid-worse-being-uninsured>.

had private insurance as the primary payer...the most important predictor of treatment and outcome in the study was whether the patient had Medicaid or private insurance.”²⁶

PROGRAM INTEGRITY CHECK-UP: HOW DOES MEDICAID RANK?

Given the high cost and poor quality of the services provided by Medicaid, it is important to also review the Medicaid program’s vulnerability to fraud, waste, and abuse. The Medicaid program has been classified as a high-error risk program by the Government Accountability Office (GAO). According to the president’s Office of Management and Budget, Medicaid generated more than \$21.9 billion in improper payments in 2011 (see graphic on right) – including more than \$15 billion in overpayments due to eligibility review errors alone.

PROGRAM	IMPROPER PAYMENTS
Medicare Fee-for-Service	\$28.8B
Medicaid	\$21.9B
Unemployment Insurance (UI)	\$13.7B
Medicare Advantage (Part C)	\$12.4B

The examples of program integrity concerns range from simple physician billing errors to sophisticated fraud schemes, costing the program billions of dollars. Rather than promoting greater integrity in the program, the president’s health care law imposes significant restrictions on states wishing to improve their eligibility verification systems and ultimately, broadens the opportunity for greater fraud, waste and abuse in the program. Every dollar that is misplaced or mismanaged in the Medicaid program is another dollar that could have provided care for the nation’s most vulnerable – the core mission of the program since its inception.

CONCLUSION

The purpose of this analysis is to review where the Medicaid program fails its enrollees in providing high-quality care and to highlight the level of funds invested in the program today and the trillions more taxpayers will spend if the president’s health care law is fully implemented. As confirmed in the “check-ups” covered in this report, the program is failing in critical areas. We can do much better in providing high quality health care for the poorest and sickest among us, and we must.

With federal debt at an all-time high of \$16 trillion and states being crushed by their exploding budgets, the value of the Medicaid program will be increasingly scrutinized. Its future ability to provide coverage for the neediest will depend on its ability to compete with state spending for education, transportation, and public safety. Moreover, as states

²⁶ O’Shea, John. “More Medicaid Means Less Quality health Care.” Heritage Foundation. Available online at http://www.heritage.org/research/reports/2007/03/more-medicaid-means-less-quality-health-care#_ftn6.

determine whether or not they will move forward with a program expansion in 2014, they should recognize the risky investment as Washington may not be able to keep its promise to continue the generous funding of the expansion population for long and states will be left with the tab.

While the program was enacted with a promise that the federal government would pick up much of the added cost of adding millions more Americans to the Medicaid rolls, costs may eventually be passed along to the states. In either case, such an expansion is projected to cost over a trillion dollars and potentially weaken an already strained program intended to serve our most vulnerable fellow citizens.

Energy and Commerce Committee Republicans remain committed to modernizing the Medicaid program so that it is sustained and protected for our poorest and sickest citizens. We will continue to fight for those citizens because they are currently subjected to a broken system. The program needs true reform, and we can no longer simply tinker around the edges with policies that add on to the bureaucratic layers that decrease access, prohibit innovation, and fail to provide better health care for the poor. Instead, this committee will review and support policies that allow states to build upon their best practices to ensure the Medicaid program is more responsive to those who depend on this program so we can ensure their improved access to high-quality care and a better life.