

The Need for Medicaid Reform: A State Perspective

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Summary

Medicaid has undoubtedly played a considerable role in the lives of many, providing access to health care for our nation's most vulnerable populations. There is no question it has helped many of its participants. However, designed in 1965 the program has not kept pace with the modern health care market. Its rigid, complex rules designed to protect enrollees have created an intractable program that does not foster efficiency, quality or personal responsibility for improvement in health status. Escalating state costs have not translated into quality or consistent outcomes.

Failure to reform the program will jeopardize states' ability to care for those Medicaid was envisioned to serve including low income children, pregnant women, and the aged, blind and disabled. While the program is jointly funded by the state and federal government, it is not jointly managed. States are largely dependent on federal policy, regulation and permission to operate their programs.

Administrative review and approval processes add layers of administrative bureaucracy to the program that thwart states' ability to innovate.

Notwithstanding the cumbersome regulatory review process, there are many examples of state innovation that have emerged. To transform Medicaid, states must be given the flexibility and opportunity to innovate without these undue federal constraints. Reform efforts should center, at minimum, around encouraging consumer participation in healthcare, holding states accountable based on quality outcomes versus compliance with bureaucratic requirements, encouraging flexible managed care approaches and allowing states to use flexible funding mechanisms.



INTRODUCTION

Good morning members of the Committee. My name is Seema Verma. I am the President of SVC Inc, a policy consulting company and in this role have been advising Governor offices, state Medicaid programs, and state Departments of Health and Insurance. I have worked in a variety of states including Indiana, South Carolina, Maine, Nebraska, Iowa and Idaho. I am also the architect of former Indiana Governor Mitch Daniels's Healthy Indiana Plan, the nation's first consumer directed health plan for Medicaid beneficiaries.

OVERVIEW

Designed in 1965 for our most vulnerable populations, the Medicaid program has not kept pace with the modern health care market. Its rigid, complex rules designed to protect enrollees, have also created an intractable program that does not foster efficiency, quality or personal responsibility. The impact of these issues is more pronounced as states are entrenched in the fierce debate around Medicaid expansion. Reluctance to expand is not indifference to the plight of the uninsured, but trepidation for the fiscal sustainability of the program and knowledge that expanding without reform will have serious consequences on Medicaid's core mission to serve the neediest of Americans.

INCREASING COSTS OF MEDICAID & STATE BUDGETS

Medicaid comprises nearly 24%ⁱ of State budgets, and its costs are growing.ⁱⁱ This is due to enrollment growth, population demographics, and federal requirements. The aging baby boomer population will soon require expensive long term care. The Affordable Care Act (ACA) requires maintenance of effort and implementation of hospital presumptive eligibility, Modified Adjusted Gross Income which eliminates asset tests for the non-disabled, and the ACA insurer tax will cost states an estimated \$13.0



to \$14.9 billion.ⁱⁱⁱ Additionally, there is the clawback provision burden where states have an unprecedented requirement to finance the Medicare program.

ACCESS & QUALITY

Despite growing outlays of public funds, a Medicaid card does not guarantee access or quality of care. In a survey of primary care providers, only 31% indicated willingness to accept new Medicaid patients.^{iv} In 2012, 45 states froze or reduced provider reimbursement rates,^v Medicaid access issues are tied to under compensation of providers; on average Medicaid payments are 66% of Medicare rates^{vi} and many providers lose money seeing Medicaid patients. Medicaid beneficiaries struggle to schedule appointments, face longer wait times, and have difficulty obtaining specialty care.^{vii} These access challenges will be more pronounced as Medicaid recipients compete with the tens of millions of newly insured under the ACA. Studies also show Medicaid coverage does not generate significant improvements in health outcomes,^{viii} decrease emergency room (ER) visits, or hospital admissions,^{ix} and participants have higher ER utilization rates than other insured populations.

STATE CONSTRAINTS

At Medicaid's core is a flawed structure. While jointly funded, by the federal and state governments, it is not jointly managed. States are burdened by federal policy and endure lengthy permission processes to make routine changes. Notwithstanding the cumbersome procedure, 1115 waivers provide a pathway for state innovation. However, the approval route is so daunting that states often abandon promising ideas if a waiver is necessary. Absent are evaluation guidelines, required timelines, and there is a capricious nature to the approvals, as waivers do not transfer from one state to another. Even with positive outcomes, a new administration has the authority to terminate a waiver.

Despite intense federal oversight, results vary substantially and there are no incentives for states to achieve quality outcomes. For example, the average cost to cover an aged Medicaid enrollee is \$5,247 in New Mexico versus \$24,761 in Connecticut,^x and annual growth rates also vary.^{xi} Replacing oversight of day to day administrative processes, the federal and state governments should collaborate to identify program standards and incentives. States should be provided with flexibility to achieve these goals and successful states should be rewarded with reduced oversight.

Medicaid's uncompromising cost-sharing policies are illustrative of a key failure. These regulations disempower individuals from taking responsibility for their health, allow utilization of services without regard for the public cost and foster dependency. While some policies may be appropriate for certain populations, in an era of expansion to non-disabled adults, they must be revisited. Revised cost-sharing policies should consider value based benefit design and incent enrollees to evaluate cost, quality and adopt positive health behaviors. Indiana's Healthy Indiana Plan (HIP) waiver applied principles of consumerism with remarkable results; lowering inappropriate ER use, and increasing prevention.

CONCLUSION:

Congress should reform Medicaid to assure long-term fiscal sustainability and access to quality services that improve the health of enrollees. A fundamental paradigm shift in management is required and the program should be reengineered away from compliance with bureaucratic policies that do not change results to aligning incentives for states, providers and recipients to improve outcomes. States are best positioned to develop policies that reflect the local values of the people they serve and should be given the flexibility to do so.

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- ⁱ National Governors Association & National Association of State Budget Officers. (2012). The Fiscal Survey of States. Retrieved online: <http://www.nasbo.org/sites/default/files/Fall%202012%20Fiscal%20Survey.pdf>
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- ^{vii} Bisgaier, J, & Rhodes, K. (2011). Auditing Access to Specialty Care for Children with Public Insurance. *The New England Journal of Medicine*, 324(24), 2324-33. Retrieved online: <http://www.nejm.org/doi/pdf/10.1056/NEJMsa1013285>
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- ^{ix} *Ibid.*

^x Based on Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2009 MSIS and CMS-64 reports, Retrieved online: <http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee-fy2009/>

^{xi} Based on Urban Institute estimates from CMS Form 64. Retrieved online: <http://kff.org/medicaid/state-indicator/growth-in-medicaid-spending-fy90-fy10/>