

**Testimony of**

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Commerce; Subcommittee on Health

On

“Strengthening Medicaid and Prioritizing the Most Vulnerable”

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## **Testimony Summary**

- Reform of the Medicaid program is needed and long overdue
- Ensuring that Medicaid eligibility is limited to people without resources to pay for long-term services and supports (LTSS) instead of including those who can shelter their resources would be an improvement, but this is a complex area and should be fully analyzed to ensure it is effective.
- The Medicaid Improvement Fund can provide an incentive for states to reduce their waiting lists for HCBS services, but how funding allocations are made can create unintended incentives and therefore should be carefully developed.
- Six areas for which reform is sorely needed are eligibility levels and requirements, reasonable and enforceable co-pays and premiums, services for people dually enrolled in both Medicare and Medicaid, managed care, prescription drugs, and value-based purchasing.
- In addition, other reforms are needed to reduce the undue administrative burdens on states.
- Finally, Congress should explore changing the role of the Centers for Medicare and Medicaid Services (CMS) in Medicaid. Specifically, instead of a command and control model, a pay-for-performance approach could help manage costs and incentivize innovation.

Good morning, Chairman Burgess, Ranking Member Green, and distinguished Members of the Subcommittee. I am John McCarthy, currently the CEO of Upshur Street Consulting, LLC. I recently stepped down from the position of Medicaid Director for the state of Ohio, and previous to that was the Medicaid Director for the District of Columbia. I appreciate this opportunity to share my recommendations for strengthening the Medicaid program.

The three bills that are up for discussion begin to address some common-sense reforms to eligibility requirements for the Medicaid program. Having recently served as the Vice President on the Board of Directors for the National Association of Medicaid Directors, I know that it is important to Medicaid Directors that the integrity of the program is maintained to make the program financially viable to serve those who qualify. These three bills promise to move the program in that direction.

First, the discussion draft of “The Prioritizing the Most Vulnerable Over Lottery Winners Act of 2017” would place reasonable exclusion periods from Medicaid eligibility when a person wins the lottery. Limiting Medicaid eligibility for lottery winners is an eligibility change that many support, and a policy change I advocated for over the last few years.

Second, the discussion draft of the “Close Annuity Loopholes in Medicaid Act” requires a state to apply half of an annuity’s payout to the spouse that is not institutionalized to the income of the spouse that is institutionalized and applying for Medicaid. Ensuring that Medicaid eligibility is limited to people without resources to pay for long-term services and supports (or LTSS), instead of also covering those who can shelter their resources, would be an important improvement. For most states, the greatest spending per person is for the aged, blind, and disabled (ABD) population who are the greatest users of LTSS so this is an important area to carefully explore. However, the bill does have some technical issues that need further

examination. For example, the institutionalized spouse could purchase the annuity and then name the spouse the annuitant and avoid assigning half of the payment to the institutionalized spouse. Because this area of Medicaid policy is so complex, a very close analysis of this issue is needed to ensure the problem is fully addressed.

Lastly, the “Verify Eligibility Coverage Act” eliminates federal dollars being used on services before a person proves their citizenship or immigration status. This change would provide the person requesting eligibility with an incentive to produce documentation as quickly as possible, and help to ensure federal dollars are not spent on individuals who do not qualify for the program.

All the bills include the creation of the Medicaid improvement fund. The main stated goal of the fund is to reduce waiting lists for home- and community-based services (HCBS) waivers. I agree this is an important issue. It was one of the goals of the first Kasich administration budget to eliminate the wait list for the PASSPORT waiver, which serves people over the age of 60. We eliminated the waitlist and reduced the number of nursing home bed days that were paid for, which in turn lead to over \$1 billion in savings over four fiscal years. A small initial investment was needed, but in the long term this offered a cost savings. However, this cost savings is only realized for cases in which there is diversion from an institution. If the person is on the waitlist is never institutionalized, the Medicaid program is likely to have lower expenditures than HCBS would entail. That does not necessarily mean that the person does not have the care he or she needs. The person may be enrolled in the Medicaid program and receiving some amount of state plan services at home, and additional services may be provided by non-paid caregivers or from services paid by local dollars. This program, therefore, will need to be carefully managed so that costs do not grow uncontrollably. In particular, a caution I offer

is that since the bill creates a competitive program with priority given to states with the highest number of people on waitlists, that provides an incentive to a state to have higher waitlists. Other methods for determining the appropriate funding level per state should be explored in order to manage the cost of this change. One alternative maybe to tie this proposal to the Money Follows the Person program that provides financial incentives to states to move people out of institutions and back into the community. One option may be to have the dollars proposed for this fund be able to cover the cost of the HCBS services for two years after a person leaves an institution.

The Medicaid program needs reform. There is simply too much unneeded and overly burdensome regulation that has been promulgated over the last few years that does not provide a benefit to the beneficiaries. The new Access to Care regulation and the Managed Care “Mega Rule” are just two examples. The Access to Care Regulation was a backdoor method to take away the ability for a state to set reimbursement rates for providers by putting that authority in the Centers for Medicare and Medicaid Services’ (CMS) hands. The amount of information that is requested by CMS such as surveys of providers and private sector rate data is not a true measure of the adequacy of the proposed rate. Additionally, the staff time needed to complete this work pulls the staff away from other more impactful tasks such as implementing value based purchasing.

Another rule CMS promulgated that was over complicated and was an overreaction to a couple of states that had difficult transitions from fee-for-service to managed care is the Managed Care “Mega Rule.” It is true that the managed care rules needed to be updated, but it is unclear if CMS has enough resources to implement what has been put in place. CMS should have worked more closely with the National Association of Medicaid Directors (NAMD) to update

the managed care rules, and to deal with states moving from fee-for-service to managed care CMS should have used rules that were already in place specifically the contract review and approval process along with the readiness review process.

There are several areas for which reforms are sorely needed. I will go into detail about some of them here. But this is not a complete list - there are many opportunities for improvement that I will not have time to discuss in my time today. The areas that I will briefly mention are: Eligibility levels and requirements, reasonable and enforceable co-pays and premiums, services for people dually enrolled in both Medicare and Medicaid, managed care, prescription drugs, and value-based purchasing.

**Eligibility levels and requirements.** States are required to cover individuals up to 133% of the federal poverty level (FPL), which is effectively 138% FPL with the 5% income disregard. However, exchanges provide subsidies to people down to 100% FPL. Requiring states to cover individuals who are also covered by the exchanges does not make sense. The Medicaid eligibility level should be set at 100% FPL to align the two programs. Additionally, states should have the option to implement other requirements such as work, education, or training in order to be consistent with the values of the people of that state.

**Reasonable and enforceable co-pays and premiums.** While the current law does allow for co-pays and premiums, CMS regulations make it nearly impossible to implement them. Furthermore, the amounts allowed for people above the federal poverty level are so low that it is often cost-prohibitive to implement.

**Services for people dually enrolled in both Medicare and Medicaid.** Ohio was the third state approved to implement a Duals demonstration. CMS has stated that Ohio's program is one of the better demonstrations in the country. A major barrier to success of the

demonstration is that a state is not able to require a dually eligible participant to enroll in a managed care plan on the Medicare side. A state can make it mandatory on the Medicaid side. Another barrier to success is that people on the program can change managed care plans any time. This policy leads to people changing plans multiple times within a short period of time, which then leads to confusion by the plans, providers and patients, and a loss of care coordination which is known to improve health outcomes and reduce cost. To address these issues, mandatory enrollment in a plan should be required, and a person should only be allowed to change a plan in the first 90 days or if there is a justified reason why the plan cannot meet the person's needs. Additional changes are needed to streamline the grievance and appeals process.

**Managed Care** - CMS should eliminate the need for waivers to put special populations in managed care. Many states are using managed care to efficiently and effectively deliver services to all populations, and it does not make sense to limit the ability to do so.

**Prescription drugs** - States are forced to cover all FDA-approved drugs and in turn receive rebates. However, for new high cost drugs, the rebate is not high enough to offset the large increase in expenditures. One consideration would be to let states opt out of the rebate program and requirement to cover all FDA approved drugs. A state could then create their own formulary and decide what drugs to cover in their Medicaid program. This approach could lead to negotiation on drug prices, which is currently prohibited.

**Value-based Purchasing** - States such as Ohio won State Innovation Method (SIM) grants to implement value based purchasing. Ohio and other SIM states ran into barriers in the fee-for-service portion of the program because of outdated laws and regulations. Such barriers need to be removed to promote innovation in approaches that the value-based purchasing models are meant to enable.

**Provider Requirements** - The “any willing provider” requirements for the fee-for-service program stifles provider competition, increases costs, and rewards low quality providers. States should be able to issue request for proposals for services. In Ohio, there is a surplus of nursing home beds. The average vacancy rate is about 15% statewide, but in some areas of the state that vacancy rate is much higher. A common-sense approach would be to let Ohio issue a request for proposal for a specific number of bed days and quality level. Providers would submit bids containing their price proposal and quality scores, and a state could choose the providers offering the best value. This approach would be expected to reduce costs and increase quality.

The areas in need of reform that I laid out above are only a subset of issues that are currently not working optimally in the Medicaid program. I do not have enough time today to go through all the areas. A good resource to use on what reforms are needed is the document published by the NAMD, “NAMD’s Legislative Priorities for 2017<sup>1</sup>.”

However, for real reform, the fundamental role of CMS must be re-thought. Currently, it acts as a regulator of the states. It should shift into the role of a payer and oversee the program. Instead of telling a state how much a state should reimburse providers, CMS should monitor health outcomes. This could be done by using financial incentives tied to measures like the National Committee for Quality Assurance’s (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures. For example, using the current federal medical assistance percentage (FMAP) formula, a state could receive a higher or lower percentage based on quality measures such as vaccination rates and rate of follow up appointments in seven days after an inpatient stay in a psych unit. This is similar to how states currently use pay-for-performance with their managed care plans. Other measures could also be used to obtain the outcomes desired, for example, measures like uninsured rates, patient satisfaction, or provider satisfaction,

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<sup>1</sup> [http://medicaiddirectors.org/wp-content/uploads/2016/12/NAMD-Legislative-Top-Issues-for-2017\\_FINAL.pdf](http://medicaiddirectors.org/wp-content/uploads/2016/12/NAMD-Legislative-Top-Issues-for-2017_FINAL.pdf)



to name a few. This same concept could be used with other funding mechanisms such as per capita allotments or block grants.

In conclusion, the Medicaid program is in need of reform. We need to think of new ways to oversee the program. We should focus less on command and control. Instead, both states and CMS need to be held accountable for the health outcomes of the people on the program. As health outcomes improve, the rate of growth of the program should move towards sustainability. I hope this testimony has provided you with a valuable high level overview to inform your deliberations about these bills and the reform of the Medicaid program. I'm happy to take any questions.