INSIGHT

Medicaid: After 50 Years, It's Time for Reform

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Introduction

Over the last 50 years, Medicaid has transformed from a social welfare program for the neediest in society, to the largest public health insurance program in the country, covering more than 70 million individuals— over 20 percent of our nation's population.[1] Given the growth and scope of the program, it is important to examine the program and ensure that it is accomplishing its mission while conforming to current budget realities. Unfortunately, that is not the case. Reforms must be implemented in order to restore the program's mission and ensure its fiscal sustainability.

The Case for Reform

Fiscally Unsustainable

Consistent expansions of Medicaid eligibility come with continuously increasing costs. Medicaid expenses grew 12 percent in 2014 and are expected to total $544.5 billion in 2015[2], consuming more than 9 percent of the federal budget and nearly a quarter of states' budgets.[3] Medicaid spending per beneficiary is 1.4 times greater than spending per privately insured individual, despite lower reimbursement rates.[4] Because of limited resources, increased spending on health care consequently crowds out spending on other vital services. Failure to reform our currently unsustainable entitlement programs will result in severe economic consequences and/or a program unable to deliver on its promise.

Coverage Does Not Equal Care

Not only is Medicaid's expansion and rising costs causing budgetary problems, the expansion may also be harming the very people the program was originally intended to help. Recent studies have found that many Medicaid recipients, despite having health insurance coverage, have trouble accessing care other than in the emergency room (ER). In California, increased emergency room visits are directly correlated with expansion in Medicaid eligibility from 2013 to 2014.[5] Even imposing cost-sharing for inappropriate use of the emergency room has not led to a decline in use by Medicaid recipients, which may indicate that these

individuals have no other choice but to seek care in the ER.[6] If this is the case and recipients already have trouble accessing care, then expanding eligibility only exacerbates the problem, making it more difficult for current beneficiaries to get needed care and adding new beneficiaries to an increasingly worse system. Given the limited resources available, we must face the difficult reality of ensuring this program actually benefits the truly needy, the people for whom it was originally created.

Government programs must be organized in a way that ensures achievement of the desired results. Medicaid must be reformed so that its design incentivizes both improved health among the beneficiary population and good stewardship of taxpayer dollars.

Current Medicaid Funding Models

Fee-for-Service

Traditionally, Medicaid—like Medicare—is provided to eligible beneficiaries on a fee-for-service (FFS) basis. When a Medicaid-eligible individual needs care, he or she may visit any participating Medicaid provider, and, so long as the state covers such services, the provider will be paid, regardless of whether or not said beneficiary had previously enrolled in the program.[7] These expenses are shared by both the federal and state governments. The federal share of Medicaid funding for each state is based on the Federal Medical Assistance Percentage (FMAP) formula, which is tied—inversely—to states' per capita income. Currently, the federal share of states' Medicaid funds ranges from 50 percent (the statutory minimum) to 74 percent, with an average match rate of 57 percent. For individuals newly eligible for Medicaid under a provision of the Affordable Care Act (ACA), the federal government currently covers 100 percent of the cost; that percentage is scheduled to gradually decrease to 90 percent by 2020, where it is supposed to remain.

Managed Care

In the 1980s, some states began transitioning their Medicaid programs from the standard FFS model to risk-based managed care models, through contracts with private health insurance organizations in which a capitated payment is typically provided by the state per enrollee (similar to Medicare Advantage). This transition occurred largely as an effort to control costs. (Primary Care Case Management (PCCM) organizations are also used to coordinate care of Medicaid

beneficiaries, though these types of MCOs do not share a financial risk like the other models.) As of September 2014, more than half of Medicaid beneficiaries were receiving care through a Managed Care Organization (MCO).[8] However, because most elderly and disabled Medicaid beneficiaries—who require the most costly care and account for 66 percent of all Medicaid expenditures—are not enrolled in managed care programs, only 28 percent of all federal Medicaid expenditures are for payments to managed care programs.[9] Managed care programs are subject to stricter regulations regarding access to and quality of care, beneficiary protections, and oversight; however, despite these requirements, it has been reported that there is a lack of monitoring and oversight of MCOs.[10] Studies on the success of these programs have shown mixed results. Some have found MCOs only save money in places where Medicaid FFS rates are high,[11] but other studies have found consistent savings, of as much as 20 percent.[12]

A Better Approach

Under the current open-ended entitlement program and greater than dollar-for-dollar federal matching rates, states have little incentive to control eligibility or rein in costs. For every dollar the state spends on Medicaid, the federal government, on average, provides the state $1.33 in matching funds. For the newly-eligible population under the ACA expansion provisions, states will receive at least $9 from the federal government for each dollar they spend. Conversely, for every dollar the state rescinds or saves through fraud and waste reduction, the state only saves itself 43 cents for the traditional beneficiary population and 10 cents for the expansion population. Given this extremely high match rate and the low return on investment for any savings, it is not surprising that Medicaid enrollment has increased approximately 20 percent since October 2013.[13]

Block Grants

Since the 1960s, block grants have become a common mechanism for distributing federal funds to states. Block grants provide states large lump sum payments determined by a formula, typically based on historical state spending levels or estimates of the eligible beneficiary population and often adjusted annually for changes in population and inflation (or some other economic indicator). When the primary aim is to limit government expenditures (as is usually the case), the formula determining funding levels will provide slower growth in funding than current projected cost growth.

Many have looked to block grants as an alternative funding structure for the Medicaid program, particularly because of the design's ability to control spending, and also to reduce administrative burdens and provide states flexibility to tailor the program to their needs. While these capabilities are desirable to some degree, passing on most of the decision-making authority to the grant recipient deprives Congress of the important task of maintaining oversight of the program. Given that the federal government contributes more than half of the funds (57 percent, on average) for Medicaid, oversight over how such funds are spent is not just appropriate, but should be obligatory. One way to get around this issue could be concurrent use of managed care programs which do have regulatory requirements, but, as discussed earlier, these programs are not currently sufficiently reporting or appropriately being monitored to satisfactorily serve as a solution this problem.

Further, past block grant proposals have been criticized because predetermined funding amounts do not insure against the counter-cyclical nature of the need for social assistance programs, such as Medicaid, thereby removing the entitlement aspect of the program. This could potentially lead to the denial of coverage for otherwise eligible beneficiaries, making this type of reform particularly controversial for the Medicaid program.

Capped Allotments

Capped allotments, which are the basis for funding in the successful Children's Health Insurance Program (CHIP), are similar to block grants in that states are provided a lump sum of money predetermined by a formula. In CHIP, allotments are based on a state's spending in the prior year, and this method could easily be applied to Medicaid. Compared with block grants, capped allotments do not relinquish as much authority over how the funds may be spent. Further, allowing adjustments in funding levels from one year to the next protects against funding shortfalls or overpayments as economic conditions change. However, capped allotments do remove the entitlement aspect of the program like block grants, though the impact may typically be mitigated within a year after funding adjustments are made. Thus, capped allotments have many of the same benefits provided by block grants, while overcoming their main weakness—lack of opportunity for federal oversight. Of course, they may still provide inadequate funding when compared to a traditional entitlement structure.

Per Capita Caps

A third option for program funding is per capita caps. This option provides a fixed amount of funding per enrolled (rather than eligible) beneficiary, maintaining the entitlement aspect of the program and protecting against counter-cyclical need, but limiting the amount of money available for each enrollee, forcing states to find ways to save money. Per capita caps also allow continued oversight of how program funds are being used.

Given known differences in costs depending on categorical eligibility and geographic location of each beneficiary, the amount of funding for each beneficiary should vary to account for these differences in costs and needs in order to provide adequate funding. For instance, average spending per elderly beneficiary was nearly three times greater than spending per non-elderly, non-disabled adult in 2014.[14] Additionally, health care costs can vary greatly from one region of the country to the next, even after accounting for differences in demographic characteristics.[15] To simply provide a single rate of funding for each beneficiary could result in either overpayments and waste or underpayments and loss of needed care.

Past proposals would provide exclusions for certain populations, such as dually-eligible beneficiaries, partial enrollees, CHIP recipients, and others as determined appropriate. Additionally, proposals have called for the establishment of risk corridors for disabled beneficiaries, which would reward states that spend their dollars cost-effectively by allowing them to access additional funds, but would shield states from significant loss due to the unpredictable needs of this vulnerable population.

Limitations

All of these proposals share one goal: reducing spending. However, simply providing less money to the program does not actually reduce the costs of health care; rather, it reduces expenditures without any guarantee that the quality of services or access to them will not suffer as a result. Therefore, additional payment reforms and quality standards incentivizing preventive care and healthy lifestyle choices, more efficient and effective treatments, etc. will need to supplement such funding reforms. For example, per capita caps could easily be used as premium payments for enrolling each beneficiary into a managed care

program, which may be useful in areas where these programs have proven successful.

Additionally, there are limitations to the amount of savings which can be gained if significant portions of the beneficiary population, particularly those needing the most and costliest care, are not included in these funding limits. It is important to fully consider the implications of any exclusions and conditions, though, not just on costs, but also on the availability of necessary care. If these individuals are not included in reform efforts, the full potential of the savings benefit may not be realized, but not excluding them may hinder their ability to receive necessary services.

Consideration must be given to the impact that any reform will have on maintaining—or lessening—states' stake in the success of the program and the possibility of increasing states' burdens to the point that the program will be doomed to fail. With any reform, Medicaid must maintain its joint federal-state relationship with the appropriate level of oversight and funding match rates. Maintaining appropriate match rates, and thus ensuring federal payments supplement rather than supplant state funding, can be achieved by instituting maintenance-of-effort requirements or including current FMAP levels in the funding formula. However, maintenance-of-effort requirements can cripple states by imposing unsustainable burdens that do not allow proper flexibility when states face unforeseen changes in circumstances. Including current FMAP levels in the new funding formula is a more reasonable and responsible approach. All three of these funding reform proposals could ensure that states continue to satisfy their share of the program funding by reducing federal shares if states fail to provide; CHIP currently requires states to match funds under its capped allotment formula.

Conclusion

The time for reforming our entitlement programs is now. We must be good stewards of taxpayer dollars and ensure these limited funds are being spent in the most cost effective manner to achieve the intended purposes. Failure to reduce expenditures will either crowd out money available for other vital services or force the acceptance of additional crippling debt. However, reducing expenditures is not the only goal; providing adequate, quality care to the neediest of our population is the intent of the Medicaid program. Reform efforts must keep this objective central, and any reductions in funding should ensure remaining

funding is prioritized to first provide care to those for whom the program was originally created.

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[1] http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/april-2015-enrollment-report.pdf
[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
[3] http://www.nasbo.org/sites/default/files/Summary_State%20Expenditure%20Report.pdf
[4] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
[5] http://www.californiahealthline.org/articles/2015/4/30/medical-expansion-correlates--with-spike-in-ed-visits-data-show
[6] http://content.healthaffairs.org/content/29/9/1643.abstract
[7] Payment for services also requires the provider to be an eligible and registered Medicaid provider.
[8] http://kff.org/medicaid/report/key-findings-on-medicaid-managed-care-highlights-from-the-medicaid-managed-care-market-tracker/
[9] http://kff.org/report-section/key-findings-on-medicaid-managed-care-report/
[10] https://kaiserfamilyfoundation.files.wordpress.com/2012/02/8046-02.pdf
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