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Before the
Committee on Finance
United States Senate

Hearing on
The Future of Medicaid: Strategies for Strengthening America's Vital Safety Net

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The views presented are those of the author and do not necessarily represent those of NASHP trustees or sponsors.

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Chairman Grassley, Ranking Member Baucus, and members of the committee, I appreciate the opportunity to appear before you today to discuss the Medicaid program. My name is Alan Weil and I am Executive Director and President of the National Academy for State Health Policy (NASHP). NASHP is a non-profit, non-partisan organization based in Portland, Maine, dedicated to helping states achieve excellence in health policy and practice. Before taking my current position I was a center director at the Urban Institute and, before that, executive director of the Colorado Department of Health Care Policy and Financing, which is the state Medicaid agency.

As members of this committee, you are aware of the important role Medicaid plays in financing health care services for an incredibly broad array of Americans including children, parents, people with disabilities, and the elderly. Medicaid provides financial support for our safety net institutions which provide needed care to 45 million Americans without health insurance. And Medicaid fills in many gaps in the Medicare program, especially in the areas of cost sharing, long-term care, and, for another 6 months, prescription drugs. There are many sources you can turn to for information on the Medicaid program; I have attached an article I wrote a couple of years ago that provides my perspective.

Yet, as you also know, Medicaid costs are putting pressure on state and federal budgets. Indeed, it is cost pressure that is the primary driving force behind efforts to reform the program. The challenge is to address these fiscal challenges without harming the health and functional status of the vulnerable populations the program currently serves. This is no simple task.

A Bipartisan Framework for Medicaid Reform

Before describing the work we have done in this area, I want to offer a brief framework for thinking about change in the Medicaid program. If you want to reduce the cost of the program, there are only three types of options available. First, you can shift costs to another payer, second you can shift costs to the program's enrollees, and third you can make the program more efficient.

Medicaid has a long tradition of taking the first approach—freezing or reducing provider payment rates to achieve short-term savings. Indeed, this is often the only option states feel they have when confronting an immediate fiscal crisis. And there is a long tradition of cost-shifting between the states and the federal government—a tradition that does nothing to improve the overall functioning of the program.

As states have faced protracted budget difficulties, more have turned to the second approach—eliminating certain services, capping others, increasing administrative burdens on applicants, and in some instances reducing eligibility levels. These have generally been considered options of last resort, but some Medicaid reform proposals seek to enshrine them as preferred policy. This is a very risky proposition given the extremely low income of most Medicaid enrollees.

A truly bipartisan approach to improving Medicaid needs to emphasize the third approach: making the program more efficient. On a risk-adjusted basis, Medicaid is actually less expensive than private health insurance. This is primarily due to low payment rates for services. Despite these low costs, Medicaid administrators and enrollees have many ideas for how to make the program more efficient. For the sake of the long-term stability of the program we should use tight budgets as an opportunity to design a more efficient program.

It is important to note that flexible is not the same as efficient. Those who propose flexibility should bear the burden of presenting evidence to support concrete steps they would take with their newfound flexibility to make the program more efficient. You may decide that cuts are necessary to achieve fiscal goals, but cuts should not hide behind vague language like flexibility.

There is one important additional factor when considering changes to Medicaid. For good or ill, Medicaid has become the foundation on which much of our health care system is built. Medicaid is now intertwined with state mental health systems, services for people with developmental disabilities, school-based health, child protective services, juvenile justice, public health, and welfare reform. Medicaid serves as a source of catastrophic coverage that helps make private health insurance more affordable. And Medicaid provides coverage for low-income families who would otherwise be uninsured. Changes to Medicaid can have ripple effects through all of these systems, and can make it more or less likely that your other efforts to reduce the number of Americans without health insurance will succeed. Thus, it is important that you consider changes to Medicaid in context.

Making Medicaid Work for the 21st Century

I am pleased today to be able to present to you the results of an 18-month project undertaken by NASHP with major funding from the David and Lucile Packard Foundation and additional support from the Robert Wood Johnson Foundation, AARP, and the Agency for Health Care Research and Quality within the U.S. Department of Health and Human Services. The project was called Making Medicaid Work for the 21st Century and began in 2003 when NASHP convened a group of state officials and national experts with a broad range of experience in the Medicaid program to develop recommendations that would make the program more effective and successful. (A list of the workgroup's members is included as Attachment A.)

The workgroup approached its topic in a spirit of compromise, understanding the need to balance meaningful federal standards with state flexibility in program design and implementation. Before making recommendations, the workgroup stated the importance of viewing its recommendations as a total package because the recommendations are interrelated and reflect a complex balancing of interests. The report is the result of a

consensus process, so no individual member should be viewed as having adopted the recommendations as his or her preferred position.

The final report of the workgroup identified many opportunities for strengthening the Medicaid program and enabling it to continue to play a critical role in the country's health care system. The report's detailed recommendations identify opportunities for improvement in all areas of the Medicaid program and include calls for simplifying and expanding eligibility, increasing program flexibility for optional populations, improving coordination and integration with the Medicare program and private insurance, adjusting current financing mechanisms, and providing states with tools to manage the long-term care system and, in the process, rebalance the institutional and home and community-based care systems.

Key recommendations were developed for Medicaid eligibility, benefits, and financing and include the following.

Eligibility

The workgroup regarded as its most significant recommendation that Medicaid should provide comprehensive health care coverage for the poorest Americans—all people with incomes at or below the federal poverty level—without regard to age, family structure, or health status. This new national minimum eligibility level would apply in all states and would replace the current system of categorical eligibility which ties Medicaid eligibility to other matters such as age, family structure, and health status.

In addition:

- The workgroup recommended continuing the existing option for states to extend Medicaid coverage to eligibility groups with income above minimum federal requirements.

- Current requirements to cover children and pregnant women with incomes above the poverty level should be preserved.

- States should be offered more flexibility in determining eligibility, including the ability to simplify eligibility requirements by basing eligibility just on income.

- States should be given new options for setting financial and functional criteria to qualify for long-term care services. States should be permitted to modify income and assets tests to allow those applicants seeking community care who are most likely to use up their resources within a short time of entering a nursing home to qualify for Medicaid financed acute and community care (but not institutional services) while they are still in the community. States should also be permitted to set different functional criteria for institutional and community long-term care services.

Benefits

The workgroup recommended that all individuals covered up to the new national minimum eligibility level be entitled to the same set of acute, primary care, and long-term care benefits provided under current Medicaid law.

For individuals with income above the mandatory level, states should be allowed to offer the current Medicaid benefit package or a lesser, but still comprehensive, set of benefits that meets certain benchmark standards. If a state chose to offer benefits to an optional group, it would be required to offer acute and preventive care, but could choose whether or not to offer long-term care. States could also choose to offer a different long-term care benefit package to optional eligibles than they do to the mandatory group.

The workgroup recommended continuing current rules that limit cost sharing to nominal levels for mandatory eligibility groups. The group recommended that states have the option to set higher levels of cost sharing for optional eligibility groups.

In addition:

- The workgroup gave special attention to waiver recommendations for long-term care and home and community-based services (HCBS). Given that HCBS waivers now exist in every state, the workgroup recommended that states have the option of converting these waivers into an ongoing program within Medicaid. These services would no longer be subject to the waiver requirements of cost neutrality and periodic renewal, and states could retain certain features of their waivers such as the ability to limit the number of participants.

- Parents of Medicaid-eligible children should be able to choose to enroll their children in the SCHIP program so long as certain enrollee-protection standards are met.

Financing

The workgroup evaluated the current financing structure in which the federal government matches qualifying state Medicaid expenditures, and it rejected the need for radical restructuring of this approach. Specifically, the workgroup recommended against converting Medicaid financing into a block grant to states.

The workgroup recommended that revisions be made in the formula and process for establishing the federal matching percentage (FMAP). The FMAP needs to be set in a way that more quickly and accurately reflects changes in the economy and in the fiscal capacity of states.

The federal government should provide more support to states for the Medicaid costs associated with low-income persons enrolled in Medicare. This increased level of

support should be provided in conjunction with efforts to improve care coordination and program management between the two programs.

In addition:

- The federal government should provide states with an enhanced match (at the SCHIP rate) for the new costs associated with simplifying and expanding eligibility to include all Americans with income at or below the federal poverty level.

- States should be given new opportunities to coordinate Medicaid coverage with private, employer-sponsored insurance through premium assistance programs. States should be allowed to implement premium assistance programs under a state plan amendment with certain features that now require a waiver, such as policies related to wrap-around benefit coverage, wrap-around cost sharing, and crowd-out prevention. Further, states should be allowed to require employers to enroll their Medicaid-eligible employees in the employer's health plan at times other than the open enrollment period.

Other Recommendations

The workgroup made additional recommendations related to needed changes in Medicaid, including the following.

- Allowing states to extend eligibility for Medicaid financed home and community-based (but not institutional) long-term care services to applicants whose incomes are low enough, but whose assets are too high, for them to qualify for Medicaid—if the cost of institutional care would soon deplete their assets enough to qualify for Medicaid.

- Extending the federal policy of reimbursing states 100 percent of the cost of services provided to American Indians/Alaskan Natives in Indian Health Service or tribal facilities to include all services provided to this group regardless of where the service is delivered.

Concluding Remarks

We learned two important lessons as we carried out the Making Medicaid Work for the 21st Century project. First, there are many opportunities to strengthen and improve the Medicaid program. These opportunities fall largely into the third category of change I described earlier: making the program more efficient and effective. People who work with the program are skeptical of grand claims for large savings, and they know how hard it can be to put good ideas into practice. Still, there are concrete steps that the federal government and states can take to improve the program without simply shifting costs to others or increasing costs for the most vulnerable Americans.

Second, while NASHP serves state officials who have a great deal of experience with the Medicaid program, the state perspective must be balanced against other critical perspectives, including those of more than 50 million Americans who are enrolled in the program. States bring a wealth of experience and expertise to discussions of Medicaid's future. The program has certainly been strengthened by the lessons learned from state experimentation. While states have a tremendous stake in Medicaid's success, we are not the only ones with such a stake. Our deliberations benefited greatly from the inclusion of multiple perspectives to assure that in looking out for the interests of the states we did not fail to consider the interests of others.

On behalf of NASHP and those who helped us with our work, I am pleased to share with you the results of our deliberations and to let you know that we stand ready to assist you in any way possible to strengthen and improve the Medicaid program.

Attachment A

The Making Medicaid Work for the 21st Century Workgroup

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**Although Mr. Smith and CMS staff participated in various workgroup discussions and provided technical assistance, CMS does not endorse, nor does it necessarily concur in any of the specific recommendations contained in this final report.*