Backgrounder

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A Road Map for Medicaid Reform

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Medicaid, the massive federal–state health care program for the poor and indigent, is long overdue for comprehensive reform. Policymakers have an opportunity to make meaningful improvements in the Medicaid program. Not only will Congress need to meet its budget requirements to identify Medicaid savings, but Secretary of Health and Human Services Michael Leavitt will soon appoint a special commission to offer short-term and long-term recommendations for the future of the troubled program. Concurrently, states are searching for real solutions to regain control and restore quality to their programs.

Troubled Program

The Medicaid program is in trouble. It is fiscally unsustainable and programmatically outdated, burdened by the inflexibility of bureaucratic decision making. Without major changes, low-income Americans' access to high-quality care is in jeopardy.

Nonetheless, some policymakers would prefer to maintain the status quo instead of addressing the real problems facing the program, thus allowing them to worsen. Congress, in coordination with reform-minded state governors, should reevaluate Medicaid's mission and goals and develop and enact new approaches to address the needs of and improve the quality of care for low-income Americans. Working together, federal and state policymakers can make a number of innovative changes in Medicaid and transform it into a more effective program.

Talking Points

- Medicaid is facing fiscal instability and declining quality, and the program is in dire need of reform.
- Policymakers should restore integrity to Medicaid by encouraging personal responsibility and mainstreaming working families into private coverage.
- State policymakers should utilize existing federal waivers to reform their state Medicaid programs. States should also build on premium support and consumer-directed models to better serve the Medicaid population.
- Federal policymakers should encourage Medicaid reform beyond the trivial savings required under the budget agreement. Specifically, they should restructure the management and budget of long-term care financing, streamline the federal waiver process for states, and enact other mechanisms to help low-income families purchase private health care coverage, such as refundable health care tax credits, which would relieve the stress on state Medicaid programs.

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Using Welfare Reform as the Model

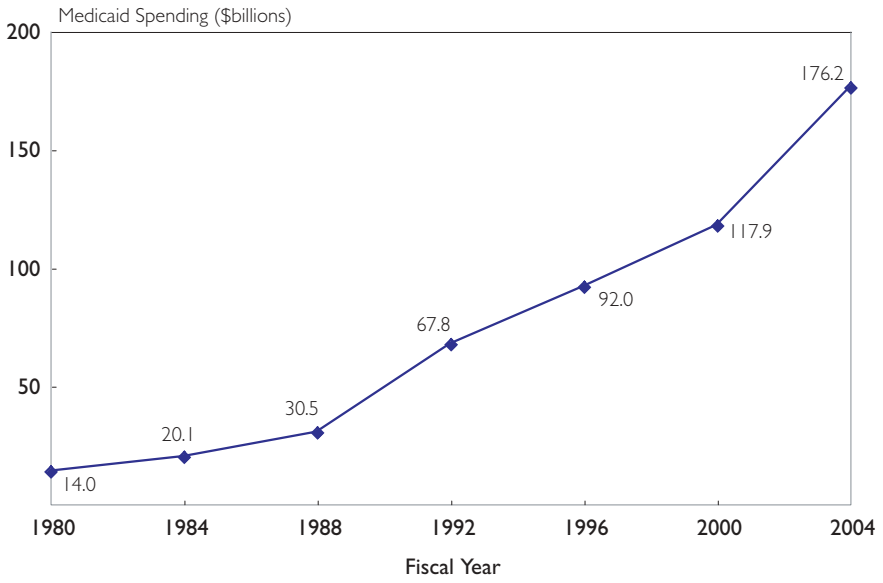
Congress should use the welfare reform of 1996 as a model for reforming Medicaid. Welfare reform inspired change by giving states flexibility, but it also required that they meet clear federal policy objectives and outcomes. In regard to Medicaid, this would mean:

- Restoring integrity to the program by ending state financing gimmicks, making a programmatic distinction between the provision of welfare services and the provision of medical services, and closing the loopholes on asset transfers;
- Allowing Medicaid beneficiaries to assume personal responsibility for and individual control of their own health care by promoting consumer-directed care models;
- Streamlining and expanding the federal waiver process, which allows states greater flexibility to experiment with innovative approaches to improve health care access and quality for low-income Americans; and
- Helping individuals and families "mainstream" into private health care coverage through refundable tax credits and giving states greater flexibility in further supplementing tax credits with Medicaid dollars.

Meanwhile, state officials should use existing opportunities to begin making important changes in their Medicaid programs. These efforts should include enabling certain classes of Medicaid beneficiaries to buy private health care coverage by offering premium assistance to enrollees and allowing them to manage their own care by expanding the use of consumer-directed models, such as the "cash and counseling" demonstration that has proven successful in Arkansas, Florida, and elsewhere.

Chart 1 B 1863

Medicaid Outlays, 1980-2004



Source: Office of Management and Budget, *Historical Tables, Budget of the United States Government, Fiscal Year 2006* (Washington, D.C.: U.S. Government Printing Office, 2005), p. 308, at *www.whitehouse.gov/omb/budget/fy2006/pdf/hist.pdf* (June 16, 2005).

Medicaid's Exploding Costs

Medicaid is expected to provide care for over 46 million individuals and cost $338 billion in federal and state spending in fiscal year 2006.[1] The cost of the program has more than doubled over the past 10 years and is expected to reach $5 trillion over the next decade.[2]

1. Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2006* (Washington, D.C.: U.S. Government Printing Office, 2005), p. 137, at *www.whitehouse.gov/omb/budget/fy2006/hhs.html* (May 27, 2005).
2. The Honorable Michael Leavitt, Secretary, U.S. Department of Health and Human Services, "FY 06 Budget for the Department of Health and Human Services," statement before the Committee on Energy and Commerce, U.S. House of Representatives, February 17, 2005, at *www.hhs.gov/asl/testify/t050217.html* (May 27, 2005).

In federal spending alone, Medicaid is expected to cost the federal government $193 billion in fiscal year 2006, a significant increase over $14 billion in 1980.[3] Medicaid accounted for 13 percent of federal mandatory spending in 2003 and is expected to reach 2 percent of U.S. gross domestic product by 2015.[4]

For states, the exploding cost of Medicaid is of even greater concern. In 2003, for the first time ever, Medicaid spending replaced education as the largest component of state budgets, consuming 22 percent of state spending.[5] Unlike the federal government, which routinely runs big deficits, nearly all states are required to balance their budgets. Therefore, Medicaid spending directly and immediately affects state budgets and forces states to address the fiscal issues head-on. Most states have adopted techniques to slow spending in the program, but these techniques are only short-term answers and can jeopardize enrollees' access and quality of care.

Medicaid's Out-of-Date Structure

Medicaid's governance is unique. Because of the federal–state structure of the program, there is no single Medicaid program; instead, it varies from state to state. In other words, while the federal government requires state Medicaid programs to cover certain "mandatory" populations and services, states can go beyond the mandatory requirements and extend Medicaid to "optional" populations and services.[6]

Most states have expanded their programs beyond the mandatory requirements. Today, most Medicaid services fall outside the federal mandatory requirements. According to the Kaiser Family Foundation, a prominent think tank specializing in Medicaid policy, two-thirds of Medicaid spending is on services classified as "optional" under the federal requirements.[7] Furthermore, 56 percent of elderly Medicaid beneficiaries qualifying for the program belong to "optional" populations under federal requirements.[8] Thus, Medicaid is in need of restructuring. It has moved far beyond its original intent as enacted, and the outdated and rigid categories further frustrate states' ability to make changes.

Worries over Declining Quality

The fiscal troubles and structural challenges of Medicaid have consequences. The growing constituencies based on optional beneficiaries and services make it politically difficult to retract any "optional" expansions in order to regain fiscal control of the program. Therefore, most states employ cost containment strategies that do not directly cut beneficiaries or eliminate services from the program, but instead indirectly affect enrollees.

Most prominent among these are techniques that cut provider reimbursements and limit prescription drug costs. An analysis published by the Kaiser Family Foundation found that "in FY 2004, 48 implemented new pharmacy cost controls; and 50 states froze or reduced rate increases for at least one group of providers."[9] Of course, while such indirect cuts are more hidden to enrollees, they clearly have an adverse affect on enrollees' access and quality of care.

In fact, Medicaid's reimbursement rates have dipped so low and its bureaucracy has become so

3. Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2006*, *Historical Tables,* (Washington, D.C.: U.S. Government Printing Office, 2005),p. 308, at *www.whitehouse.gov/omb/budget/fy2006/pdf/hist.pdf* (June 16, 2005).
4. Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2006 to 2015*, January 2005, p. 57, at *mirror1.cbo.gov/ftpdocs/60xx/doc6060/01-25-BudgetOutlook.pdf* (May 27, 2005).
5. Vernon K. Smith and Greg Moody, "Medicaid in 2005: Principles and Proposals for Reform," Health Management Associates, February 2005, p. 19, at *www.nga.org/cda/files/0502MEDICAID.pdf* (May 27, 2005).
6. For a complete list of mandatory and optional populations and services, see Centers for Medicare and Medicaid Services, "Medicaid: A Brief Summary," modified December 3, 2004, at *www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp* (May 27, 2005).
7. Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Optional Populations: Coverage and Benefits," Henry J. Kaiser Family Foundation, February 2005, p. 5, at *www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=51052* (May 27, 2005).
8. *Ibid*, p. 2.

burdensome that many providers, especially physicians, have been forced to stop accepting Medicaid patients. A 2002 Medicare Payment Advisory Commission (MedPac) survey found "more than 30 percent of all physicians now refusing to accept any new Medicaid patients."[10] Another study concluded that "Despite some improvement…physicians continue to be paid less for Medicaid beneficiaries than for other groups of insured patients, and they are much less likely to accept new Medicaid patients than other insured patients."[11]

Medicaid beneficiaries also face limitations on access to prescription drugs. As noted, 48 states imposed prescription drug cost controls in 2004.[12] These restrictions take the form of prior authorization, where an enrollee's physician must receive permission from the state to write a prescription, and dispensing limits, where enrollees are limited to a certain number of prescriptions.[13] Both types of controls have serious health implications for Medicaid enrollees.[14]

With the continuing growth of Medicaid, problems with the quality of care are likely to increase. For example, a recent study on treatment and prevention of diabetes, a rapidly growing chronic disease, found that dual-eligible diabetics enrolled in both Medicaid and Medicare had higher rates of adverse outcomes and used fewer preventive services than Medicare diabetics who were not enrolled in Medicaid.[15]

In other words, without adequate access to physicians and services, such as prescription drugs, many Medicaid beneficiaries do not receive important care and treatment. It is evident that Medicaid is spread too thin and can sustain its current form only by further rationing care, thereby adversely affecting care for those who truly need it.

Seizing Existing Opportunities to Promote Reform

Federal lawmakers have been far too slow to address the growing crisis in Medicaid. The Bush Administration has tried to raise awareness of the need for change. In the fiscal year 2004 budget proposal, President George W. Bush recommended restructuring Medicaid financing to reflect the needs of the program more accurately.[16] Regrettably, Congress showed little interest in taking on this issue. This year, the Bush Administration proposed some modest steps in the budget to rein in Medicaid spending and restore "integrity and accountability" to the program.[17]

Congressional Budget Action. The House of Representatives closely matched the President's

9. Kaiser Commission on Medicaid and the Uninsured, "State Fiscal Conditions and Medicaid," Fact Sheet, Henry J. Kaiser Family Foundation, November 2004, p. 2, at *www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=49527* (June 17, 2005).
10. Medicare Payment Advisory Commission, "2002 Survey of Physicians About the Medicare Program," p. 2, at *www.medpac.gov/publications/contractor_reports/Mar03_02PhysSurv_summary2.pdf* (May 27, 2005).
11. Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, and Len Nichols, "Changes in Medicaid Physician Fees, 1998–2003: Implications for Physician Participation," *Health Affairs Web Exclusive*, June 23, 2004, p. W4-382, at *content.healthaffairs.org/cgi/reprint/hlthaff.w4.374v1.pdf* (May 27, 2005).
12. Kaiser Commission on Medicaid and the Uninsured, "State Fiscal Conditions and Medicaid," p. 2.
13. Peter J. Cunningham, "Medicaid Cost Containment and Access to Prescription Drugs," *Health Affairs*, Vol. 24, Issue 3 (May/June 2005), p. 782, at *content.healthaffairs.org/cgi/reprint/24/3/780* (May 27, 2005; subscription required).
14. *Ibid.* See also Derek Hunter, "Government Controls on Access to Drugs: What Seniors Can Learn from Medicaid Drug Policies," Heritage Foundation *Backgrounder* No. 1655, May 27, 2003, at *www.heritage.org/Research/HealthCare/bg1655.cfm*.
15. Maryland Health Care Commission, "Trends in Diabetes Prevalence and Care Among Medicare Beneficiaries in Maryland—2002," December 2004, p. 3.
16. Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2004* (Washington, D.C.: U.S. Government Printing Office, 2003), pp. 125–127, at *www.gpoaccess.gov/usbudget/fy04/pdf/budget/hhs.pdf* (June 9, 2005).
17. Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2006*, pp. 143–144.

modest proposal. Its budget would have required $20 billion in Medicaid savings over the next five years.[18] The Senate originally proposed requesting $15 billion in savings from Medicaid, but that was later removed by an amendment offered by Senator Gordon Smith (R–OR).[19] Under the final federal budget agreement, accepted by the House and Senate, Congress will need to identify only $10 billion in Medicaid savings by 2010[20]—not a cut, but a slowing in its rate of growth. As noted by Robert Samuelson, a *Washington Post* columnist on economic policy, such a Medicaid reduction is "trivial," constituting less than 1 percent of the estimated $1.1 trillion in Medicaid spending over the same period.[21]

The final budget agreement also established a Medicaid Commission to provide Congress with recommendations on achieving the $10 billion savings requirement as well as longer-term program changes.[22]

The budget reconciliation agreement offers a unique opportunity to discuss and debate the future of Medicaid. State and federal policymakers should seize this opportunity to make meaningful changes in the program. In fact, instead of simply tinkering with trivial savings, Congress should consider overall reforms that would enable states to make lasting improvements in the Medicaid program.

Principles for Long-Term Medicaid Reform

If federal and state policymakers expect to save Medicaid from fiscal bankruptcy and to protect beneficiaries from deteriorating quality of care, they need to rethink Medicaid's basic purpose and role. This will lead them to think differently about how to organize and structure the program.

First, policymakers should focus on approaches that are patient-centered instead of system-centered. The current Medicaid structure is based on a system that reimburses providers for the services that they supply to beneficiaries. A patient-centered approach would direct Medicaid funds to the patient and reflect the individual needs of that patient.

Second, policymakers should move away from the rigid structure that compartmentalizes individuals based on the outdated "mandatory" or "optional" categories. Instead, the program should focus on those most in need, and states should have the ability to determine that standard.

Third, policymakers should target solutions so that they best serve the individual. Today, Medicaid is dictated by a one-size-fits-all approach that provides care to a very diverse group of individuals. Instead, the program should focus on providing assistance that recognizes this diversity and should design policy solutions that, while they may differ, best serve the unique needs of the individual, whether a healthy child or an elderly adult with chronic conditions.

Fourth, particularly in the financing of long-term care, policymakers should separate the provision of social services from the provision of medical services. Many long-term care services are not medical at all, but welfare services involving the provision of housing, food, and services related to assisted living. At the federal level, within the U.S. Department of Health and Human Services, these functions should come under the management and budget of the Administration for Children and Families, not the Centers for Medicare and Medicaid Services.

What State Officials Should Do

State officials are experienced at handling Medicaid's ongoing crisis and have struggled to find appropriate ways to manage the program. As discussed earlier, most states have adopted measures

18. Andrew Taylor, "Fiscal 2006 Plan Narrowly Adopted," *CQ Weekly*, May 2, 2005, p. 1148.

19. *Ibid.*

20. *Ibid.*

21. Robert J. Samuelson, "Deficit Disorder," *The Washington Post*, May 11, 2005, p. A17.

22. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Medicaid Program; Establishment of the Medicaid Commission and Request for Nominations for Members," CMS–2214–N, at *www.cms.hhs.gov/faca/mc/frnotice.pdf* (June 9, 2006).

to control spiraling costs. These efforts may offer short-term relief, but they do little to improve the long-term outlook. Many states have reached their breaking points and recognize that the program cannot continue as is. As John Hurson, a prominent Democrat Maryland state legislator, has stated, "[W]e can't sustain the current Medicaid program. It's fiscal madness. It doesn't guarantee good care, and it's a budget buster."[23]

Currently, states can make some changes in their Medicaid programs. Some require a federal waiver, and others do not. State policymakers should take advantage of the current waiver structure, as cumbersome as it may be, and introduce reform into their programs. States should consider building on the following models when rethinking the structure and function of their Medicaid programs:

- **Premium Assistance.** State policymakers should seize the opportunities offered under the Health Insurance Flexibility and Accountability (HIFA) waiver to launch a premium assistance program under Medicaid.[24] Such an approach would enable states to use existing Medicaid and State Children's Health Insurance Program funds to help certain low-income individuals and families purchase private health insurance. Many families and individuals would prefer to buy private coverage, whether through the workplace or on their own. A Commonwealth Fund survey found that 65 percent of adults would prefer private coverage.[25] These funds would give some individuals and families that opportunity.
- **Consumer-Directed Care.** State policymakers should use and build on the Independence Plus waiver to expand consumer-directed care to the broader Medicaid population.[26] This waiver allows states to give certain disabled Medicaid persons the power to manage their personal care services. With assistance from a care counselor, individuals and family members select and budget the services that they want and receive. Evaluations have shown that these individuals are more satisfied with their services and overall lives under this approach.[27] Instead of simply being assigned services through the Medicaid program, individuals can engage in the process and make decisions that best suit their needs. This design should be expanded and integrated with disease management and preventive care efforts.[28]

Some states are using the current waiver process to make even broader reforms in the delivery of care to Medicaid beneficiaries. At the forefront is the State of Florida. Governor Jeb Bush (R) has initiated the "Empowered Care: Putting Patients First" proposal, which aims at improving care for Medicaid beneficiaries by allowing for greater flexibility in benefit structure; giving them the ability to choose

23. Robert Pear, "States Proposing Sweeping Change to Trim Medicaid," *The New York Times*, May 9, 2005, p. A1.
24. Under the HIFA waiver, states are encouraged to "maximize private health insurance coverage options." See Centers for Medicare and Medicaid Services, "Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative," modified September 16, 2004, at *www.cms.hhs.gov/hifa/default.asp* (May 27, 2005).
25. Jennifer N. Edwards, Michelle M. Doty, and Cathy Schoen, "The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care," Commonwealth Fund *Issue Brief*, August 2002, p. 7, at *www.cmwf.org/usr_doc/edwards_erosion.pdf* (June 9, 2005).
26. Press release, "New Freedom Progress Report Released," Department of Health and Human Services, May 9, 2002, at *www.hhs.gov/news/press/2002pres/20020509a.html* (May 27, 2005).
27. See Leslie Foster, Randall Brown, Barbara Phillips, Jennifer Schore, and Barbara Lepidus Carlson, "Improving the Quality of Medicaid Personal Assistance Through Consumer Direction," *Health Affairs Web Exclusive*, March 26, 2003, at *content.healthaffairs.org/cgi/reprint/hlthaff.w3.162v1* (May 27, 2005). See also James Frogue, "The Future of Medicaid: Consumer-Directed Care," Heritage Foundation *Backgrounder* No. 1618, January 10, 2003, at *www.heritage.org/Research/HealthCare/BG1618.cfm*.
28. See Robert E. Moffit, Ph.D., and Nina Owcharenko, "Covering the Uninsured: How States Can Expand and Improve Health Care Coverage," Heritage Foundation *Backgrounder* No. 1637, March 14, 2003, p. 9, at *www.heritage.org/Research/HealthCare/bg1637.cfm*.

their coverage, including private coverage; and encouraging beneficiary involvement in health care decisions by creating personal care accounts.[29] Other governors, such as Mark Sanford (R–SC), have also expressed interest in reforming their Medicaid programs.[30] These efforts will test the boundaries of the existing federal waiver authority and will provide federal policymakers with vital information on the obstacles that limit states' ability to reform their programs.

What Congress Should Do

In concert with state efforts, federal policymakers should also take steps to deal with the crisis facing Medicaid. Congress should address the immediate budget requirements, but it also should consider longer-term reforms. Specifically, federal lawmakers should:

- **End state financing gimmicks.** In 2004, the U.S. General Accounting Office (now Government Accountability Office) found that over the years, states have "devis[ed] financing schemes that inappropriately boost the federal share of program expenditures" and recommended that the federal government exercise greater oversight to stop these schemes.[31]
- **Eliminate asset transfer loopholes.** Congress should eliminate all estate-planning techniques that enable and encourage middle-class individuals and families to shelter their assets in order to qualify for long-term care services under Medicaid.[32] Stricter eligibility standards would ensure that Medicaid is protected for those who need it most. Meanwhile, Congress should restructure the budget and management of Medicaid's long-term care financing, distinguishing between the provision of medical services and the provision of welfare services, including housing and assisted living.
- **Offer states new flexibility with accountability.** Congress should give states greater flexibility in the structure and administration of their Medicaid programs in return for meeting basic outcome measures of quality and cost. By choosing this option, a state could exercise broad discretion with its Medicaid programs and avoid the laborious federal waiver process. In exchange, states would have to meet certain performance measures and maintain a slower rate of growth.
- **Link other key health policy initiatives to Medicaid reform.** Finally, Congress should not consider Medicaid reform in isolation, but instead should consider other ways to help low-income and middle-income Americans with their health care needs. For example, refundable health care tax credits would enable many low-income individuals and families to purchase private health insurance. States could supplement these federal tax credits with state Medicaid premium assistance. Creating incentives for individuals to prepare and save for their long-term care expenses is another impor-

29. Florida Agency for Health Care Administration, "Overview of Florida's Medicaid Reform Proposal," at *www.empoweredcare.com/keypoints.aspx* (May 27, 2005). For a detailed description of the proposal, see Florida Agency for Health Care Administration, "Empowered Care: A Proposed Concept for Florida Medicaid," draft, March 14, 2005, at *www.empoweredcare.com/docs/empoweredcare_proposed_concept.pdf* (May 27, 2005).

30. Jim Davenport, Associated Press, "State Seeks Federal Approval for Medicaid Overhaul," *TheState.com*, June 16, 2005, at *www.thestate.com/mld/thestate/news/breaking_news/11912094.htm*.

31. U.S. General Accounting Office, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO–04–228, February 2004. See also George Reeb, Assistant Inspector General, Centers for Medicare and Medicaid Audits, U.S. Department of Health and Human Services, "Inter-Governmental Transfers: Violation of the Federal–State Partnership of Legitimate State Tools," testimony before the Committee on Energy and Commerce, U.S. House of Representatives, March 18, 2004.

32. For more information, see Mark McClellan, M.D., Administrator, Centers for Medicare and Medicaid Services, "Long-Term Care and Medicaid: Better Quality and Sustainability by Giving More Control to People with a Disability," testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, April 27, 2005, pp. 13–14, and Center for Long-Term Care Financing, "A Realist's Guide to Medicaid and Long-Term Care," September 7, 2004, at *www.centerltc.org/realistsguide.pdf* (May 27, 2005).

tant policy initiative.[33] These policies would give middle-income families an alternative to exploiting the Medicaid safety net.

Conclusion

States should take steps to change their Medicaid programs. Specifically, they should enact premium assistance programs to mainstream some Medicaid enrollees into private coverage and adopt consumer-directed models to promote personal responsibility and enable individuals to take control of their health care decisions. Because experience shows that the states' path to change is often a piecemeal process and burdened by bureaucratic rules and regulations, federal policymakers should look for ways to make this process easier and remove obstacles to change.

At the same time, Congress can no longer afford to ignore the nation's largest and growing government health care program. Members of Congress must take immediate steps to protect taxpayers and restore the integrity of the Medicaid program by ending state financing gimmicks and closing loopholes on inappropriate asset transfers. Moreover, Congress should enact key health care initiatives, such as health care tax credits, and private long-term care incentives that complement Medicaid reform and relieve the increasing pressures on state Medicaid budgets.

The best Medicaid policy would mainstream as many individuals and families as possible into private coverage and encourage self-direction for those the Medicaid safety net was intended to help. When considering changes in the Medicaid program, federal and state policymakers should ensure fiscal control and improve the way that low-income individuals and families receive care.

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33. For examples, see Center for Long-Term Care Financing, "A Realist's Guide to Medicaid and Long-Term Care."