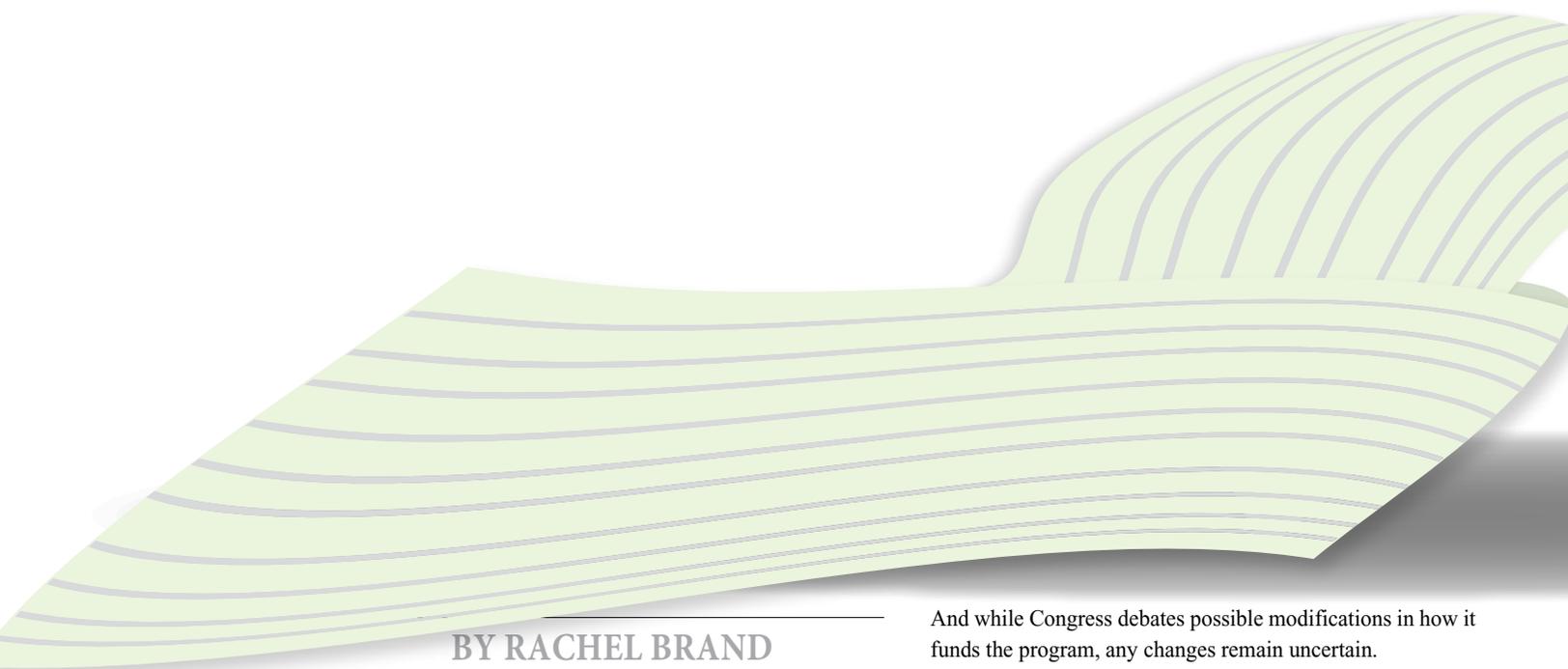


# The 800-Pound Gorilla

State lawmakers are trying to cut costs so the program will survive, even when millions more are added to the rolls.



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BY RACHEL BRAND

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**A**lthough many of the headlines in the debate over federal spending and the deficit focus on Medicare and Social Security, the program of greatest concern to states is Medicaid.

The 46-year-old program, which cost state and federal governments nearly \$400 billion in 2009, eats about 16 cents of every dollar in state general funds. It's been growing two or three times faster than state budgets because of the rising costs of health care and the increasing number of people enrolling because of the stagnant economy.

Meanwhile, state lawmakers are looking down the road three years to when an additional 16 million people will go onto the Medicaid rolls under federal health care reform.

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And while Congress debates possible modifications in how it funds the program, any changes remain uncertain.

"It's a budget killer, but it's a philosophy," says Florida Representative Mark Pafford. "[Because of Medicaid] you will not see babies dying in the gutter. You don't see old people dying of heat exhaustion, or homeless dying on the street."

But for state lawmakers, Medicaid is decidedly on the table for reform.

"We can no longer have an 800-pound gorilla eat up so much of our budgets," says Washington Senator Linda Parlette. "Any time you're short of money, it forces you to make policy decisions that are different."

State policymakers are asking the federal government for more flexibility to change the Medicaid program without a lot of red tape. They want to expand managed care, experiment with new payment models, create medical homes, and streamline services for those eligible for both Medicaid and Medicare. They want to tether provider payments to patients' health results and link Medicaid funding to general fund rev-



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*Senator  
Linda Parlette  
Washington*



*Senator  
Dan Liljenquist  
Utah*



*Representative  
Mark Pafford  
Florida*

enue growth. They even are looking at asking patients to pay a portion of their care.

The goal: a less expensive, better, more “sustainable” health care system for the poor and disabled.

“This wave of change is motivated by the desire to cut costs,” says Alan Weil, executive director of the National Academy for State Health Policy. “It’s also responsive to an intuitive sense that we’re not doing a very good job in terms of outcomes in a fragmented system.”

### **Time for Change**

The federal government pays about 57 percent of the annual cost—\$366 billion in fiscal year 2009—though the exact split with each state varies based on per capita income.

Federal rules govern who qualifies for medical care and the basic services that must be covered. All states, however, cover more than the basic services. The rules also bar enrollees from paying more than a few dollars for services. If a state wants to experiment with a program that covers more of the uninsured

through Medicaid, make managed care mandatory, or create new financial incentives, it must request an 1115 waiver and negotiate with federal administrators.

Medicaid spending has grown, on average, at 7 percent a year for the past 10 years, somewhat less than the growth in the private sector but still a big financial burden for states. Four states weighed dropping the program in recent years, but study commissions recommended against it, in part, because of the challenges of providing long-term care. Long-term care and other services for the severely disabled and elderly consume 67 cents of every dollar spent on Medicaid.

Even before federal health reform moves millions of people into the program in 2014, it has dealt a blow to state Medicaid budgets.

Health care reform contains a provision known as “maintenance of effort.” It requires states to continue covering anyone who was enrolled in the program as of March 2010 when the federal health reform legislation was signed into law, in essence tying states’ budgetary hands and limiting tools to con-

## Medicaid Facts

**WHAT IS MEDICAID?** Medicaid is a 46-year-old health care program for the very poor, elderly and disabled. It is means-tested, jointly funded by the federal and state governments, but managed by states. It is known as the nation's health care program for low-income Americans, though currently it covers only certain categories of people.

**WHO DOES IT COVER?** In 2010, Medicaid covered a total of about 60 million people, and about 50 million people on average (enrollees cycle in and out of the program). That includes:

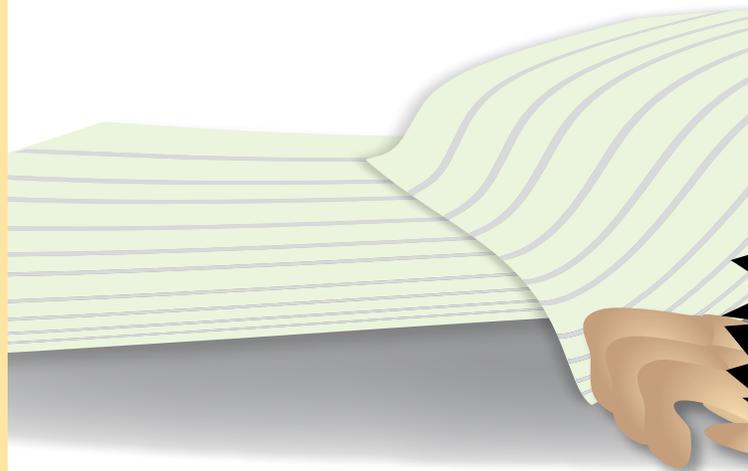
- ◆ 46 million low-income children and their parents. Medicaid is the largest source of health insurance for American children.
- ◆ 8.8 million nonelderly people with disabilities, among them 4 million children with physical and mental illnesses.
- ◆ 8 million low-income seniors, who also qualify for Medicare. These so-called "dual eligibles" are much poorer and in worse health than other Medicare enrollees. Medicaid helps pay seniors' Medicare premiums and cost sharing, and covers long-term care.
- ◆ Low-income pregnant women for the duration of their pregnancy.

**WHAT DOES IT PROVIDE?** Medicaid has a list of mandatory services and a separate list of optional services. Many states choose to cover optional services, such as prescription drugs, because they save money in the long run. Mandatory services include physician, hospital and laboratory services; nursing and home health care, among others. Optional services include drugs, dentistry, case management and rehabilitation services.

**WHAT DOES IT COST?** In fiscal year 2009, Medicaid spent a total of \$366 billion. Medicaid has been growing faster than any other category of state spending for the past decade.

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—Washington Senator Linda Parlette



Senator  
Joe Negron  
Florida

tain program growth.

"We didn't sign up for Medicaid to have it bankrupt our state," says Utah Senator Dan Liljenquist.

### Changing the Model

Over the years, states have tried to limit doctor visits, procedures, payments and drugs. They also have tried to better manage patients with chronic diseases and promote managed care—anything to rein in costs. Still, the program grows because Medicaid is countercyclical—enrollment climbs when the economy stagnates and because Medicaid shoulders much of the long-term care cost in this country.

Lawmakers in Florida, Utah and Washington are trying different approaches to controlling Medicaid costs. Each state is proposing a program that allows more budget certainty by setting a fixed payment for each patient as opposed to payments for every service that's provided.

This means determining ahead of time how much a Medicaid enrollee should cost. A pregnant mom might cost \$3,000 a year;

a disabled senior \$25,000. The state will contract with a health insurer or group of doctors to deliver a year's worth of care at that price.

"The only certain way to reduce Medicaid costs is to allow the Legislature to set a specific capped amount to be spent on Medicaid each year, the same way we set spending levels in other areas of the budget," says Florida Senator Joe Negron, who wrote the bill to enroll most of Florida's 3 million Medicaid patients into managed care.

The waivers also push for flexibility in benefits for groups of patients.

"We're not going to micromanage every office visit you do, and how you provide care," says Utah's Liljenquist, whose state's proposed waiver would put 80 percent of the state's Medicaid patients into accountable care organizations, networks of providers who agree to share cost savings based on outcomes.

"We're going to send you the money, and we want you to change how you practice medicine."



### Limiting Growth, Sharing Costs

Utah's Medicaid reforms, intended to save \$770 million over 10 years, stem growth in another way. With unanimous legislative support, the requested waiver would tie per patient Medicaid cost growth to general fund growth.

If the state budget grows by 10 percent, then Medicaid per patient spending can grow that much. But if the budget stands still, or drops, the budget will need to be cut, starting with a list of benefits on a pre-determined schedule.

Likewise, Florida's legislation calls for a 5 percent, across-the-board reduction in costs.

Patients also would pay more under Florida's proposed waiver, which still must be approved by the federal government. Medicaid co-pays would jump to as much as \$100 for the wrongful use of the emergency room. There are annual deductibles and cost-sharing for drugs.

"Sometimes patients can be demanding and want a drug that, perhaps, [private] insurance wouldn't cover," says Parlette, a registered pharmacist. "Maybe you can take a generic drug, but

## Big Changes Are On the Way



A sea change approaches as states prepare for a major expansion of Medicaid under federal health reform. Beginning Jan. 1, 2014, all uninsured Americans with incomes up to 133 percent of federal poverty guidelines will qualify for Medicaid.

Using the law's required method to calculate income, known as "MAGI" for modified adjusted gross income, the effective income threshold will be about 138 percent of the poverty level, or about \$30,800 for a family of four in 2011.

The Medicaid expansion is expected to cover about 16 million of the anticipated 32 million newly insured Americans under the provisions of the Affordable Care Act. Creating insurance exchanges and maintaining employer-based coverage comprise the other two coverage strategies.

Even though people usually think of Medicaid as the program that covers "the poor," in its current form, it covers only certain categories of poor people, such as children, pregnant women, low-income elderly people and those with significant disabilities. Virtually all children and pregnant women with incomes up to 133 percent of poverty already qualify for Medicaid. The large proportion of low-income uninsured adults between the ages of 26 and 65 will make up the bulk of the newly covered population.

Typically, a nondisabled childless adult cannot qualify for Medicaid today, no matter how poor. Across the country, Medicaid now covers parents of Medicaid-eligible children with incomes that average around 50 percent of the federal poverty level. The coverage range varies widely among states. For example, in 2009, Alabama, Arkansas, Idaho and Texas covered working parents with incomes somewhere below 27 percent of the poverty level. Several other states—Connecticut, Illinois, Maine, Massachusetts, Minnesota, New Jersey, Rhode Island, Vermont and Wisconsin—and the District of Columbia already covered working parents with income at or above the 133 percent level.

The Affordable Care Act calls for the federal government to pick up all of the medical costs for newly eligible enrollees for three years, beginning in 2014. States will be required to pay for a share of the costs after that, topping out at 10 percent by 2020. States, however, must pay their usual "matching rate"—which ranges from 20 percent to 50 percent of medical costs—for the newly enrolled people who already qualified for their state's Medicaid program but were not enrolled. An estimated 4.9 million Americans fall into this group, according to the Urban Institute.

—Martha King, NCSL

## Taking the Long View

Although Medicaid is often described as a health care program for the poor, it also plays a crucial role in covering long-term care for millions of people.

In fact, it is the single largest payer of long-term care covering the needs of daily life, such as eating, dressing and bathing, for at least 8 million Americans. Long-term care can be expensive, with median costs ranging from \$39,135 to \$77,745 per year depending on the type of care needed.

It's been difficult for states to contain costs for the growing population of the elderly and people with disabilities, so state legislators have played a key role in reforming long-term care systems.

In particular, many states have reformed their Medicaid-funded systems by moving away from costly institutional care, which few people want, toward popular and often less costly home- and community-based services.

The focus on "rebalancing" allows for more patient choice and the active engagement of the patient's family and local support network. The Affordable Care Act provisions encourage states to "rebalance" long-term care systems. For example, federal Medicaid matching rates will rise for states that increase access to noninstitutional services.

Another creative financing program is being expanded with federal health reform. Money Follows the Person is a Medicaid initiative that allows flexible financing for long-term care services. People using this program can use the money in the way they see fit. Thirteen states received grants to operate or improve upon this initiative.

States are doing the same thing with their elderly and people with disabilities as they are doing with other Medicaid populations—moving them to managed care. The expectation is that managed care can better coordinate care and increase efficiency for people with multiple conditions who receive long-term care services.

—Katherine Mason, NCSL



*“The HMO model in Florida has never proven that it has improved access or quality of care.”*

—Ted Fisher, executive director  
Florida Academy of Family Physicians

if you're demanding a brand name, you have to pay for it.”

### Quality, Access Concerns

No one denies Medicaid is imperfect and expensive. But some say handing delicate, vulnerable patients over to HMOs is a bad idea.

Florida's proposed program builds on a five-county managed care pilot program started in 2005.

“The HMO model in Florida has never proven that it has improved access or quality of care,” says Ted Fisher, executive director of the Florida Academy of Family Physicians. “To the contrary, anecdotally, in Broward County, there have been a lot of problems with access.”

In Florida, the proposed waiver emphasizes saving the state 5 percent a year on total Medicaid costs. It also gives for-profit HMO contractors 5 percent of any further savings.

However, some lawmakers are concerned about what they see as the focus of the proposed waiver.

“The total emphasis [of the new requested waiver] is on cutting costs, with no consideration to quality and access,” says Pafford.

What's more, he says, the introduction of insurance companies will disrupt finely tuned, hard-won relationships between medically needy patients and their doctors.

“You have networks that have developed over 40 to 45 years, largely made up of nonprofits, health care districts,” says Pafford. “When you move toward what will be private managed care—with guaranteed profits—you're going to dismantle, or starve to death, the system that is in place. You may kill the back plan, which is the current system.”

### Is It Legal?

In its proposal for a Medicaid waiver, Utah officials called the restrictions in the Medicaid limits or caps on charging patients co-pays and deductibles “archaic.” But the Medicaid law may bar Utah from imposing higher cost sharing fees on patients, as is proposed.

Some also see it as a barrier to care for some patients.

“The annual per family \$40 deductible can be a great hardship for clients,” wrote Judi Hillman for the Utah Health Policy Project. “A family could easily be priced out of access to medically

*“The only certain way to reduce Medicaid costs is to allow the Legislature to set a specific capped amount to be spent on Medicaid each year.”* —Florida Senator Joe Negron

## Medicaid Block Grants: All About the Details

When U.S. Representative Paul Ryan’s budget plan passed the U.S. House of Representatives in April, it included a provision that pleased some state lawmakers and gave others heartburn: block grants for Medicaid.

Block grants traditionally have been a way for the federal government to consolidate a group of discretionary programs, usually under a broad common topic, and to reduce the overall funding in exchange for giving states considerable freedom in how the money is spent. That’s the theory anyway.

Determining how that theory will work in practice is a tough call, and one not aided by Ryan’s budget proposal, which offers few details on how the block grants would be handled.

And “the devil is in the details,” said Joy Johnson Wilson, senior federal affairs counsel for the National Conference of State Legislatures.

Medicaid currently is a state-federal partnership under which the federal government pays about 57 percent of the annual cost—\$366 billion in fiscal year 2009—though the exact split with each state varies based on per capita income.

Unlike typical block grant programs that include a number of discretionary programs, Medicaid is an entitlement program. Everyone who is eligible is entitled to coverage. The federal government also imposes a variety of rules on how the money can be spent, who is eligible, what services are provided and more. The most similar existing state-federal program is Temporary Assistance for Needy Families or TANF. That program was changed from individual entitlement to an entitlement to states in the form of a block grant during the Clinton administration.

Medicaid has never been financed with block grants, though Congress did pass such a plan during the Clinton administration, which was vetoed. At a session during NCSL’s Legislative Summit in San

Antonio in August, Wilson laid out what is known about the possibility of Medicaid block grants.

“Ryan’s budget assumes certain savings will result from block grants, but there is no specific proposal,” she said. “But it may be considered as part of this new ‘committee of 12’ ” that is supposed to come up with a plan to cut \$1.5 trillion from the federal budget by Thanksgiving.

If that committee does consider Medicaid block grants as one way to trim the federal budget, there are a few questions key to states.

◆ **Entitlements.** Would every eligible citizen continue to be “entitled” to receive all services? Block grants could switch that entitlement to the state, where policymakers would decide on the rules of eligibility and services. Who gets to choose “is a huge decision that needs to be made,” Wilson said.

◆ **Maintenance.** Will states be required to maintain their current Medicaid eligibility standards? If so, it would reduce the flexibility available to states in using block grants.

◆ **Elderly and disabled.** With about 67 percent of all Medicaid spending going to care for severely disabled people and the elderly, lawmakers will want to know how these people would be treated in terms of federal vs. state responsibility and funding under block grants. The answer would help determine whether block grants would be a good deal for states.

◆ **Bad economy.** How would block grants address the counter-cyclical nature of Medicaid? As the economy worsens, state budgets shrink and the demand for services, especially Medicaid, increases. A block grant approach that does not account for this could leave states in very serious fiscal distress every time the national economy falters.

—Edward Smith, NCSL

necessary care.”

What if, for instance, a fee stopped a mom from bringing a child with an asthma attack to the emergency room? The child might die.

Deciding between waste and access, where to put financial incentives, and how to trim Medicaid has never been easy.

The amount of flexibility states have in handling Medicaid also may be affected by a case now before the Supreme Court. The court heard arguments in early October on the case, which deals with whether doctors, hospitals and patients can challenge state cuts in Medicaid payments that violate federal law.

The California Legislature cut fees for hospitals, doctors and other providers by as much as 10 percent and put the changes into effect without federal approval, as required by law. A Supreme Court ruling is expected in early 2012.

Reforms in other states are often hampered by the long period states wait to hear back from the federal government about their waivers, killing momentum behind reform, says policy analyst Nina Owcharenko of the Heritage Foundation. This time, policymakers are asking the Obama administration to decide on waivers related to new health reform requirements by 2012.

“The waiver process can be very long,” Owcharenko says. “That’s one reason why many states advocate for additional flexibility [under the law]. It will be telling to see what happens.”

### SL ONLINE

Learn more about Medicaid and its role in federal health reform at [www.ncsl.org/magazine](http://www.ncsl.org/magazine).