STRENGTHENING MEDICAID

Building on a Solid Foundation: Medicaid's Role in a Reformed Health Care System

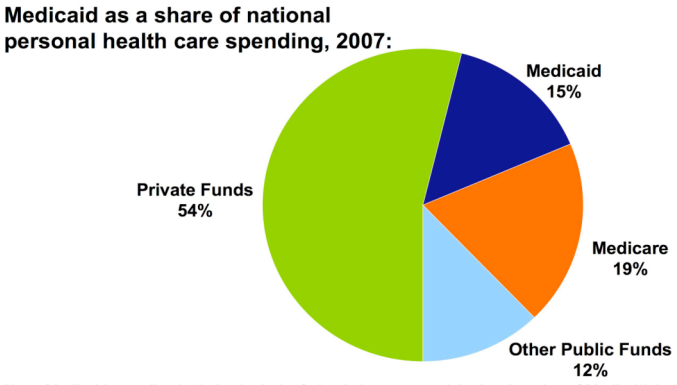
by Vikki Wachino, Cindy Mann, and Martha Heberlein

Overview

Health care reform is once again a front and center issue—at the White House and in the halls of Congress, in state capitols and corporate boardrooms, and around kitchen tables across America. Covering the uninsured, reigning in health care costs, and obtaining better quality and value for our health care dollars are goals that have broad public and policymaker support. While the policy debates are just beginning, broad consensus exists that a newly reformed system ought to build on the components of the current system, including the Medicaid program. This means that a central question underlying health care reform is: How can each of those components work together to meet national health care reform goals? This question raises many important issues, including how to best build on and strengthen the Medicaid program.

Medicaid is a cornerstone of the nation's health care infrastructure, accounting for about one in every six health care dollars spent in the U.S. (Figure 1).[1] This year, it will cover nearly 68 million children, parents, pregnant women, seniors, and people with disabilities. (Figure 2, next page).[2] Medicaid's contribution, however, extends well beyond the numbers of people it serves. Medicaid covers, with remarkable success, people who have the greatest needs: children and adults whose financial means are very modest and people who are in poorer health compared to the population at large, including individuals with significant disabilities and people with multiple, chronic illnesses. In addition, the current recession reminds us of Medicaid's important "countercyclical" coverage role. Along with the much smaller Children's Health Insurance Program (CHIP), Medicaid buffers the falloff in private, employer-based health insurance that accompanies economic downturns, preventing many children and adults who are losing their private insurance from becoming uninsured.[3]

Figure 1:
Medicaid is a Major Purchaser of Health Care



Note: Medicaid spending includes both the federal, the state, and the local portion of Medicaid, but does not include spending in SCHIP. Source: M. Hartman, *et al.*, "National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998," *Health Affairs*, 28(1): 246-261 (January/February 2009).

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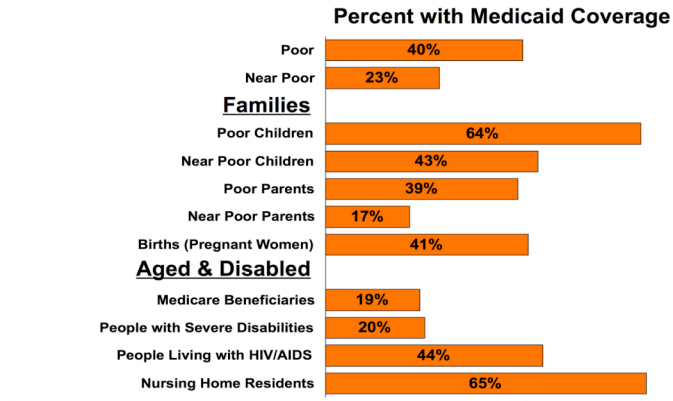
Given the many different ways in which Medicaid makes unique contributions to our health care system, it is appropriate that Medicaid continue to play a major role in a reformed system. If Medicaid is to operate optimally in such a system, it will be essential to carefully consider its role, its strengths, and its areas for improvement so that it can best meet its current and expanded responsibilities and work seamlessly in conjunction with the other core components of a reformed system. This paper considers ways of doing this, focusing on three key areas: Medicaid eligibility and access; cost, efficiencies, and quality; and overall financing.

Recommendations

1) Establish a national minimum Medicaid coverage standard to improve and assure coverage to low-income people across the nation.

Figure 2:
Medicaid's Role in Coverage



Note: "Poor" is defined as living below the federal poverty level (FPL), which was $17,600 for a family of 3 in 2008. "Near poor" is defined as income between 100% and 199% of FPL. Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates of March 2008 CPS; and National Governor's Association, "Maternal and Child Health Update: States Increase Eligibility for Children's Health in 2007" (November 25, 2008).

Medicaid covers different groups of people at different income levels, a pattern shaped by the combination of federal rules and state options. The result is that eligibility varies by group (e.g., children, parents, pregnant women) and by locality. These gaps and variations will need to be addressed in order to provide a consistent coverage guarantee as a foundation for health reform. A national minimum coverage standard for Medicaid would target coverage to where the need for it is greatest and is the most logical way to set a uniform base for coverage upon which other federal reforms can be built. In addition, it would dramatically simplify Medicaid by streamlining its maze of eligibility categories. Simplification also would make the program easier for the public to understand and navigate and simpler for states to administer.

A new standard could be phased in over time, and states could maintain current eligibility categories for groups that exceed the income standard and have higher public program coverage standards for children through CHIP. It would need to be coupled with modernized enrollment procedures that would both streamline enrollment and coordinate enrollment with other components of the new system. In addition, issues relating to Medicaid provider payment levels will need to be addressed, and, as will be the case with any significant expansion in coverage, steps will need to be taken to ensure access to primary and specialty care for those who become newly eligible. While there are many options for how best to finance improvements in Medicaid coverage, given structural state fiscal constraints, the federal government rather than the states, should be primarily responsible for added costs, although maintaining state investment in Medicaid coverage is also critical.

2) Controlling costs and improving efficiency and quality.

For many years, Medicaid has helped spur and test new approaches to managing costs and improving efficiency, but Medicaid – like other large purchasers of health care – could be doing more to maximize value. Technology can help. Tools ranging from electronic prescribing to electronic medical records can facilitate coordination of care, minimize unnecessary procedures and reduce administrative costs. The American Recovery and Reinvestment Act of 2009 (ARRA) included significant new resources to promote implementation of electronic health records in Medicaid. Health information technology can also promote quality care, and the recent CHIP reauthorization legislation included a major new quality initiative for children. This initiative can provide a base for launching further quality initiatives in Medicaid, covering other populations and services. Many states have moved forward on different types of quality initiatives, but federal leadership and support is needed.

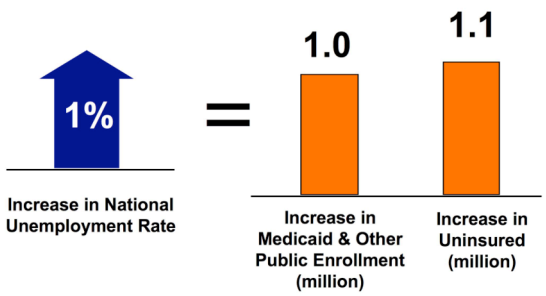
In addition, as a major purchaser of prescription drugs, Medicaid has made strides in controlling drug costs and managing the drug benefit, but more could be done to assure the best value for the dollars spent. The federal government should support state efforts to conduct clinical effectiveness reviews, employ evidence-based formularies, and manage care for high-cost users in ways that can help maintain beneficiary access to needed drugs *and* control costs. At the same time, Medicaid needs to get the best possible price for the drugs it purchases by updating the program's drug rebate and improving administration of the rebate program, saving money both for the federal government and for states. Significant rebate proposals have been included in President Obama's Fiscal Year 2010 budget proposal, with the savings directed into a fund for health reform.

3) Assuring that the Medicaid program is on sound fiscal footing.

The fundamentals of Medicaid's financing system are strong and have allowed the program to serve its mission well, but growth in health care costs, the decline in employer-based health coverage, the aging of the population, and economic downturns, such as the one we are experiencing today, pose fiscal challenges. Currently states pay, on average, 47 percent of Medicaid costs, but state resources are strained by the task of financing health coverage in downturns and for a growing population that includes people with particularly intensive health care needs (Figure 3).[4]

Stabilizing Medicaid coverage during recessions is a key goal for reform. Relief to states was provided as part of the ARRA, as it was on a more modest scale during the 2003 recession, but Medicaid needs a built-in financing stabilizer that automatically boosts the share of federal funding during economic downturns. This would provide predictable financing to states to help them maintain coverage during downturns—an essential element if national health reform is built upon a reliable base of coverage.

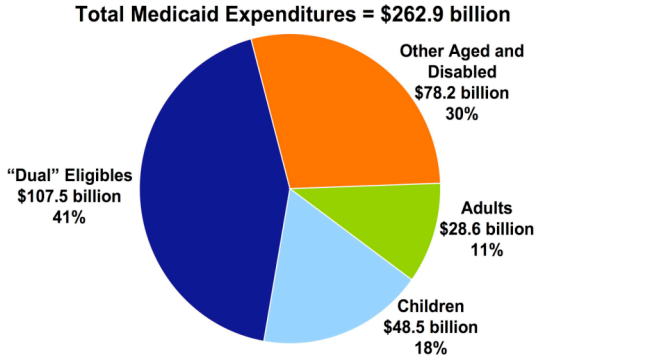
Figure 3:
Medicaid Reduces the Impact of Unemployment on Uninsurance by Nearly One Half



Note: a 1% increase in unemployment also equals a 3-4% decline in state revenues. Source: S.Dorn, *et al.*,"Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses," Kaiser Commission on Medicaid and the Uninsured (April 2008).

More fundamentally, some realignment of the fiscal responsibilities assigned to the states and the federal government for providing health and long-term care for people who are enrolled in both Medicaid and Medicare (the "dual" eligibles) is in order. Medicaid pays the cost of services that Medicare does not cover. It also pays the Medicare premiums and cost sharing on behalf of low-income Medicare beneficiaries and fills in the coverage gap for many people with disabilities who must wait two years to qualify for Medicare. These Medicare gaps drive Medicaid spending to a significant degree, with services for dual eligibles accounting for more than 40 percent of all Medicaid spending (Figure 4).[5] Some realignment of Medicare's and Medicaid's financing responsibilities will ensure that the nation is better prepared to handle long-term fiscal challenges, including the health and long-term care needs of an aging population. Different options for realigning responsibilities are possible, and any of these options could be calibrated and phased in to align with broader policy goals and to accommodate budgetary constraints.

Figure 4:
"Dual" Eligibles Accounted for More Than 40% of Medicaid Spending in 2005



Note: Spending on prescription drugs for dual eligibles, which became a Medicare responsibility in 2006, is excluded in order to approximate the share of post-2005 Medicaid spending that is attributable to duals. However, because this amount also excludes "clawback" payments states began paying the federal government in 2006, this estimate is probably conservative. Source: J. Holahan, D. Miller, & D. Rousseau, "Rethinking Medicaid's Financing Role for Medicare Enrollees," Kaiser Commission on Medicaid and the Uninsured (February 2009).

With or without major health reform, strengthening Medicaid should be a national priority. For too long, critical questions about the program's gaps in eligibility, access, and fiscal challenges have gone unaddressed. Successful efforts to manage costs and increase efficiency have been underway for years, but more can be done to make sure that Medicaid is not only run efficiently, but also helping to propel forward system wide efforts at maximizing value in health care. The time has come to give Medicaid the attention and support it needs.

Medicaid's Role

Since 1965, Medicaid has been the means by which the nation covers many of its low-income uninsured people. Medicaid provides affordable, comprehensive coverage to people who have little or no disposable income, many of whom have complicated and expensive health conditions that make them uninsurable in the private insurance market. Today, Medicaid covers:

- One-quarter of the nation's children and more than half of all low-income children;
- One in five Americans who have serious disabilities;
- Nearly two-thirds of all nursing home residents; and
- Slightly less than twenty percent of all seniors, for whom Medicaid supplements and fills in gaps in Medicare coverage.[6]

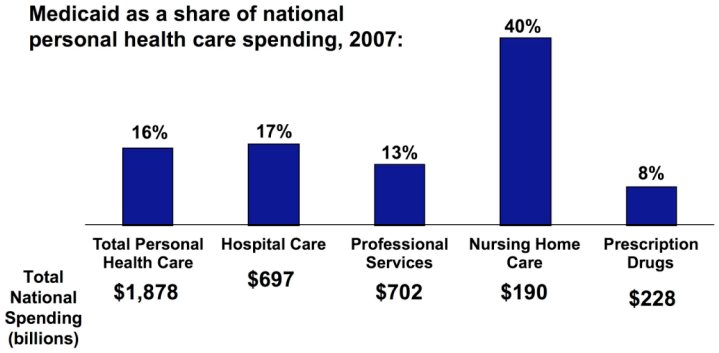
Medicaid touches many people, and it enjoys strong public support, with nearly three out of every four Americans describing Medicaid as "very important."[7]

As a result of its coverage role and the type and scope of services that it covers, Medicaid plays a huge role in the health care system (Figure 5).[8] Medicaid:

- Finances more than one out of every six dollars spent on health care in the United States in 2007;
- Pays for 40 percent of the nation's nursing home care; and
- Purchases seventeen percent of all hospital care in the country.

Medicaid's impact is particularly significant for safety-net providers, but it also finances care provided by a wide range of other providers and diminishes the burden of uncompensated care that would otherwise be absorbed by health care providers, insurers, employers, and taxpayers.[9] It also buttresses private insurance by disproportionately insuring people who are in poor health and have greater acute health care needs than the general population.

Figure 5:
Medicaid is a Major Purchaser of Health Care



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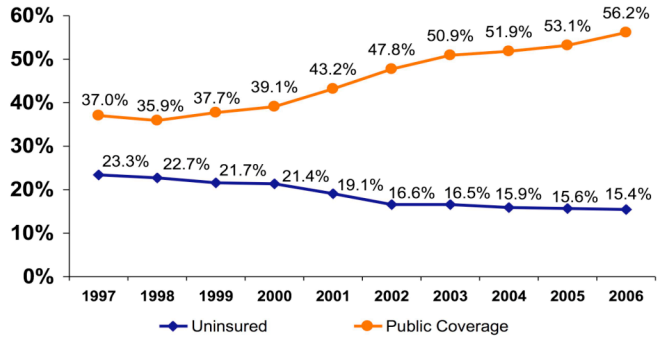
Covering people who cannot obtain affordable private coverage. Medicaid has played a major role in covering low-income uninsured Americans. Its impact is most marked for children. Between 1997 and 2006, the proportion of low-income uninsured children in the U.S. fell from to 23 percent to 15 percent (Figure 6).[10] This success is attributable to the joint role that Medicaid and its smaller companion program, the Children's Health Insurance Program (CHIP), played in covering uninsured kids.

Figure 6:
Decline in the Rate of Uninsured Low-Income Children is Attributable to Enrollment in Medicaid and CHIP



Note: data reflects low-income (<200% FPL) children. Source: Johns Hopkins University Bloomberg School of Public Health analysis of the National Health Interview Survey for the Center for Children and Families (March 1, 2008).

Although Medicaid has long been a vital part of the nation's system of health coverage, the decline in employer-based coverage and the severe downturn in the American economy have made it more important than ever. Medicaid has served as the nation's health coverage back up by assisting many of those who lose coverage as a result of the twin challenges of weak economic conditions and a reduction in the availability of affordable private coverage.

Guaranteeing affordable coverage. By limiting cost-sharing and premiums and providing a comprehensive benefit package, Medicaid ensures that people can afford to enroll and that once they enroll they can afford to get the care they need. Medicaid is designed to meet the needs of low-income people by covering services that many private insurers, whose benefit packages are designed for a higher-income population, do not cover. Medicaid also assures coverage is affordable by limiting premiums and cost-sharing, reflecting an extensive research literature showing that high out of pocket costs prevent people with low incomes from receiving needed care.[11]

Significantly, Medicaid, like Medicare, guarantees coverage to all who are eligible. This guarantee has been central to Medicaid's success in covering the nation's low-income uninsured, although in practice this guarantee of coverage is not as extensive as Medicare's because there is no automatic enrollment in Medicaid as there is in Medicare. Medicaid's coverage guarantee means that when a Medicaid-eligible individual applies for coverage, he or she must be enrolled; waiting lists are not permitted in Medicaid. Participation rates among eligible people have been steadily rising in Medicaid, particularly for children where the greatest advances in simplifying application procedures have been made (Box 1, next page).

Box 1:
Current Medicaid Enrollment Procedures—Major Advances Over the Years

As Medicaid has changed from a program rooted in the welfare system to a health insurance program for the low-income uninsured with no link to welfare eligibility, states and the federal government have overhauled the enrollment process, especially for children and families. As eligibility expansions have taken place, enrollment processes have been simplified and mainstreamed. For example:

- In every state, families can apply for Medicaid coverage for their children by mail. In-person interviews are only required for children in three states.
- In many states, families can also apply by phone or through community-based application assistors, and some states have online applications (for example, see Wisconsin's online application and tracking system at ACCESS Wisconsin).
- The Medicaid applications themselves have been shortened and simplified; in a number of states they are just a few pages long.
- Medicaid enrollment has also been successfully coordinated with other coverage programs, most notably CHIP. Joint applications for Medicaid and CHIP are in use in 35 of the 39 states with separate CHIP programs. The joint enrollment form allows the state to screen for eligibility for either program and enroll the child in the appropriate program.

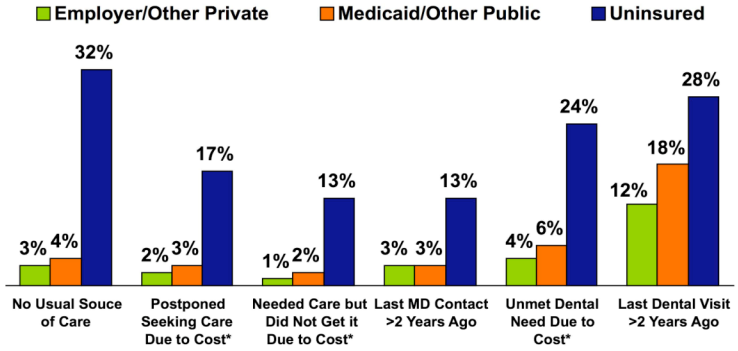
Source: D. Cohen Ross & C. Marks, "Challenges of Providing Health Coverage for Children and Parents in a Recession," Kaiser Commission on Medicaid and the Uninsured (January 2009).

The federal/state partnership. Medicaid is funded and administered jointly by the federal government and the states. This unique federal/state partnership has many positive features, although it also poses some challenges. The federal government requires states to cover some groups of people and certain services, and states have discretion to set eligibility levels above federal minimums and decide which "optional" groups of people and services to cover within broad federal guidelines. States and the federal government share financial responsibility for Medicaid, with the federal government paying about 57 percent of Medicaid's costs, although the specific federal matching rate varies by state.[12] (Overall, states contributed resources of $167 billion in 2009.[13])

Significantly, federal contributions are not capped but are provided, on a matching basis, for allowable program costs. States can set provider payment rates and design their programs in ways that take account of local issues, including delivery system resources. At the same time, many states face structural fiscal constraints and each makes different policy and political choices. The variations in coverage across the nation, which frequently reflect disparities in state fiscal resources, give rise to significant coverage inequities.

Access and provider payments. Research shows that Medicaid improves access to care for the people it covers, especially for preventive and primary care, which are vital to maintaining beneficiaries' heath and over the long-term avert unnecessary costs associated with avoidable, costly, heath conditions (Figure 7).[14] However, reports of diminished access have grown in recent years, especially for specialty care and some services, including dental care. Similarly, concerns have been raised about the adequacy of provider payments, which are set by the states, and the degree to which Medicaid payments lag behind those of Medicare and private insurers. These issues must be addressed to ensure that Medicaid continues to meet the needs of current beneficiaries as well as the people who would become eligible for health coverage if eligibility is expanded. In response to these concerns, a new commission was created by the CHIP reauthorization law to examine Medicaid payment and access issues.[15]

Figure 7:
Medicaid Coverage Improves Children's Access to Care



Note: Questions about dental care were analyzed for children age 2-17. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. An asterisk (*) means in the past 12 months. Source: Kaiser Commission on Medicaid and the Uninsured analysis of National Center for Health Statistics, "Summary of Health Statistics for U.S. Children: NHIS, 2007."

Linkages with private coverage when it is available. Although the number of Medicaid beneficiaries who have access to cost-effective private insurance is small, for some people Medicaid can work and does work in combination with private coverage. These "premium assistance" arrangements provide enrollees access to affordable, comprehensive care through Medicaid while maintaining the contribution of employer-based insurance as first-dollar coverage. Ensuring that Medicaid and private insurance can work effectively in combination grows in importance as Medicaid covers people with incomes significantly above the poverty level, as they are more likely to have access to private coverage than people with lower incomes.[16] The new CHIP reauthorization law provides new opportunities for state Medicaid and CHIP programs to improve such integration, but more work in this area is needed.[17]

Strengthening Medicaid as Part of a Reformed Health Care System

This paper proposes three broad approaches to strengthening Medicaid. These reforms are intended to maximize Medicaid's contribution to achieving key national health care reform goals, but can be pursued with or without major health care reform legislation. These three approaches are:

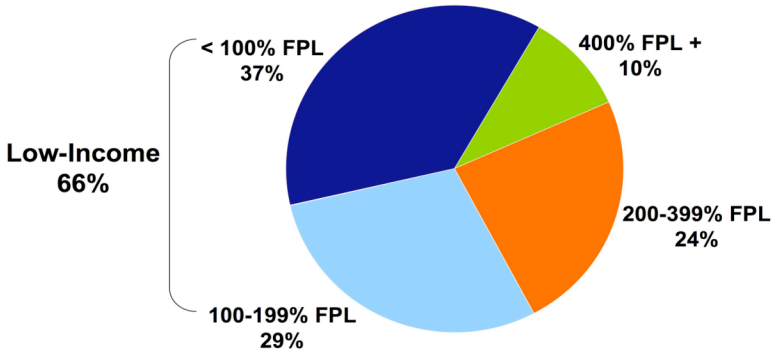
1) Improving and expanding coverage to uninsured, low-income people;
2) Controlling costs and improving efficiency; and
3) Putting the Medicaid program on a sound fiscal footing.

This paper discusses each of these approaches in turn.

1) Establishing a National Coverage Standard to Improve and Expand Coverage to Uninsured, Low-income People Across the Country

In 2007, 45 million people in this country had no health insurance coverage, an increase of 8 million people since 2000.[18] Assuring coverage to all uninsured people in America is a national goal; it consistently rates, along with controlling health care costs, as one of voters' top two priorities for health care reform.[19] The problem of uninsurance is greatest among low-income people, who have limited access to affordable employer-based coverage:[20] two out of every three uninsured Americans are from low-income families (Figure 8).[21]

Figure 8:
Two-Thirds of the Uninsured are Low-Income

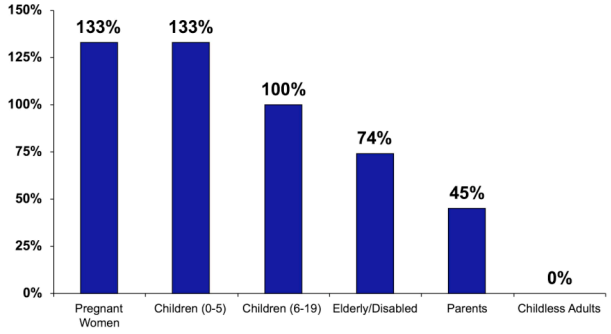


Source: Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer" (October 2008).

While Medicaid provides a solid foundation for achieving coverage goals for low-income people, not all low-income individuals now qualify for Medicaid. To be eligible, people must fall into one of a few broad groups: children, parents and pregnant women, seniors, and people with disabilities. They must also meet citizenship or immigration-status requirements, as well as income and, in some cases, asset tests. These features result in significant coverage gaps.[22] Adults who do not have dependent children living at home are excluded from Medicaid coverage altogether if they are not disabled, elderly or pregnant, and minimum income eligibility levels for parents are quite low (Figure 9, next page).[23] Even for children, the area in which public program coverage gains have historically been greatest, Medicaid minimum federal eligibility requirements have a "stair step" structure. This structure means that as children age they become ineligible for Medicaid coverage even if their family income does not change. States have filled in these stair steps either through optional Medicaid expansions for children or through CHIP, but the minimum requirements that are based on the age of the child can still cause confusion and result in children in the same family being covered by two different programs. Medicaid's complex categorical eligibility structure – in some states, there are as many as 70 different eligibility categories – complicates the program, making it harder for the public to understand who is eligible and more difficult for states to administer.

Because Medicaid eligibility policies vary widely by state, there are also large geographic disparities in who gets covered and who does not. Two otherwise identical individuals who happen to reside in different states will have very different experiences gaining coverage. For example, a parent with two children who works full time making just over $9 an hour would be eligible for Medicaid coverage in Arizona, but would not be eligible in most other states. In neighboring Colorado, a parent with two children earning $9 an hour would be ineligible if he or she works more than 25 hours a week. This variation raises basic questions of fairness and equity (Figure 10).[24]

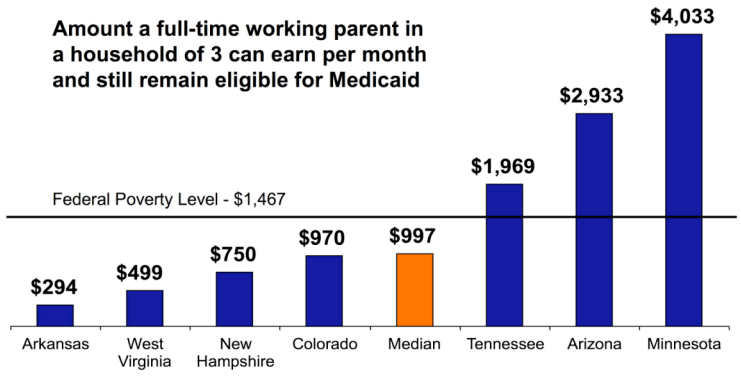
Figure 9: Federal Minimum Medicaid Income Levels, by Eligibility Category



Note: The income level for parents represents the median maximum AFDC payment level as of June 16, 1996. Sources: B. Bruen, *et al.*, "State Usage of Medicaid Coverage Options for Aged, Blind, and Disabled People," Urban Institute (August 1999); and Kaiser Commission on Medicaid and the Uninsured, "Medicaid Eligibility for Families and Children" (September 1998).

Establish a national minimum coverage standard. Converting Medicaid eligibility to a national minimum coverage standard without regard to "eligibility category" would be a major step forward in covering the uninsured and would provide a consistent base of coverage upon which other coverage reforms could be built. Such a standard would eliminate gaps in coverage, promote fairness in eligibility decisions, and dramatically simplify the program. It would also limit state-to-state variations that are more often than not driven by differences in states' financial resources, rather than differences in need. Coverage disparities should be replaced with a national standard supported with new federal funding. Many of the reform proposals explicitly propose or assume a national eligibility standard for Medicaid.[25] Indeed, it is difficult to imagine how a national health reform proposal covering all people could be structured with Medicaid as its base without adopting a national Medicaid uniform eligibility standard that applies to all people, in all states.[26]

Figure 10: Variation Across States Raises the Question of Fairness



Sources: Center for Children and Families analysis of D. Cohen Ross & C. Marks, "Challenges of Providing Health Coverage for Children and Parents in a Recession," Kaiser Commission on Medicaid and the Uninsured (January 2009).

The national Medicaid coverage standard should be set at a level that effectively targets the population where the need is greatest for the types of benefit and financial support that Medicaid offers. Ultimately, the level selected must complement the larger structure of any health care reform plan of which it is part. Since the population with incomes below 150 percent of the federal poverty level (the poverty level is $18,310 for a family of three in 2009) has very limited ability to afford to purchase coverage and low rates of access to health coverage through employers, this income threshold represents a reasonable point for considering an appropriate eligibility standard. Under this construct, all individuals with incomes below this level, including children, parents, childless adults, people with disabilities and seniors, would be eligible for Medicaid. If reforms to the employer-based system do not provide sufficient access for people with incomes somewhat above 150 percent of poverty, the minimum Medicaid eligibility standard could be set higher. The Commonwealth Fund's Commission on a High Performance Health System recently issued a set of detailed health reform recommendations, which includes setting the Medicaid income eligibility standard at 150 percent of poverty.[27] Given the higher CHIP eligibility levels for children that are already in place, a separate eligibility standard could be set for children. Senator Baucus' plan calls for a national minimum Medicaid standard at 100 percent of poverty, with a minimum CHIP standard for children at 250 percent of poverty.[28]

Regardless of the level at which the coverage standard is set, it could be phased in over a period of years, much as existing children's Medicaid eligibility levels were phased in over time.[29] Existing eligibility categories that permit states to cover at their option some groups of people with incomes that exceed the national eligibility standard (such as pregnant women, people with disabilities for whom Medicaid coverage is a critical work support, or people with breast or cervical cancer) should be maintained, reflecting that private coverage may not be adequate for these groups of individuals with significant health care needs.

Financing a uniform coverage standard. States will need increased federal assistance to implement an expanded national coverage standard in Medicaid. There are many ways to provide that support. For example, the federal government could simply assume all new costs of an expansion and related improvements, or the federal matching rate could be raised somewhat for all Medicaid enrollees, or for those with incomes under a certain level (such as the poverty line), to offset the new costs. Alternatively, or perhaps in combination with these strategies, the federal government could offset new financial responsibilities states assume as a result of the new coverage by increasing federal financing for other Medicaid responsibilities. For example, as a state picked up new costs for covering the low-income population, the federal government could assume greater costs for Medicaid-financed long-term care. Some experts who have proposed similar coverage expansions have proposed to help states finance the expansions through increasing the federal matching rate by as much as 30 percent for coverage expansion groups coupled with increased levels of federal support for some services, such as services Medicaid provides to Medicare beneficiaries ("dual" eligibles).[30]

One key financing issue is how to account for the variation among states in the degree to which they already cover different groups of people in Medicaid. While there are some exceptions, in general poorer states have the lowest eligibility levels in place today while wealthier states are more likely to have expanded Medicaid through federal options or waivers. Decisions therefore will need to be made about whether states that have already brought their eligibility standards for some or all groups of optional categories up to the new federal minimum should receive additional federal assistance for this coverage or whether the new funding should be directed only to fill existing gaps.

Couple expanded eligibility with new systems to assure participation. To maximize Medicaid's effectiveness in covering uninsured low-income people and reach the nation's coverage goals, Medicaid eligibility expansions need to be coupled with policies to increase participation rates. This requires simplifying the process to make it easier for eligible people to enroll in and maintain coverage and prohibiting practices that create barriers to coverage that do not serve any legitimate program objective.

States' experiences with simplifying the Medicaid and CHIP enrollment process for children and families since the CHIP program was created in 1997 provide ample evidence regarding what approaches are most likely to be successful (Box 2).[31] The CHIP authorization law contains new incentives for states to adopt some of these approaches to enroll eligible children.

Box 2:
Reaching the Eligible But Unenrolled: Progress Being Made

Medicaid and SCHIP have made significant strides in reaching eligible but unenrolled children. A recent examination of the data for different time periods between 1999 and 2005 documents this progress over time. Between 1996 and 2001, eligibility levels for children increased significantly. Large numbers of children gained coverage, as a result of the eligibility expansions and improvements in participation rates. Beginning in 2001 and continuing through 2005, eligibility levels remained fairly level, yet enrollment continued to increase. These enrollment increases are the result of increased participation rates among eligible children. During this period, the percent of eligible uninsured children who were enrolled in Medicaid and CHIP jumped from 66 percent to 78 percent.

Source: J. Hudson & T. Selden, "Children's Eligibility and Coverage: Recent Trends and a Look Ahead," *Health Affairs* (August 16, 2007).

Maximize the integration of Medicaid and private insurance when it is available. In any reformed health care system, approaches should be developed to maximize the integration of public and private insurance, to make sure that Medicaid is acting as a supplement for the minority of beneficiaries who do have access to affordable private coverage. The sharpest decline in access to employer-sponsored coverage in recent years has been for employees with incomes below 200 percent of the poverty level.[32] Unless health reform significantly alters this reality, the opportunities for successful premium assistance programs for low-income Medicaid beneficiaries are limited. Nonetheless, these should be considered as an option in instances where they are cost-effective and do not disadvantage participants with respect to benefits and cost-sharing. Other options, including allowing employers to buy into Medicaid for their workers, might also be considered. Smooth transitions from Medicaid to ESI or other new forms of coverage that may become available under a reformed health care system is also an important issue to consider. For example, the recent CHIP reauthorization law eased the transition between Medicaid/CHIP and employer coverage by making loss of Medicaid/CHIP eligibility a "qualifying event" for the purposes of enrollment in employer-sponsored insurance governed by the Employee Retirement Income Security Act (ERISA).

Ensuring that enrollees have access to care and comprehensive benefits. To ensure that the people Medicaid covers under the new national coverage standard receive comprehensive, affordable care, they need to receive the full Medicaid benefit package, which is designed to meet the health care needs of the low-income population without undue financial burdens. Some modernizations, however, may be warranted. Prescription drug coverage, for example, is an optional benefit for adults in Medicaid, a throwback to a much earlier time when drugs were less important and far less expensive. Making prescription drugs a mandatory Medicaid service would reflect their importance in the health care system, as well as the decision every state has made to cover them.

Emerging concerns about maintaining access to care and the adequacy of provider payments for all Medicaid beneficiaries will also need to be addressed to make sure that Medicaid coverage always translates into access to needed care. The CHIP reauthorization law creates a new Medicaid and CHIP Payment and Access Commission to evaluate children's access and payment issues, modeled on the nonpartisan Medicare Payment Assessment Commission.[33] This should be built upon and expanded to monitor access to care for the entire Medicaid population. The commission should be charged with identifying particular regions, specialties, or types of providers for which access is not adequate. It should also recommend policies to address underlying causes of any access problems, including provider participation, provider payment rates, geographic issues, and language and cultural barriers, and consider initiatives to restructure the way that Medicaid reimburses health care providers to promote quality and efficiency.

2) Controlling Costs and Improving Efficiency

Since Medicaid is a large part of the health care system, it plays a role, alongside other major insurers, in helping to control health care costs. For many years, Medicaid has developed new approaches to managing costs and improving efficiency. The efforts state Medicaid programs have made in recent years to manage prescription drug costs and Medicaid's role in developing home and community-based care options as an alternative to nursing home care are two examples of approaches to improving care and controlling costs that Medicaid has helped pioneer. But Medicaid could be doing more to help maximize value for the dollar in the nation's health care system. Some ideas are discussed below.

Improving quality. Measuring and managing quality need to be a major focus for all health care payers, including Medicaid. Many states already have quality initiatives in place in their Medicaid programs, ranging from reporting basic measures of effectiveness, satisfaction, and use of care to pay-for-performance programs (Box 3, next page). The CHIP reauthorization law includes a significant new child health quality initiative, but more can be done to intensify quality measurement and improvement efforts. In addition, quality care is dependent on continuity of coverage; efforts to stabilize enrollment among eligible people through new enrollment and retention efforts will contribute to achieving better quality care.

Although many states voluntarily collect quality data, the measures that they employ generally focus on access to discrete components of primary and preventive care. Focusing additional attention on services in which Medicaid plays a big role – like inpatient care, maternity care, or care for people with chronic conditions – could significantly advance efforts to measure quality in Medicaid and lead to care improvement. At the federal level, the Centers for Medicare and Medicaid Services (CMS) should build on the quality initiative in the new CHIP law, which will develop core quality measures for all children regardless of insurer. CMS could develop consensus around a core set of quality measures for all of the populations Medicaid serves, in conjunction with states and public and private sector experts. Similar efforts have been underway in Medicare for some time. Over time, states and CMS could begin reporting on these measures.

Approaches to care coordination, such as making sure beneficiaries have a "medical home" and access to the types of care that can help them maintain their health and avoid costly, preventable care can also promote quality of care, especially for people with chronic conditions. In addition, in recognition that the evidence on the effectiveness and impact of pay-for-performance programs is conflicting, CMS could also sponsor evaluations of the impact that Medicaid pay-for-performance programs have on quality, outcomes, and costs.

Box 3:
Most States Have Initiatives to Improve Quality in Medicaid

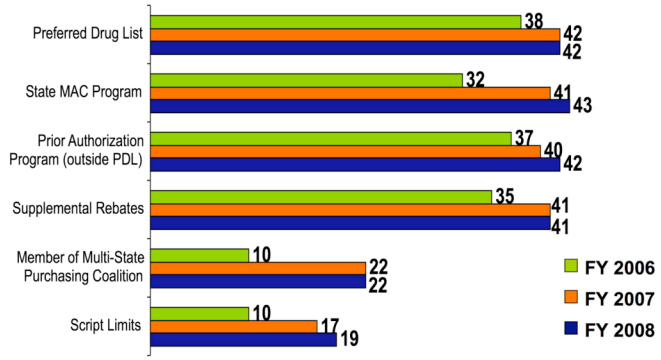
Medicaid and SCHIP programs in 35 states have more then 100 quality improvement initiatives underway already. States like California, North Carolina, and Ohio, for example, have implemented quality improvement initiatives for neonatal care. Some states, like Vermont, have developed quality improvement partnerships to bring together state, private sector, and outside experts to improve children's health care across insurers. Additional states could replicate or intensify efforts to improve and manage quality. Establishing state quality improvement advisory councils, for example, could help states foster cross-program collaborations, prioritize potential performance measures, and identify best practices. Moreover, because lack of coverage, even for short time periods, adversely impacts access and quality, improving participation rates and maintaining continuous enrollment in Medicaid is a key piece of efforts to manage and improve quality in Medicaid.

Source: L. Simpson, G. Fairbrother, & J. Schuchter, "Moving Forward with Quality: State and Federal Approaches to Measure, Manage and Improve Quality in the Medicaid Program." Center on Children and Families, (December 2007). L. Duchan & V. Smith, "Quality Performance Measurement in Medicaid and SCHIP: Results of a 2006 National Survey of State Officials." Alexandria, VA: National Association of Children's Hospitals and Related Institutions, (September 2006).

Improving How Medicaid Manages Prescription Drugs. Medicaid is a major purchaser of prescription drugs, which are a vital part of meeting the health care needs of Medicaid beneficiaries. In 2006, Medicaid spent more than $19 billion on prescription drugs, and the rate of growth of prescription drug spending has been a source of concern across public and private insurers. State Medicaid programs have been actively managing spending in their prescription drug programs for many years (Figure 11).[34] Despite this high level of effort, not all the tools available to states and the federal government to manage prescription drug programs have been fully employed.[35] In addition, some states have adopted policies – such as caps on the number of prescriptions a beneficiary can fill or high levels of cost-sharing – that can impede beneficiary access to needed drugs, even though other methods are available that can maintain access while managing costs. States and the federal government could:

- **Increase reliance on clinical evidence to manage the pharmacy benefit.** Although evidence-based pharmacy-management programs, such as evidence-based formularies, have helped a number of states determine which drugs are most effective, clinical

Figure 11:
State Efforts in Prescription Drug Cost Containment

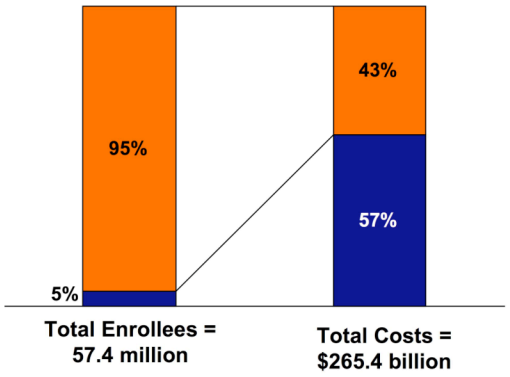


Sources: V. Smith *et al.*, "Headed for a Crunch: An Update on Medicaid Spending, Coverage, and Policy Heading into an Economic Downturn," Kaiser Commission on Medicaid and the Uninsured (September 2008).

effectiveness review efforts could be expanded and intensified. Participation in the Drug Effectiveness Review Project, a cross-state collaborative, could be expanded well beyond the thirteen states that currently belong. In addition, the federal government could increase federal funding for cost-effectiveness or comparative effectiveness research to help inform states' decisions. The ARRA provides new funding for comparative effectiveness research at HHS. CMS or the Agency for Healthcare Research and Quality could provide assistance to states with comparative effectiveness research or develop model drug formularies. If, as many health reform proposals contemplate, a larger comparative effectiveness institute is created to evaluate health care treatments, drugs, and technologies across the health care system, this could also aid states' efforts in Medicaid.

- **Adopt best practices for managing high cost patients and high prescribers.** In Medicaid, five percent of beneficiaries are responsible for more than half of total program spending (Figure 12).[36] Managing the costs of these beneficiaries while maintaining or improving access to needed services is an essential part of managing Medicaid spending in general and Medicaid prescription drug spending in particular. To this end, some states periodically review all prescription drugs used by beneficiaries to ensure that the drugs a beneficiary is taking are all medically necessary and safe. These models could be shared and encouraged through federal action (Box 4, next page).

Figure 12:
5% of Medicaid Enrollees Account for 57% of Spending



Sources: Kaiser Commission in Medicaid and the Uninsured and Urban Institute estimates based on 2004 MSIS.

- **Improve state drug utilization review efforts.** Federal law requires states to operate Drug Utilization Review (DUR) programs to review prescription drug use for safety, medical necessity, clinical appropriateness, duplication, interactions with other drugs, and potential abuse or misuse. It is not clear, however, how many states fully comply with these requirements. CMS should review compliance and fund research to identify best practices for conducting DUR programs. States could advance DUR efforts by publishing some state generic dispensing and therapeutic substitution rates and monitoring DUR trends.

Box 4:
State Efforts to Manage Care and Spending on High-Cost Medicaid Populations

In 2005, a survey of 37 states found that 70 percent of Medicaid programs track high-cost drug users and just under two-thirds of all states run special programs for high-cost populations. Some states are also reviewing physicians' prescribing patterns to identify cases in which providers are prescribing an unusually high number of prescription drugs. In some cases, states intervene with high-prescribing physicians to notify and educate the provider. Missouri, for example, runs a Mental Health Medicaid Pharmacy Partnership Program, working with providers to manage psychotropic drugs for seniors and people with disabilities.

Source: J. Crowley & E. Park, "Advancing Efficient Management and Purchasing of Prescription Drugs, Center on Children and Families (March 2008).

Improving How Medicaid Purchases Prescription Drugs. Because prescription drug spending is a major driver of Medicaid spending, it is critical to make sure that state Medicaid programs are getting the best possible price for the drugs that they purchase.[37] Key policies that determine the price Medicaid pays for prescription drugs have not been updated in many years. For example, the rebate that manufacturers pay to the federal and state governments for drugs that are prescribed to Medicaid beneficiaries has not been updated in over a decade. Increasing the rebate would significantly lower the effective price of drugs to the Medicaid program, saving money both for the federal government and for states. Extending an inflation adjustment that currently applies only to the rebate on brand name drugs to generics would limit generic drug price increases and was recently recommended by the HHS Office of Inspector General. Applying the Medicaid drug rebate to drugs purchased on behalf of beneficiaries enrolled in Medicaid managed care plans would also generate savings. President Obama's 2010 budget proposal includes proposals to increase Medicaid rebate amounts, extend the Medicaid rebate to managed care plans, and apply the rebate to new formulations of existing drugs.

The federal government and states could also improve how they administer the drug rebate programs. The federal government could take a more active role in ensuring that manufacturers are paying the correct rebate amounts. States could increase their commitment to working with the federal government to ensure manufacturer compliance with the rebate. And both the federal government and the states could increase the transparency of key pricing information to help ensure that Medicaid is not overpaying for prescription drugs.

Expand use of innovative health information technology applications in Medicaid. Health information technology (HIT) is a key tool that both public and commercial insurers are using to improve care and increase efficiency in the health care system. HIT can help measure quality, facilitate coordination of care, minimize unnecessary procedures, and reduce administrative costs. Medicaid HIT approaches need to be carefully crafted to take into account beneficiaries' complex health needs and issues related to language, literacy, and access to technology.

Expanding the use of electronic prescribing has the potential to reduce errors and increase efficiency throughout the health care system. Ideally, e-prescribing efforts would be developed across insurers, but a number of states have already launched e-prescribing initiatives in their Medicaid programs, including Connecticut, Florida, Montana, and New York. Some states have also begun using automated telephone

systems to easily communicate important health information, such as information regarding immunizations for children, to large numbers of people. Expanding the use of electronic health records and personal health records can help improve efficiency, reduce communication and coordination barriers across providers, and engage patients more directly in managing their health information. The ARRA includes $19 billion to spur provider adoption of HIT. This amount includes significant new provider incentive payments in Medicaid and Medicare to increase adoption and use of HIT, including EHRs. Several states, including Hawaii, Missouri, and the District of Columbia, have already moved forward to use EHRs in Medicaid and other programs.[38]

Improve Medicaid program management. Managing the Medicaid program effectively is essential to making sure that beneficiaries obtain the health and long-term care services they need, providers offer high quality care in a system that operates efficiently, and public resources are spent well.[39] Yet many reform plans overlook this critical area. To improve the way in which the Medicaid program is administered, states and the federal government could upgrade the systems that govern the eligibility and enrollment process to make it easier for states to rely on other databases to enroll and retain eligible people and collect key information that could improve administration. These eligibility systems are likely to be especially important in a reformed health care system to help people transition easily between public programs and other sources of coverage. An enhanced match for such upgrades and for system maintenance, as is available for Medicaid claims data systems, along with new federal standards and oversight, is likely needed to accomplish these changes. In addition, giving states access to Medicare claims data would help advance efforts at improving quality and coordinating care for seniors and people with disabilities who are enrolled in both Medicare and Medicaid. More broadly, to improve and evaluate basic program management the federal government should work with states to identify best practices in managing state Medicaid programs and disseminate them across states.

3) Putting the Program on Sounder Fiscal Footing to Ensure that Medicaid Continues to Meet the Needs of the Low-Income Population.

A stronger Medicaid program also means ensuring that the program's financial structure is adequate to meet the demands that are placed on it. Medicaid's financing system with its matching structure and federal commitment to share all appropriate costs, has many strengths. However, some changes are needed to help states expand coverage and access and improve participation. Two types of financing changes are called for. First, an automatic financing stabilizer is needed to help states respond effectively during recessions. ARRA included Medicaid fiscal relief as a key item in the recovery package, but a matching rate adjustment in downturns should be automatic. Second, methods for realigning the fiscal responsibilities assigned to the states and the federal government for providing health and long-term care for people who are enrolled in both Medicaid and Medicare (the "dual" eligibles) would better reflect Medicare's role and the federal responsibility for financing care for seniors and address Medicaid's long-term fiscal challenges.

Establishing an automatic, temporary Medicaid financing stabilizer during economic downturns. Financing and maintaining Medicaid coverage during recessions, when even more people turn to Medicaid coverage, can be extremely challenging for states. When economic conditions weaken, people lose jobs and Medicaid enrollment increases. At the same time, state revenues typically decline, and so states struggle to maintain Medicaid eligibility levels, benefits, and provider rates. Almost all states are required to balance their budgets; unlike the federal government, they cannot run deficits. States typically accumulate "rainy day funds" during good economic times, but when a recession hits these funds are often depleted well before the recession ends.

The federal government has recently recognized that state fiscal stress during economic downturns can lead states to cut back Medicaid coverage in ways that are counterproductive to the goal of fostering

economic growth as well as good health. The federal government responded to the 2002-2003 recession by temporarily increasing its share of Medicaid spending to help states maintain Medicaid coverage and balance their budgets. The temporary increase provided in 2003 as part of the Jobs and Growth Tax Relief Reconciliation Act (JGTRRA) was successful in helping states maintain Medicaid coverage.[40] An even larger Medicaid relief mechanism was adopted in the ARRA. However, delays and the uncertainty of the legislative process can make fiscal relief less effective than intended or provide "too little, too late." The 2003 fiscal relief, for example, did not come until well into the fiscal crisis, after many states had already made cuts to Medicaid and other programs to balance their budgets. The recent and much larger fiscal relief in the economic recovery law similarly comes after some states have already been experiencing fiscal stress for many months. In addition, the duration of the relief provided is set in the law and is not defined by the economic conditions that prompted the relief. It is possible, therefore, that the duration will be longer than what is needed in some states and fall short of what is needed in others.

The federal government could provide more predictable and targeted assistance to states and the Medicaid program by establishing an automatic financing stabilizer to help states maintain health coverage during downturns. This would be similar to the automatic mechanism that assists states in providing unemployment benefits during recessions. Some type of stabilizer is essential to prevent contraction in coverage, which is wholly inconsistent with the goal of guaranteeing coverage. A recommendation for such a stabilizer was included in Senator Baucus's blue print for health reform.[41] The mechanism could target temporary assistance when just a few states are facing serious fiscal challenges, or it could be designed to activate only when a broader group of states are experiencing fiscal stress, depending on how it is designed. There are also different alternatives for the trigger by which this support would be activated, and, since any fiscal relief would not be provided indefinitely, deactivated.[42] An essential element of any automatic fiscal stabilizer is to tie receipt of increased federal assistance to states' maintaining Medicaid eligibility, as both JGTRAA and ARRA did.

Realigning state and federal fiscal responsibilities for providing health and long-term care. It is also time to reexamine the relative fiscal responsibilities that have been assigned to the federal government and the states. Ensuring appropriate alignment of these financing responsibilities will ensure that Medicaid is as prepared to handle long-term challenges in the health care system, including the costs of caring for an aging population. Although both the federal government and states appropriately share in Medicaid's costs, fiscal responsibility for some of the risks facing Medicaid and the health care system needs to be assigned to the level of government that is best able to assume it.

Even in recent, relatively robust economic times, the pressures on Medicaid have been growing. Affordable health care coverage through employers has become less available for many Americans, particularly those with low incomes. At the same time, costs for seniors and people with disabilities have been growing and can be expected to continue to grow in the future, as the technology of medical care continues to intensify and the baby boom generation reaches retirement age. The degree to which individual states feel these pressures varies, due in part to differences in demographics. For example, almost 15 percent of the population in Maine is over 65 while only 9 percent of the population in Utah is elderly.[43]

Medicaid's current allocation of financing responsibilities should be reexamined to ensure that the program can meet growing demands. Reforms to support and improve the employer-based insurance market could help ease fiscal pressures on Medicaid, but even if such steps are taken, financing for "dual" eligibles requires re-examination. Although financing for Medicare, which cares for seniors and some people with disabilities, is ostensibly a federal responsibility, gaps in Medicare coverage and the lack of cost sharing protections for low-income people in the Medicare program drive Medicaid spending to a significant degree. Medicare depends on Medicaid to maintain comprehensive coverage for enrollees, finance the overwhelming majority of long-term care services, and make Medicare coverage affordable

for needy seniors and people with disabilities by paying Medicare premiums and cost-sharing. In 2005, almost 8.8 million people were enrolled in both Medicare and Medicaid.[44] Although these "dual" eligibles represent only 18 percent of Medicaid enrollees, in 2005 they accounted for more than 40 percent of Medicaid spending.[45] Reforms to Medicaid financing could help states avoid difficult choices over the long term, such as scaling back Medicaid eligibility, benefits, or provider payment rates or reducing funding for competing state priorities like education or infrastructure.[46]

Because the federal government has greater fiscal capacity than states do and can deficit spend, it is better able to bear some of these risks and challenges. A larger federal funding role also spreads the risk of factors that can significantly increase Medicaid costs but which states often have little control, such as growth in underlying health care costs, uncertain economic conditions, and an aging population.

There are several different ways in which the federal contribution to Medicaid spending relating to the elderly and disabled populations could be increased, and these options are not mutually exclusive. Policymakers could select from among or adopt a combination of these ways to best meet overall policy goals, including federal deficit reduction goals. These approaches could be carried out in concert with the financing changes suggested to help fund the coverage expansion proposed in the first section of this paper, and they could be calibrated and phased in to accommodate federal budget constraints.

- **Increase the federal matching rate for services provided to dual eligibles.** The federal government could increase its share of Medicaid spending on the services that Medicaid provides to "dual" eligibles. The most direct way to do this is to raise the federal matching rate for Medicaid coverage provided to "dual" eligibles above normal matching rates. This type of approach would recognize the important role that Medicaid pays in funding services to low-income Medicare beneficiaries and reflect that coverage for seniors is appropriately a federal responsibility. The level of the enhanced rate could be set in light of federal budget targets, and the rate changes could be phased in over time.

- **Federal payment of Medicare premiums and cost sharing.** Currently, Medicaid makes Medicare coverage affordable for low-income seniors for whom Medicare's cost sharing and substantial deductibles would be prohibitive. Making the payment of these contributions a federal responsibility would assign them to the appropriate level of government. It has recently been estimated that having Medicare fully assume premiums and cost sharing payments for the dual eligibles would reduce state spending and increase federal spending by $11.3 billion over one year.[47]

- **Eliminate or shorten the Medicare waiting period for people with disabilities.** Individuals who qualify for Social Security Disability Insurance should be made eligible for Medicare benefits without having to wait two years. This would relieve Medicaid of some or all of the responsibility of providing health and long-term care coverage to many low-income people with disabilities while they await Medicare eligibility and help many other disabled individuals who do not qualify for Medicaid during the Medicare waiting period. The Congressional Budget Office recently estimated that eliminating the waiting period would decrease federal spending on Medicaid by $32 billion between FY 2010 and 2019, but because Medicare spending would increase substantially total federal spending on mandatory programs would increase $113 billion over those ten years.[48] More limited options are possible including shortening rather than eliminating the waiting period. Eliminating the waiting period only for people without access to private insurance would decrease federal costs substantially but provide the same level of Medicaid savings over ten years, according to CBO.

Each of the above options would buttress states' ability to finance and strengthen health coverage for the low-income population, and align responsibilities to the level of government most able to assume these costs and spread them equitably across states.

Conclusion

Medicaid has been described as the "workhorse" of our health care system. It steps in where other payers and insurers dare not go, but it often does so without all of the tools and support it needs to meet its important responsibilities. As a cornerstone of our system, it is appropriate for Medicaid to serve as the coverage base for our nation's reformed health system as many have proposed. If it is to take on this role as part of the nation's commitment to guarantee coverage to all, programmatic and fiscal changes will need to be made. With such changes, we can ensure that our new health care system is built on a strong and stable foundation.

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[46] *op. cit.* (25), J. Holahan & A. Weil.
[47] Estimates based on 2005 data. *op. cit.* (5).
[48] CBO also estimated a modest increase in tax revenues associated with eliminating the Medicare waiting period, Congressional Budget Office, "Budget Options Volume 1: Health Care," (December 2008).

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