House Policy Committee

MEMORANDUM

To: Republican Members
From: Health Subcommittee Chairman Ernie Fletcher
Re: Briefing Series on Medicaid Reform
Date: July 12, 2002

The Health Policy Subcommittee held a series of meetings on the need to reform Medicaid (June 6, 2002, June 12, 2002, and June 18, 2002) with officials from the Department of Health and Human Services, including Bobby Jindal, the Assistant Secretary for Planning & Evaluation, and Dennis Smith, the Director of State Operations at the Center for Medicare Services (CMS).

The first briefing provided a broad overview of Medicaid's financial structure, the Medicaid benefit package, and trends in Medicaid. The second reviewed Administration waivers and the different ways states are approaching reform and addressing financial problems. The final meeting considered several innovative approaches to Medicaid reform which Congress, states, and the Administration can undertake. For further information, please contact Holly Rocco in Chairman Flethcer's office at 225-4706.

<u>The purpose of these meetings was to:</u>

- Help develop majority policy on Medicaid reform; and
- Pave the way for legislation to improve service for Medicaid beneficiaries.

<u>Highlights</u>

- 1967, Medicaid was a $1 billion program. In 2001, Medicaid cost approximately $226 billion ($130 billion federal share) and covered 40 million Americans. Medicaid will cost roughly $280 billion ($159 billion federal share) in 2003.
- 10% of Medicaid beneficiaries are elderly, 17% are disabled, 50% are

children, and 23% are non-disabled adults.

- Medicaid covers one-fourth of the nation's children and is the largest single purchaser of maternity care and nursing home/long-term care services. The elderly and disabled comprise one-third of Medicaid beneficiaries but account for two-thirds of Medicaid spending.

- The State Children's Health Insurance Program (SCHIP) was established in 1997. It makes available approximately $40 billion over 10 years for states to provide health care coverage to low-income, uninsured children. Approximately 4.6 million children were enrolled in SCHIP programs in 2001. SCHIP gives states broad flexibility in program design while protecting beneficiaries through federal standards. Unfortunately, this broad flexibility remains largely untapped. Some of the ways states have implemented SCHIP could be used as a model for broader change.

- Medicaid spending varies from state to state. Three states (NY, CA, and TX) account for approximately 30% of the total Medicaid and SCHIP spending. Nine states (NY, CA, TX, PA, FL, OH, MI, IL, and NC) account for approximately 53% of Medicaid and SCHIP spending.

- States can provide optional services under Medicaid beyond those that are federally mandated. These optional state services account for a larger share of Medicaid spending than the mandatory services, and thereby account for some of the expenditure disparities between states. Other factors contributing to state by state disparities in Medicaid spending include:

  - The ability of states to contribute more to their programs;

  - Different state eligibility requirements and admission criteria;

  - Different numbers of prescription drugs allowed per person in each state; and

  - Different state shares of payments to disproportionate share hospitals.

- Medicaid is unsustainable in its current form. As baby boomers age, long-term care costs could sink some Medicaid programs by 2010 and most by 2030. It has been estimated that Medicaid's long-term care costs will at least quadruple by 2020.

- Congress and the Administration must examine ways of moving Medicaid away from institutionalized care and toward home and community based care.

- The Administration provides several waivers including Pharmacy Plus, Independence Plus, and Health Insurance Flexibility and Accountability (HIFA). Some of their goals are to:

  - Expand access to health care coverage for low-income individuals;

  - Give states flexibility to design benefit packages that promote access to care;

  - Increase access to assistive and universally designed technologies;

  - Integrate Americans with disabilities into the workforce;

  - Provide guidance for states to create programs that allow people with disabilities to plan, obtain, and sustain community based services; and,

- Provide guidance to states on how to develop programs within existing federal requirements using streamlined application approaches.

- 16 states have taken advantage of the Administration's waivers and implemented comprehensive health care reform Demonstrations as of 12/31/2001.

- CMS pointed to Tennessee's NEW TennCare plan under the 1115 as one model for waiver programs. It is a statewide 5-year program consisting of four parts, including mandatory Medicaid services, Medicaid assistance, and a pharmacy benefit for the elderly. TennCare provides health care benefits to Medicaid beneficiaries, uninsured State residents and those with medical conditions that make them uninsurable. The plan emphasizes preventative care by providing it to adults and children without co-payments or deductibles. Nine managed care organizations (MCO) contract with providers on a fee-for-service or capitation basis. Participants with incomes over the federal poverty level pay graduated premiums so that payments increase with income.

- CMS mentioned Utah's program as another model under a waiver. It is a combination of private coverage and Federally Qualified Health Center (FQHC)-based, but is moving more toward FQHC. The program provides differential benefit packages and covers primary care and preventative services. In Utah there is no managed care like in Tennessee, so the FQHC's provide primary care. The waiver is unique in that it requires Medicaid clients living in urban counties to select an MCO that provides—through an ongoing patient/physician relationship—primary care services and referral for all necessary specialty services. In the rural areas of Utah, Medicaid clients are offered the selection of a Primary Care Provider (PCP) or MCO, when available; traditional fee for service remains an option, as well. Services not covered under the waiver are provided under fee-for-service. The State arranges for an annual independent review of the quality of services delivered under each MCO contract with the State. The review is performed by HealthInsight, the federally-designated Peer Review Organization for Utah.

- As the Administration continues with the waiver approach, Congress should be supportive, but must also exercise its essential oversight duties. We must work with the Administration to ensure that states move in a direction that will:

  - Put patients first;

  - Promote patient satisfaction and responsibility;

  - Allow provider participation;

  - Encourage patient and provider education;

  - Allow patient choice in plans;

  - Encourage flexible benefit packages tailored to patient need;

  - Focus resources on the truly needy;

  - Promote Medicaid best practices;

  - Reduce bureaucracy and the number of bureaucrats;

- Reduce waste, fraud and abuse; and,

- Ensure Medicaid remains solvent in the future.

Conclusion:

- Improper utilization, lack of preventative services, and lack of general education about Medicaid are problems we need to overcome.

- We should encourage the use of waivers, however there needs to be some oversight to ensure accountability, program integrity, and that the programs meet certain principles and objectives.

- Personal responsibility needs to be encouraged in plan design and implementation. For example, many dentists do not participate in Medicaid because of the high level of missed appointments. Missouri's "three strikes, you're out" plan—which penalizes people who fail to pay their co-pay three times—may serve as a model for curbing this problem.

- The Medicaid Commission in the recent House-passed prescription drug bill, H.R. 4954, is a good step forward—but is just one part of the reform process.

- Medicaid reform can be the Welfare reform of this decade.

Next Steps:

- Chairman Cox and Subcommittee Chairman Fletcher will continue to work with Energy and Commerce Committee on Medicaid reform.

- Continuation of Briefings in Health Policy Subcommittee: Governor Leavitt of Utah has been invited to discuss his ideas and actions.

- Begin developing a GOP Communications plan on Medicaid reform.