Governance Program

Governors' Council

Making Federalism Work:

The Governors' Council Medicaid Recommendations

May 2013

BIPARTISAN POLICY CENTER

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Founded in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole and George Mitchell, the Bipartisan Policy Center (BPC) is a non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation and respectful dialogue. With projects in multiple issue areas, BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.

ABOUT THE GOVERNORS' COUNCIL

In 2011, BPC launched the Governors' Council to bring pragmatic state-based perspectives to national issues. The Governors' Council brings together a bipartisan group of Governors who have proven records of working across the aisle with their state legislatures, Congressional delegations and other Governors. They offer this experience along with practical, reasoned solutions on a variety of issues and public policy challenges critical to the national debate.

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This short paper continues a discussion of the issues addressed in the previous Bipartisan Policy Center (BPC) Governors' Council report, *Reforming Medicaid Waivers: The Governors' Council Perspective on Federalism Today*. Medicaid provides essential health care services to millions of low-income and disabled Americans. As the largest state-federal partnership program, it is also on the front lines of many important and contentious issues in 21st-century federalism. Medicaid requires intense collaboration between states and the federal government, and it presents an ongoing source of budgetary strain for both parties.

As governors, we've seen firsthand both the importance of Medicaid to many of our citizens as well as areas where the program falls short in best meeting their needs. We also have deep concerns about the long-term growth in the cost of this partnership. These cost pressures will increase in the years ahead as coverage expands under the Affordable Care Act (ACA). Already, many governors have been forced to eliminate or reduce benefits to enrollees and to continuously lower provider payments to the point that these reductions threaten the stability of hospitals and physician practices in their states.

There are other, more positive options. Based on our direct experience with Medicaid in our own states, we wish to make some recommendations for what we believe would be significant but sensible changes to the program. This is not an exhaustive list, but we describe some changes that can have an immediate impacts—such as improving the quality of health care we provide to Medicaid beneficiaries and using the dollars committed by both states and the federal government more efficiently.

We want to recognize and commend the work that is currently being done by our former colleague Secretary Kathleen Sebelius and her team at the Department of Health and Human Services (HHS) to streamline the program and to address some of the issues we have previously raised. Their work—in establishing templates for quick approval of waivers already effective in other states; in publishing online, recent state plan amendments; in approving the Medicaid Health Home template; and in standardizing rules for reporting, compliance, and evaluation—is important and welcome. We remain hopeful that progress can be made on our recommendation to establish a path for successful waivers to be converted to permanent changes in the Medicaid program, although we recognize that some of these changes will require congressional action.

We recommend the following:

1. Dual Eligibles

States can substantially improve the quality of care delivered to "dual eligibles" by providing them with an integrated Medicare and Medicaid benefit. To accomplish this, states should have the option to require the enrollment of dual eligibles in managed or coordinated care programs that have been approved by the Centers for Medicare and Medicaid Services (CMS).

Dual eligibles (Medicare beneficiaries whose low income also qualifies them for Medicaid) are a high-need and high-cost group of Americans. Many of them have multiple interrelated health problems. Thus, the effective coordination of health care for this group is especially important if the United States is to ensure quality and manage costs. Historically, Medicare and Medicaid were enacted by Congress as two distinct programs, separately administered by the federal government and the states. **This has inevitably resulted in overlapping benefits and in duplicative and sometimes contradictory administrative procedures. As the United States seeks to better integrate these two programs, the structure Americans are faced with today reflects legal silos within the federal government and not the needs of the participants.** It is inefficient and confusing, and serves neither dual eligibles nor taxpayers well.

Recognizing this, the ACA provided unprecedented authority for the HHS secretary to waive federal Medicare requirements, and when combined with previous Medicaid waiver authority, allows the secretary to pilot new integrated models of care in partnership with the states to test a fully integrated Medicare and Medicaid system. If proven effective in both improving quality of care and saving money over a three-year period, the secretary will then have the authority to expand these programs and make them permanent without additional congressional authority.

The Governors' Council is certainly not the first to identify this problem. We're aware of the existing demonstration projects within the Medicare-Medicaid Coordination Office to explore variations on what we are proposing. While we recognize the complexity that this effort presents and applaud Secretary Sebelius and Medicare-Medicaid Coordination Office Director Melanie Bella for their efforts, we are concerned that the existing models tested by the CMS under the financial integration demonstration are encountering substantial difficulties; it appears that only four states have been approved thus far. We're especially concerned that a few states that originally applied have now withdrawn their applications.

States have cited some substantial difficulties with these particular demonstration programs. One difficulty has been reimbursement rates, which are based on historical costs and don't differentiate between states that have already achieved efficiencies and states that have not. In effect, inefficient states are rewarded and efficient ones punished. Another difficulty is the short implementation timeframe combined with delays in rate setting and a lack of guidance. This has limited the ability of many states to intelligently participate. As CMS develops rules, there is concern that pressure from advocacy groups and others has resulted in decisions that compromise the genuine integration of care; one example of this

would be the exclusion of Medicare Part D plan payments. Finally, we would respectfully observe that an arrangement in which the state carries most of the burden and the federal government accrues most of the savings naturally dampens a state's enthusiasm for participation.

The federal government urgently needs to coordinate health care for these vulnerable Americans far better than it does now. Efforts in this area should build on existing state Medicaid managed care and similar coordinated care programs that have been extensively reviewed and approved by CMS. They are monitored and re-approved on a regular basis. They are widely seen as an effective and high-quality way of delivering care, and CMS encourages their expansion. We strongly recommend:

- To the extent of the office's authority, the HHS secretary should authorize an option for states to require adult dual eligibles to enroll in coordinated care.
- The existing financial integration demonstration programs permitting this should be improved and streamlined or alternative demonstrations developed, with the goal of swiftly becoming a permanent pathway for the full integration of dual eligible Medicare and Medicaid services for any state wishing to use it.
- Recognizing the existing legal limitations on the HHS secretary's authority to implement this integration, we call on Congress to enact legislation giving statutory authority to states to require adult dual eligibles to enroll in managed or coordinated care programs.

2. Eligibility and Benefits

Medicaid should keep the current mandatory benefits and eligibility in place. But there are opportunities in optional parts of the program to make more efficient use of the available funds.

a. Congress should allow states the ability to extend those Medicaid benefits that are optional to specific, high-need portions of the population without being required to extend those benefits to all beneficiaries.

b. States should be allowed to make broader use of meaningful and enforceable cost-sharing. In a recently proposed rule, HHS would authorize states to implement additional cost-sharing for emergency room visits for non-emergency care and for prescriptions. This is helpful, but there are many other areas in the health care delivery system where carefully designed cost-sharing would encourage the use of more cost-effective providers. Medicaid beneficiaries should have some of the same involvement in their own health care decisions as is becoming common in insurance plans in both government and private industry. Furthermore, experience with real cost-sharing in the Medicaid program will help prepare individuals for transition into exchanges, which use cost-sharing extensively.

c. HHS and states should begin exploring ways to use existing Medicaid funding to support public health initiatives aimed at Medicaid beneficiaries. Many of the health issues among Medicaid beneficiaries (as with the population at large) have causes that are not effectively addressed by conventional medical care with its emphasis on treatment of acute problems. Examples of such root causes would include tobacco use, obesity, and excessive alcohol consumption. Similarly, the treatment of chronic disease—such as diabetes—is often improved by a component of education and behavior modification that can be more effectively delivered outside of the tradition medical care system.

We recognize the legitimate concern that some states might attempt to use Medicaid to fund existing public health programs, but we believe that suitable protections could be worked out and Medicaid dollars ultimately used more effectively for the benefit of its beneficiaries.

3. Infrastructure Development

States should be able to use existing funding for infrastructure development and investment in delivery system and payment reform. As part of an effort to work with states to innovate using current statutory authority (i.e., without the need of a waiver), CMS launched a series of Medicaid and Children's Health Insurance Program (together known as "MAC") alliances: MAC Learning Collaboratives. These collaborative work groups include states, federal partners, and national experts, and they address both health information technology (HIT) infrastructure and delivery-system reform. We commend CMS for helping states work within existing flexibilities to enact payment and delivery reforms, such as Value-Based Purchasing. However, we do not believe that the MAC Collaboratives program as it is currently structured adequately provides states with the technical tools and flexibilities needed for success. We believe these programs could be more transparent, more inclusive, and provide greater technical assistance, while fostering state innovation and opportunities for shared learning.

4. Medicaid Expansion

When the Supreme Court found that the ACA could not force states to expand Medicaid to cover certain populations, many states were left grappling with decisions about whether and how to cover significant numbers of citizens. While this is a politicized issue and different states will doubtless come to different conclusions, there are two areas where some immediate HHS assistance could make it easier for states to deal with this issue

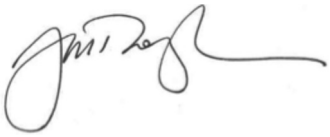
a. The Basic Health Plan (BHP) established in the ACA allows states to establish a program to care for individuals between 133 and 200 percent of the federal poverty level. This has the potential of providing more stable coverage for these individuals. States are still waiting for detailed guidance on the parameters of the program operation and coverage required. We would request HHS to immediately provide this guidance so that governors can responsibly plan for how this might be implemented.

b. Until such time as the Congress might grant statutory authority to states to cover individuals in the range of 100 percent to 133 percent of poverty and receive 100 percent of reimbursement, without covering the entire group, HHS should streamline the waiver process to allow this program to additionally cover those individuals. This would be an alternative to expanded Medicaid coverage that would be attractive to many governors.

As governors, we have a good deal of direct experience with the workings of the Medicaid program. Our recommendations are not long-term approaches to improvements, but rather changes that can be made quickly. We consider it important to improve the quality of care, the experience of participants, and the efficiency of the Medicaid program. We believe these are practical suggestions for how the federal government might begin to accomplish this.

Respectfully,

Phil Bredesen
Former Governor of Tennessee



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