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The Role of Medicaid

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Any serious efforts to control the federal budget must include Medicaid. Although the share of the federal budget devoted to Medicaid is substantially smaller than that for Medicare, the anticipated rate of growth in Medicaid is slightly higher than that for Medicare and substantially above anticipated growth in federal revenues. Medicaid dominates the markets for some services and can help move the health system toward greater efficiency by serving as a model for effective delivery.

Medicaid spending is expected to grow for the same reasons health care spending is expected to grow—advances in medical technology and increasing needs of the population—but Medicaid is also affected by forces unique to it. Those forces are the focus of this chapter.

Medicaid's Place in Budgets and the Health System

While the federal government struggles with Medicaid spending, the states struggle even more. The federal government spent \$181.5 billion on Medicaid in 2005, while the states spent \$133.6 billion (table 4-1).

Table 4-1. *National Health Expenditures (NHE), by Source of Funds, Amounts, and Average Annual Growth from Prior Year Shown, Selected Calendar Years 1993–2015^a*

<i>Source of funds</i>								
<i>(billions of dollars)</i>	1993	2002	2003	2004	2005 ^b	2006 ^b	2010 ^b	2015 ^b
NHE	916.5	1,607.9	1,740.6	1,877.6	2,016.0	2,163.9	2,879.4	4,031.7
Private funds	514.2	881.4	957.2	1,030.3	1,101.4	1,148.4	1,544.7	2,116.4
Consumer payments	442.3	763.0	829.7	894.2	955.2	991.2	1,334.1	1,818.1
Out-of-pocket payments	145.3	210.8	223.5	235.7	248.8	246.2	316.3	421.0
Private health insurance	297.0	552.2	606.3	658.5	706.4	745.0	1,017.7	1,397.1
Other private funds	71.9	118.4	127.5	136.1	146.2	157.1	210.6	298.3
Public funds	402.3	726.5	783.4	847.3	914.6	1,015.5	1,334.7	1,915.3
Federal	277.7	509.5	554.4	600.0	645.9	742.0	971.4	1,407.8
Medicare	148.4	266.3	283.8	309.0	335.5	420.1	536.0	792.0
Medicaid ^c	76.8	147.3	162.5	173.1	181.5	184.0	258.9	384.4
Other federal ^d	52.5	95.8	108.1	118.0	128.9	137.8	176.5	231.3
State and local	124.7	217.1	229.0	247.3	268.7	279.2	371.2	519.4
Medicaid ^c	45.6	101.7	108.7	119.6	133.6	136.0	191.5	285.3
Other state and local ^d	79.1	115.4	120.3	127.7	135.0	143.2	179.7	234.1
<i>Average annual growth</i>								
<i>(percent)</i>	1993 ^e	2002	2003	2004	2005 ^b	2006 ^b	2010 ^b	2015 ^b
NHE	11.5	6.4	8.2	7.9	7.4	7.3	7.4	7.0
Private funds	11.0	6.2	8.6	7.6	6.9	4.3	7.7	6.5
Consumer payments	11.0	6.2	8.7	7.8	6.8	3.8	7.7	6.4
Out-of-pocket payments	8.0	4.2	6.0	5.5	5.6	-1.0	6.5	5.9
Private health insurance	13.7	7.1	9.8	8.6	7.3	5.5	8.1	6.5
Other private funds	11.1	5.7	7.7	6.8	7.4	7.5	7.6	7.2
Public funds	12.2	6.8	7.8	8.2	7.9	11.0	7.1	7.5
Federal	12.7	7.0	8.8	8.2	7.7	14.9	7.0	7.7
Medicare	13.7	6.7	6.6	8.9	8.6	25.2	6.3	8.1
Medicaid ^c	15.4	7.5	10.3	6.6	4.9	1.4	8.9	8.2
Other federal ^d	9.0	6.9	12.8	9.1	9.2	6.9	6.4	5.6
State and local	11.3	6.4	5.5	8.0	8.7	3.9	7.4	7.0
Medicaid ^c	13.6	9.3	6.9	10.0	11.8	1.8	8.9	8.3
Other state and local ^d	10.4	4.3	4.3	6.1	5.8	6.0	5.8	5.4

Source: Christine Berger and others, "Health Spending Projections through 2015: Changes on the Horizon," *Health Affairs* 25, no. 2, web exclusive (February 22, 2006): W61–W73. Data from Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

a. Numbers might not add to totals because of rounding. The year 1993 marks the beginning of the shift to managed care. Growth rates are calculated consistent with the methodology of the National Health Expenditure Accounts. For example, the 2015 growth rate above is equal to the level of 2015 expenditures over the level of 2010 expenditures raised to the one-fifth power (the average growth over five years); "2015 growth rate" is shorthand for 2010–15 growth rate. Medicaid spending growth rates are projected to decline from historical trends, yet they remain higher than Medicare and private funds.

b. Projected.

c. Includes Medicaid and State Children's Health Insurance Program (SCHIP) expansion (Title XIX).

d. Includes Medicaid and SCHIP expansion (Title XXI).

e. Average annual growth from 1970 through 1993.

Medicaid expenditures represent 9 percent of the federal budget but 22.9 percent of the typical state's budget and 16.9 percent of the typical state's general fund.¹ Behind these averages exists substantial variation: in Wyoming, Medicaid only consumes 7.7 percent of the state's overall budget, but in Louisiana, Maine, Mississippi, Missouri, Pennsylvania, and Tennessee, it consumes more than 30 percent.

The Centers for Medicare and Medicaid Services (CMS) anticipates that federal Medicaid spending will increase from \$181.5 to \$384.4 billion over the next ten years, with an annual growth rate of around 8 percent in most years. This is a slight decline from the past but is higher than the forecast for any other payer, including Medicare and private health insurance premiums (table 4-1).

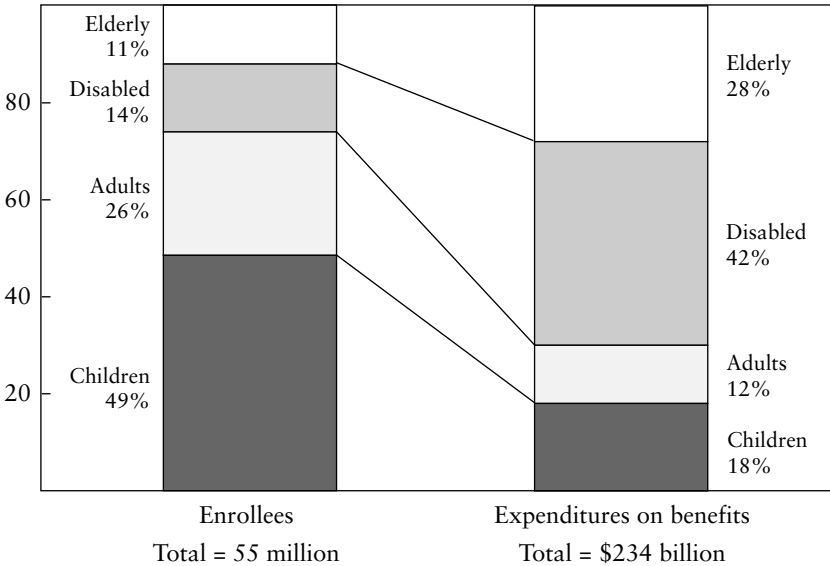
Medicaid's rapid cost growth represents a combination of increased spending per enrollee and an increase in the number of enrollees. Between 2000 and 2003, Medicaid spending increased by one-third, while the cost per enrollee grew at a rate slower than that of private health insurance premiums.² Hadley and Holahan concluded that Medicaid costs less than private health insurance on a per-enrollee basis largely because of lower provider payment rates.³

Medicaid is a means-tested entitlement program that pays for health care services for 55 million Americans.⁴ Medicaid is actually a variety of programs wrapped into one. It provides health care coverage to pregnant women, low-income children, and some poor parents. It pays for long-term care services, including nursing home care and care delivered in the home and community, for frail elders and people with severe disabilities. The program pays for the cost sharing in Medicare that can be unaffordable for poor and near-poor elders. The program is also a source of direct financing to many hospitals that treat large numbers of people without health insurance.

While almost half of Medicaid recipients are children, they account for only 18 percent of program costs (figure 4-1); people with disabilities account for 42 percent of Medicaid spending. This eligibility category is extremely heterogeneous and includes people with severe and persistent mental illness (Medicaid pays for more than a quarter of the nation's spending on mental health services), children with developmental disabilities, people with HIV/AIDS, people with spinal cord injuries, and people with degenerative physical and neurological conditions.⁵

Figure 4-1. *Medicaid Enrollees and Expenditures by Enrollment Group, 2003*

Percent



Source: Estimates based on 2003 MSIS data, Urban Institute and Kaiser Commission on Medicaid and the Uninsured.

All Medicaid recipients receive a comprehensive set of medical benefits, with some services required by the federal government and others offered at the discretion of the state. States can (and do) set limits on the “amount, duration, and scope” of benefits, meaning, for example, limits on the number of prescriptions that can be filled (amount) or the period of time physical therapy visits will be covered (duration) or the extent to which all types of mental health services will be paid (scope). Under federal law Medicaid provides children a broader set of benefits than it provides adults.

For the frail elderly and people with disabilities, Medicaid is more than a health care program. Nursing home care includes both medical and residential (that is, room and board) services, and people with disabilities may obtain services that are not medical in nature, such as “personal care assistance”—getting out of bed or preparing meals.

Medicaid's Structural Uniqueness

Compared with the other health programs discussed in this volume, Medicaid is unique for five reasons: it has joint state-federal administration, it has means-tested eligibility, its budget has countercyclical components, it is the dominant payer for certain providers, and it generally has low provider payment rates. All of these features need to be considered when attempting to contain program costs.

STATE-FEDERAL ADMINISTRATION. States have day-to-day responsibility for running the program within the constraints of laws and policies set by the federal government. States that wish to operate outside of the established rules can make formal applications to CMS to waive the rules under a number of provisions of the Social Security Act. The broadest waiver authority appears in section 1115, which grants the secretary of health and human services broad (but not unlimited) authority to waive provisions of the law for the purposes of research and demonstration. On the basis of a rule from the Office of Management and Budget, waivers must be cost neutral to the federal government.

The federal government pays for 57 percent of the overall costs of the Medicaid program.⁶ The federal share for covered benefits is set by a formula that varies with state median income, with a floor of 50 percent federal participation. Special matching rates exist in certain categories: administrative costs are shared 50:50, and development costs of claims payment systems are 90:10. Special rates also extend to certain services: family planning services receive a 90 percent federal match.

The shared financing and administrative structure is a constant source of tension in the Medicaid program. The federal government and the states clash over which level of government controls program design. More important for the purpose of this book, the structure provides incentives to increase spending in two critical ways. First, states have a strong incentive to define as many state expenditures as possible as “Medicaid” so they can obtain a federal matching payment to offset a portion of the costs. The challenges raised by this incentive are discussed in greater detail below. Second, the marginal cost to either the federal government or a state is less than one dollar for every dollar of services provided, making it easier for either to decide to expand the program than if

financing rested entirely at only one of the levels of government. It is important to note that this inflationary tendency offsets a constricting one. When it comes to social benefits, states inherently under-spend because of concerns about becoming a welfare magnet—a state that attracts needy people from states that have lower benefits.

State administration creates important opportunities for program efficiency. States have brought innovations to Medicaid in many areas, including widespread reliance upon managed care, development of consumer-directed care models, employment of disease management programs, experiments with simplification of program administration, and creative efforts to blend public and private coverage. States truly function as laboratories in the Medicaid program, trying out new ideas and disseminating what works. Flexibility permits states to craft programs that are appropriate to their residents' values, the structure of the health care market, and the availability of health care providers. However, the cost of state flexibility is some administrative redundancy and a degree of variation around the country—particularly with respect to eligibility—that is hard to defend given the dominant funding role of the federal government.

MEANS-TESTED ELIGIBILITY. Medicaid eligibility is dependent upon having very low income and (for most eligibility categories) limited financial assets. Given the extremely limited resources of the enrolled population, any change that eliminates covered benefits is likely to translate primarily into forgone use of health care services. Increases in cost sharing that would be considered modest by a commercial population (from \$3 to \$5 for a prescription) can be a complete impediment to obtaining services (or simply a cost shift to providers who may not even attempt to collect) for a Medicaid population.⁷

The health consequences of these changes are a matter of some debate. The results of the 1987 RAND health insurance experiment suggested that the overall consequences for health status of moderate increases in patient out-of-pocket costs are minimal or nonexistent.⁸ But there were negative effects for low-income people, and more recent analyses considering the interaction between types of care (for example, drugs and physician visits) and the impact of cost sharing on adherence to the treatment regimen warn that health consequences can be substantial.⁹

COUNTERCYCLICAL SPENDING. Medicaid's income-based eligibility rules mean that more people become eligible for the program when the economy weakens and worker incomes fall. In addition, as firms become less likely to offer coverage to their employees or expect their employees to pay more, low-wage workers without a realistic option of holding employer-sponsored insurance are more likely to turn to Medicaid, at least for their children (only a small share of the workers themselves are eligible).

These events occur at a point in the economic cycle when federal and state revenues are likely to be falling. Thus Medicaid cost growth caused by enrollment accelerates just as its funding sources are declining. This inherent dynamic ensures that Medicaid will periodically come under substantial pressure as a budget buster. In addition, it means that when political attention focuses on the program the perception of budget growth will be somewhat overstated, since it will reflect a combination of per-person cost growth and unusually high enrollment growth. This phenomenon was most apparent in the early part of this decade.

DOMINANT PAYER. Medicaid is the dominant payer for many of the services it purchases, which creates an opportunity to influence efficiency. The most obvious example is nursing home care: Medicaid finances care for 60 percent of all nursing home residents.¹⁰ But there are other examples as well. Medicaid pays for residential treatment facilities, adult day care, home care aides, and other services or providers closely linked to the specific needs of a subgroup of the Medicaid population. Many of these services and provider types are not covered by other forms of insurance and are not purchased frequently by people without insurance.

This role for Medicaid has a number of implications. From a political perspective, these providers are dependent upon Medicaid for their livelihood, and they can become a formidable lobbying force with respect to their payments. From a practical perspective, it can be difficult to define or determine appropriate payment rates since there may be little or no private market for similar frail, low-income patients that can be used to establish fair rates or that can provide sustainable rates with normal profits.

LOW, ADMINISTRATIVELY ESTABLISHED PROVIDER PAYMENT RATES. Medicaid pays providers using a fee schedule established by each state, although payments made through managed care organizations may

differ from the schedule. In addition, for services that have a mix of payers, such as hospital and physician care, Medicaid generally pays below-market rates. It can do this because some providers have little choice but to accept the established rate and because some of its contracting providers have a charitable, tax-exempt mission.

Medicaid's low payment rates discourage providers from participating in the program if they have other options. Hence recipients can face barriers to access, particularly for some specialty services. From the perspective of the program's fiscal health, the implications are that savings cannot be generated through lowering provider payment rates and that Medicaid providers are unlikely to be able to pursue innovations and investments unless they receive or expect to receive an increase in their rates.

How Could Medicaid Spending Be Controlled?

Conceptually, it would be easy to reduce Medicaid spending. Program eligibility could be curtailed or covered services scaled back. These steps could be taken year after year to meet a predefined budget target, and Medicaid would make its contribution to solving the fiscal problems of the country. Yet this would not be a solution at all because it means these costs are shifted either to providers, other payers, or the people the program is intended to cover. Medicaid was created out of recognition that low-income Americans were not gaining the benefits that the health care system has to offer. Mechanically chipping away at Medicaid risks recreating these problems.

Our goal must be greater efficiency. In this context, efficiency could mean a few different things:

—Medicaid could be redesigned so that beneficiaries attain the same health and functional status while receiving fewer or less intensive services.

—Medicaid could purchase the same health care services at a lower cost (without those costs simply appearing elsewhere).

—People who rely upon Medicaid could have their needs met through other vehicles, such as employer-sponsored health insurance or private insurance for long-term care.

Ultimately, the challenge is to constrain the growth in program spending without denying people the services they need. In this section we discuss four broad categories of policy changes and handicap their potential

benefits and costs: changing state incentives, delivery systems, enrollee incentives, and policies designed to reduce demand for the program.

Policies Designed to Change State Incentives

A variety of policy options are available that would increase state incentives to reduce Medicaid program costs. At one extreme is the option of converting the Medicaid program into a block grant to states. A block grant is a lump sum of money determined in advance through a formula. Federal requirements regarding eligibility rules, covered benefits, and provider payment rates could be preserved (which would cause the states to object) or eliminated (which would cause advocates for Medicaid recipients to object).

The obvious benefit of a block grant to the federal government is that it provides complete budget predictability and a simple lever for controlling future spending. State reactions to a block grant depend upon how large the grant is in the first year, what factors are used to increase the grant over time, how much flexibility it actually gives states to modify their programs, how high a priority the states place on meeting the needs of the Medicaid population, and how the states feel about bearing the risk of filling in the gap between the cost of meeting their populations' needs and the amount the federal government gives them to do so. Currently, if Medicaid spending increases for any reason—a change in the overall economy, a new medical technology, a new disease (for example, HIV/AIDS), changes in eligibility, benefits or payments to providers, or a natural disaster (for example, Hurricanes Katrina and Rita)—the federal government shares the cost with the state. But if a state figures out how to save money in the program, both the state and federal government share in the savings. Thus, the incentives for the states to save are not as high as they could be. Under a block grant a state would have strong incentives because it could keep all the savings.

A block grant would almost certainly change state behavior. States have even responded to congressional *debate* over a block grant—they increased their spending in what they thought would be the base year so they could secure a larger grant in the future, but then they slowed spending when the block grant legislation was vetoed by President Clinton.¹¹

The Democratic Party's alternative in the mid 1990s to a block grant was a milder version of constraint—the “per capita cap.” The per capita

cap limits the federal contribution per enrollee to the state, but it ensures continued matching funds for every person enrolled in the program. The proposal has conceptual appeal: states are held faultless against events outside of their control, such as disasters and economic downturns that cause Medicaid enrollment to grow, but they have strong incentives to control spending per capita, which is where they potentially have leverage. Yet the concept suffers in two critical details. First, determining an appropriate growth factor in per capita spending is difficult (imagine projecting your private insurance premium out ten years into the future). Second, because per capita spending is easy to manipulate by cutting benefits, and Democrats did not want to encourage states to cut benefits, the per capita cap proposal limited state flexibility in ways that made it hard for states to imagine that they could operate within the limits.

Over the years policy analysts of varying points of view have proposed a broad range of “swap” proposals. President Reagan proposed to have the federal government assume full responsibility for Medicaid while states financed welfare, food stamps, and other programs.¹² Today governors regret having rejected that offer. Other proposed swaps include giving full responsibility to either the state or federal level of government for the “dual eligibles”—those eligible for both Medicare and Medicaid—while shifting remaining populations to the other level of government. Since a swap means that one level of government bears full financial responsibility for meeting the needs of the population, it creates many of the same financial incentives as a block grant.

The argument for the swap is that shared fiscal responsibility is a recipe for cost shifting and inefficiency, and indeed there is evidence to support this view. Yet, swap proposals always founder on the shoals of budget projections. Neither level of government wants to take on a larger current or expected future fiscal burden. Neither level of government is sufficiently confident that, given full responsibility for a population, it will be able to meet the needs of that population at lower cost.

Ultimately, support for any of these ideas—block grants, per capita caps, and swaps—arises from a simple notion: given greater financial responsibility, states will be more effective at controlling program costs. Advocates of these approaches believe those savings can come from efficiencies; detractors believe they will come from cuts in services to Medicaid enrollees. What is clear is that under any of these alternative

structures states will have strong incentives to achieve efficiencies; what is not clear is whether states have the tools necessary to do so. That question is discussed in later sections of this chapter.

Budget caps also raise substantial fairness issues, since they lock in existing interstate inequities with respect to eligibility levels and provider payment rates. With a cap, the governor or legislature of a state operating a limited program cannot obtain new federal funds even if the state wants to modify its program to bring it up to the level that another state already had in place. In addition, it is difficult for the federal government to set rules that prevent states from scaling back on their coverage and using their block grant funds to support other programs.

A primary benefit of budget caps is that they eliminate fiscal gaming—a recurring problem within Medicaid. Fiscal gaming refers to practices states adopt that are intended *primarily* to maximize federal matching revenue to the states, and not to reimburse providers for the costs of delivering medical services to the eligible population. Budget caps eliminate state incentives and opportunities for gaming.

Over the years states have figured out a number of legal mechanisms to pay providers exaggerated rates, obtain federal funds to cover a share of those rates, and use the federal funds to either reimburse the provider or fill the state treasury. The federal reaction to fiscal gaming to date has been to limit the games one by one. The Government Accountability Office (GAO) says that, although efforts by Congress and the CMS have narrowed fiscal gaming, it has not been eliminated. GAO's 2004 report on improving federal oversight notes that "states can and do continue to claim excessive federal matching funds, using them for non-Medicaid purposes or to inappropriately increase the federal share of Medicaid program expenditures."¹³

The politics of fiscal gaming is filled with irony. Members of Congress rail against egregious practices but defend the same when they are committed by their own states. When a new state trick is discovered, legislation designed to close the loophole gives a few states extra time (during which they will obtain substantial federal dollars) to come into compliance. CMS administrators complain of state practices but do not propose regulations that would control them. Meanwhile, states can make garden-variety excessive or inefficient payments to providers without bumping up against any federal rules or attracting any notice.¹⁴

Some amount of fiscal gaming may be the price of a matched financing structure. Block grants and caps offer one way out, but so does a more coherent approach targeted specifically at the problem. A recent paper from the National Academy for State Health Policy describes a series of structural steps that could more clearly define what revenue sources can be used to serve as the state match and what types of expenditures are eligible for receiving the federal share.¹⁵ An alternative approach is inspired by Coughlin and Zuckerman who calculated the *effective* federal match percentage (which includes fiscal games) and compared it with the *nominal* federal match percentage derived by federal statutory formula.¹⁶ Rules could be developed so that states with high effective rates relative to their nominal rate would have to repay the difference.

Policies Designed to Change How Care Is Delivered

Within broad federal parameters, each state decides how to operate its Medicaid program, especially with regard to provider participation and payments. States are currently using three levers for improving systems of care for Medicaid enrollees: managed care, disease management, and pay-for-performance, but they could do more.

INCREASED USE OF CAPITATION ARRANGEMENTS FOR MANAGED CARE. A majority of Medicaid recipients are enrolled in managed care plans, and more than thirty states require Medicaid recipients to enroll in such plans. Under Medicaid managed care, health maintenance organizations, prepaid health plans, or comparable entities agree to provide a specific set of services to Medicaid enrollees, in return for a predetermined periodic payment per enrollee. They also agree to follow rules established by the state regarding matters such as the number of physicians, by specialty, who will be available for patient care; quality standards; and patient satisfaction targets. Table 4-2 shows the number of plans and enrollees in Medicaid managed care.

One policy approach is to further encourage growth in Medicaid managed care. Growth in Medicaid managed care has slowed because the easiest and lowest cost groups to enroll, women and children, have largely been enrolled. The more costly and higher-risk disabled have yet to be confronted by most states. Nonetheless, the earliest Medicaid managed care demonstrations documented savings of 5 percent for children and

Table 4-2. *Medicaid Managed Care Plans*^a

<i>Managed Cared Entity Type</i>	<i>Number of Plans</i>	<i>Number of Enrollees</i>
Health insuring organization	5	500,780
Commercial managed care organization	157	9,780,823
Medicaid-only managed care organization	130	8,606,164
Primary care case management	36	6,559,561
Prepaid inpatient health plan	107	8,119,325
Prepaid ambulatory health plan	43	4,986,161
Program of All-Inclusive Care for the Elderly	33	11,824
Other	8	549,358
Total	519	39,113,996

Source: "Summary Statistics as of June 30, 2005" in *Medicaid Managed Care Enrollment Report* (Department of Health and Human Services, Centers for Medicare & Medicaid Services, Finance, System and Budget Group).

a. This table provides duplicated figures by plan type. The total number of enrollees includes 10,538,411 individuals who were enrolled in more than one managed care plan. It also includes individuals enrolled in state health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

adults, and studies of individual states have continued to demonstrate the value of managed versus unmanaged care especially for this population.¹⁷ The savings to be expected from Medicaid managed care for the disabled and dual eligibles, largely the remaining group in unbridled fee-for-service, are less well documented, although the potential yields are greater given the higher cost of this population.

The hopes for managed care must be kept in perspective. The traditional managed care model that has served Medicaid reasonably well with respect to low-income families and children faces new challenges when applied to the more complex needs of people with disabilities and frail elders. The Arizona Health Care Cost Containment System (AHCCCS), which has all Medicaid eligibles enrolled in managed care including for long-term care services, has been in operation more than twenty years. The Program of All-Inclusive Care for the Elderly (PACE) has been in operation for more than fifteen years and was converted to a permanent feature of Medicaid in 2005. Many states have successfully used risk-adjusted managed care payments for their disabled populations. And a number of states have developed capitated payment models for people with mental disabilities. Some states have well-established managed care organizations with experience in enrolling the disabled and frail elderly. Yet most states are on a steep learning curve for further development.

Managed care is particularly difficult to implement in rural areas. There is a sense that Medicaid managed care has succeeded in reaching the goal of predictable, moderate spending growth with reasonable quality of care for most states; yet the growth in managed care has stalled.¹⁸ Supplemental grants, such as PACE grants in 2005, and marginal increases in federal matching rates to encourage states to expand Medicaid managed care might restart the growth in such programs.

DISEASE MANAGEMENT AND ITS VARIANTS. What cost containment strategies are available for those not enrolled in managed care, who are primarily the elderly and disabled poor? It is an important question for Medicaid, because despite the prevalence of managed care, payments to managed care organizations constitute only 15.6 percent of total program spending.¹⁹

One possible solution is disease management. Disease management is a system of coordinated health care interventions and communications for populations with chronic disease. Patient self-care efforts are a significant aspect of disease management programs because they intervene with physicians, patients, and caregivers to encourage adherence to established medical treatment guidelines for improved outcomes and lower spending.

The idea is not new to Medicaid; it is just poorly dispersed among the states in any standard format. Managed care companies, especially health maintenance organizations, have used disease management programs on behalf of Medicaid recipients for more than thirty years. More than twenty states have disease management programs for adult Medicaid recipients with chronic conditions such as asthma, diabetes, and congestive heart failure. They make a great deal of sense for state Medicaid programs because they have been shown to decrease inpatient and emergency room costs, increase pharmacy costs in accordance with medical treatment guidelines, and produce a net decline in total spending of 3 to 5 percent for the patients enrolled in disease management.²⁰

Managed care organizations develop and operate disease management programs on their own as part of their overall care management approach. The fee-for-service portion of Medicaid programs could benefit from well-constructed disease management programs paired with intensive case management for very high cost recipients. Medicaid directors need better information regarding the relative effectiveness of various

approaches, as they have legitimately grown skeptical over time of claims that every new thing will save them money. Medicaid disease management programs that support Medicaid providers should have the greatest potential, because they help providers identify patients most in need of assistance, to adopt evidence-based practice guidelines, and report or give feedback routinely about progress in terms of appropriate health care or reasonable costs.

PAY-FOR-PERFORMANCE AND ITS VARIANTS. Traditional fee-for-service inherently rewards the volume of services provided and not necessarily quality and efficiency. By discriminating among providers on the basis of quality and efficiency (and in some cases publishing the results), public and private purchasers might be able to encourage and reward performance improvement efforts. Whether paying for better quality on the margin can help the fiscal crisis in health care is unknown.

Except for a few Medicaid managed care companies in ten states, pay-for-performance is virtually untried in fee-for-service Medicaid. North Carolina has a program with financial rewards and recognition for the above-average primary care physicians who meet minimal process measures for case management of asthma and diabetes and the use of generic medicines. Pennsylvania is making payments to acute care hospitals in the state if they reduce the seven-day readmission rate for certain conditions and reduce the time between diagnosis of pneumonia and treatment with antibiotics. The leader in using pay-for-performance methods, with at least a toe in the water, has been Medicare. With \$7 million to \$21 million on the line, Medicare has preliminary results from the Premier Hospital demonstration that show improvement in basic process measures of quality among 270 participating hospitals.²¹

Efforts to adopt pay-for-performance in Medicaid will face some hurdles not experienced by Medicare. The primary hurdle is market power. Medicaid may not command attention from providers the way Medicare does. Another hurdle is the ability to analyze and act on available claims data. Medicare has better data than do most Medicaid programs. Smaller states especially lack the infrastructure and sufficient data to go beyond the most basic information systems. Medicaid also suffers from low payment rates and a relatively high concentration of its recipients served by a limited number of already overly stretched providers.

Rewarding performance at the margin may do little to change behavior if providers do not consider themselves appropriately compensated to begin with.

In principle, better quality care should cost less, with fewer costly errors, better care outcomes, and more satisfied patients. In the same way, the performance that is measured and rewarded is usually the only aspect of care that changes. A recent report laments the lack of uniformity in measures of performance and the current coarse state of quality measures that seem to only scratch the surface of performance.²² Great anticipation is also placed in posting the comparative results of performance measurements of providers so that patients can discern differences in quality measures and vote with their feet for better quality of care. Policymakers and analysts are still learning about the effects of such consumer-directed health care, but a system of care that values the demands of patients, even low-income patients with chronic disease, would surely be superior to one that patronizes them.

Five large states (New York, California, Texas, Pennsylvania, Florida) account for more than 40 percent of total Medicaid spending.²³ If they could begin to develop measurable performance standards in fee-for-service Medicaid and show that they have had an impact on quality and cost, then other states might be able to follow.

Policies Designed to Change the Behavior of Individual Beneficiaries

Since its inception, Medicaid has been a defined benefits plan. This means that certain services, discussed earlier, must be provided by each state to receive federal financial participation, and states can add other specified benefits as they wish. New flexibility offered by the 2005 Deficit Reduction Act has prompted several states, with more to follow, to move away from defined benefits to defined contributions. A defined contribution plan does not promise a set of benefits, rather it promises a payment toward benefits. In many ways, this is bringing Medicaid into alignment with similar trends in private-sector health plans and certain components of Medicare (Part C and Part D).

Two primary models are emerging. One is the direct purchase model, whereby the state gives each Medicaid beneficiary a fixed sum of money

that he or she can use to purchase insurance coverage in the private market. A related, much more limited approach is the cash and counseling model, in which Medicaid recipients have the ability to hire, fire, and schedule their personal care services rather than work through a home health agency. The other model is the “rewards” approach for pursuit of healthy behaviors and “penalties” for failing to do so.

VOUCHERS AND VARIOUS DEFINED CONTRIBUTION APPROACHES. Florida typifies the defined contribution approach. It is assigning Medicaid recipients, in different parts of the state, to a risk-adjusted premium for the purchase of insurance from among a selection of state-approved, actuarially equivalent products, each offering different services. The approach has some features in common with the Federal Employee Health Benefits Program, in that those covered receive a fixed subsidy and the plans can vary the benefits.

Milligan, Woodcock, and Burton issued warnings about this approach. They recommended that states ensure that the risk adjustment is accurate and that vital services be grafted onto the defined benefit plans, if necessary.²⁴ With greater personal responsibility in their hands, Medicaid recipients may need a different set of consumer protections than is normally provided, and state agencies, including the insurance commission, may have to modify their normal way of doing business. Supports should be in place to help Medicaid recipients make informed choices about their health plan, primary provider, and prevention and screening services. Nevertheless, with attentive oversight and quick modification to likely pitfalls, the defined contribution approach could help Medicaid control spending and would give a new generation of recipients the type of coverage that the rest of the covered population has (with all of the advantages and disadvantages that such coverage entails).

FINANCIAL INCENTIVES FOR HEALTH-PROMOTING BEHAVIORS. West Virginia is taking a different approach by requiring eligible recipients to sign a member agreement. By signing the agreement, the Medicaid recipient promises to keep appointments with physicians, adhere to the treatment regimen in terms of taking drugs, and not overuse the hospital emergency room. Failure to keep appointments or to take drugs and unnecessary emergency room visits are three long-standing negative characteristics of any Medicaid program and known to be a source of

unnecessary Medicaid spending. Those eligible for Medicaid who refuse to sign or are noncompliant with the agreement will see a reduction in their benefits. They will either face higher cost sharing or find the amount, duration, or scope of benefits curtailed.

Private-sector employers have successfully implemented carrot-and-stick programs for weight control, smoking cessation, and prescription drug adherence.²⁵ Many state policymakers, frustrated by jammed emergency departments and the combination of rising drug budgets and rising incidence of chronic disease, believe a change is needed in the way Medicaid recipients participate in the program. Certainly, asking the Medicaid recipient to join the team providing the care cannot hurt. What is not yet clear is whether the criteria for obtaining “carrots” can be well defined (physicians have expressed concerns about becoming enforcers on behalf of the state) and what the health consequences will be for those who end up with fewer benefits because of “sticks.” The jury is still out on this development, but it bears careful watching for its potential for moderating the rise in Medicaid spending.

Policies Designed to Reduce Demand for the Program

States view Medicaid as an essential part of their current strategies to provide insurance to their low-income populations, cover the chronic care needs of people with disabilities and the elderly, and finance the health care safety net. Medicaid has accomplished much, and it can continue to do so if the underlying fiscal pressures and tensions built into it are addressed.²⁶ One way to address these pressures is to identify opportunities for other programs or systems to bear some of the burden that Medicaid currently carries. Three ideas that might reduce demand are private insurance for long-term care, premium assistance programs, and a new national eligibility standard paired with dedicated funding.

PROMOTING PRIVATE INSURANCE FOR LONG-TERM CARE. Approximately 17 percent of Medicaid spending nationwide is for nursing home care and an additional 5 percent is for home- and community-based services that enable people to live at home or in less restrictive environments.²⁷ The rising cost of long-term care, shortages of qualified caregivers in any setting, and the demands stemming from living longer

portend major problems for states and their Medicaid budgets, as well as for the federal government.

Private long-term care insurance has been suggested as a partial response. The data are not current, but estimates are that somewhere between 29 and 38 percent of purchasers of long-term care insurance who use nursing homes would qualify for Medicaid payments if they did not own a policy. This is equivalent to between 13 and 17 percent of all policyholders.²⁸ If the group could be expanded, that is, the number of people with private long-term care insurance could be made larger, especially at the lower end of income, future state spending on Medicaid would be moderated because the private insurance would be the primary payer.

One of the longest-standing approaches to encouraging the purchase of private long-term care insurance is so-called partnership programs, established in 1987 in four states—Connecticut, California, New York, and Indiana.²⁹ The partnership programs are structured so that purchasers of private long-term care insurance are guaranteed asset protection equal to the costs borne by their insurance. This stands in contrast to what happens in general to people who require long-term care services provided by Medicaid—the state has the obligation to recover its costs from the person's estate when they die. The hope is that the partnership programs will serve as a strong incentive for people to purchase private insurance for long-term care.

There are three barriers to calculating the fiscal impact of the partnership programs. The first barrier is determining the share of people who participate in the partnership programs who would have purchased private long-term care insurance even if the program had not been in place. If this share is large, the public subsidy is simply crowding out a private expenditure that would have been made anyway.

The second barrier is determining the relationship between asset protection in the partnership programs and estate recovery through Medicaid. While federal law requires states to pursue the estates of Medicaid recipients to recover the costs of serving them, most states are not particularly aggressive in this area (reflecting the same aversion to estate taxes expressed by many in the federal government). The partnership program only creates an incentive to purchase coverage if people feel that there is a

realistic chance their estate will be held liable, but if that occurs, the cost to the state of providing Medicaid services is reduced by the amount recovered.

The third barrier is determining whether or not, years after purchasing long-term care insurance, people will exhaust their private insurance coverage. If that happens, they become a fiscal burden to Medicaid despite the existence of private coverage, and there are fewer savings for states. It takes a very long time to determine the answer with any assurance. Even so, the GAO found that after nearly 20 years only 251 policyholders in all four of the participating states had exhausted their long-term care insurance benefits.

Largely because of the GAO review of partnership programs, Congress in 2005 lifted the cap on the number of states that can have them, and half the states are now considering them.³⁰ A nationwide expansion of these programs with new types of long-term products could substantially expand the market for private insurance for long-term care. What is less clear is whether a larger market for long-term care insurance will translate into meaningful savings for the Medicaid program. Some commentators remain skeptical.³¹

PREMIUM ASSISTANCE. More than a dozen states are using Medicaid dollars to help pay the employee's share of the premium in their employer's health insurance plan.³² These programs, known as premium assistance, have strong conceptual appeal despite limited success in the real world. After years of states' experiments in leveraging Medicaid with private employers, no state has found the right combination of administrative simplification, cost-conscious benefit structure, and affordable premiums to replicate a workable model in other states.³³

Premium assistance programs face a series of barriers: the limited number of poor people who have an offer of coverage at the workplace, the limited willingness of (particularly small) employers to make any effort to assist with program administration, and the difficulty of supplementing what are often inadequate benefits to meet the more substantial needs of Medicaid enrollees. Nevertheless, states continue their efforts to combine Medicaid coverage with private coverage for low-income persons who work, with the goal of shoring up private coverage while relieving the burden on the taxpayer.

NATIONAL ELIGIBILITY STANDARDS AND NEW FEDERAL FINANCING SOURCES. The politics of Medicaid is a source of strength and a barrier to reform. Changes in Medicaid at the state level are frequently laced with discussions about what other states are doing, especially neighboring states. Governors and legislators believe that on the margin low-income persons will shop for benefits, especially people with serious disabilities who find that they can get superior coverage in one state versus another or that the eligibility requirements are stricter in one than in another. One would think this attitude would produce increasing uniformity, but much diversity remains. Any talk in Washington about changing the basic formula for federal financial participation is met with lists of winning and losing states that always derails any serious discussion about change.

As difficult as it might be, some have suggested the time has come to dramatically change the federal-state partnership for the uninsured and long-term care.³⁴ The centerpiece of the reform ideas is to establish national eligibility standards, based on financial need (rather than categorical eligibility). This would eliminate the disparities across the states in terms of eligibility and make the program simpler to administer. Accompanying this idea is a suggestion that all the states institute reinsurance for high-risk populations. A prominent feature of the state-run reinsurance program would be a statewide review of medical necessity and perhaps even rate setting for high-cost individuals to moderate spending at the high-cost end of health care.

On the financing side, the federal government could offer Medicaid-related tax credits to those employers buying into a Medicaid private managed care plan for their eligible employees. Such a federal tax credit would help the states' fiscal situation by sharing the costs of Medicaid coverage, and states could further add their own tax credit for participating employers if they wished to do so.

Renaming Medicaid obviously does not reduce the burden on the state and federal treasuries. Yet a complete overhaul that simplified the program, increased the investment in care management for those with the highest costs, and created a new funding stream to support the program would temper the recurring cries for reform.

How Can Medicaid Contribute to System-Wide Approaches to Control Health Spending?

In Chapter 2, Antos and Rivlin describe a strategy for controlling health spending that blends regulatory and market-based components. They also note the leadership role that federal programs can play in making the strategy work. Medicaid can contribute to the success of this strategy, but the particular needs of the Medicaid population should also be considered as the strategy unfolds.

Medicaid can contribute to efforts to improve the pricing of health care services—particularly paying for performance (P4P). As noted above, a few Medicaid programs are experimenting in this realm, and the lessons they are learning can contribute to the overall body of knowledge on this subject. It is important to note, however, that Medicaid enters the P4P field with rates that are substantially below market. A system-wide effort to improve how the health care system prices services would include raising Medicaid payment rates for many providers. This would have clear negative consequences for the federal and state treasuries, but this increase of payment rates would improve access to care for Medicaid enrollees, with some of this improved access translating into longer-term savings for the program.

Medicaid has been a bit of a latecomer to the health information technology movement.³⁵ Unlike Medicare, which as a national program has a national claims database, Medicaid administrative data are scattered around the country, and only recently has CMS had any success creating a national Medicaid database. Over time Medicaid should have a great deal to contribute to cost-effectiveness analyses since the program is the dominant payer for such a large share of the population with serious disabilities and chronic conditions.

Medicaid has been at the forefront of developing innovative care models for particular populations served by the program, such as people with HIV/AIDS or traumatic brain injury. Yet dissemination of these models across the states has been spotty, and communication between Medicaid and private insurers on lessons learned has been inadequate. Meanwhile long-noted problems coordinating services for people covered by both Medicaid and Medicare (the dual eligibles) may be overcome in part by

the new provisions concerning Special Needs Plans in the Medicare Modernization Act of 2003, although that story has not yet been written. Under the Medicare Modernization Act of 2003 (section 231), Congress created a new type of Medicare Advantage coordinated care plan focused on individuals with special needs. Special needs individuals were identified by Congress as individuals who are institutionalized, are dually eligible, or have severe or disabling chronic conditions.

Engaging the Medicaid enrollee as a consumer raises high hopes and serious cautions. On the one hand, Medicaid's entitlement structure has emphasized the passive role of the enrollee as recipient of services. Efforts to engage Medicaid enrollees in managing their own care and their own health seem appropriate—indeed, Medicaid enrollees with disabilities were at the forefront of the consumer empowerment movement. Yet one must always keep in mind the extremely limited financial resources available to Medicaid enrollees. Levels of cost sharing that might cause a middle-class insured patient to think twice before using a service can present an insurmountable barrier to someone on Medicaid. Financial incentives must be used with great caution in the Medicaid program.

Conclusion

Comprehensive approaches that address the high cost of and inefficiencies in the health care system as a whole offer a way out of the “Medicaid as budget buster” dilemma. Rather than attempting to isolate Medicaid from the rest of the health care system and fix it, decision makers should acknowledge the critical role that Medicaid plays in the health care system and use it as a tool for improving the system as a whole.

Medicaid's experience serving a high-need population can help the overall health care system understand the needs of those with the most expensive health conditions. As analysts have come to understand the critical role chronic conditions play in driving health care costs, Medicaid's experience with these conditions could support improvements in patient care in the population as a whole.³⁶

By contrast, attempting to control Medicaid spending without addressing the shortcomings of the health care system as a whole creates a serious risk that the most vulnerable Americans will bear the burden of

fiscal controls even as they are the group least able to absorb that burden without negative consequences. There is plenty of room for improvement within the Medicaid program, and improvements must be pursued, but Medicaid cannot solve the nation's fiscal or health system challenges alone.

Medicaid's contribution to the nation's fiscal challenges stems in large part from its role as the nation's safety net. The combination of rising health care costs, increased incidence of disability and chronic disease, and declining private coverage causes more people to drop into that net. And the more the net has to carry, the more it is seen as separate from the mainstream health care system and a welfare program whose costs need to be controlled. If our nation achieved health insurance coverage for everyone, Medicaid's financing challenges would be more similar to those facing the rest of the health care system, and its possible contribution to containing overall health care costs would be more apparent. That should certainly be our goal.

Notes

1. National Association of State Budget Officers, *Fiscal Year 2005 State Expenditure Report* (Washington, Fall 2006).

2. John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending: 2000-2003," *Health Affairs* web exclusive, January 26, 2005: W52-W65.

3. Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry* 40, no. 4 (Winter 2003-2004): 323-42.

4. For further information on Medicaid and the State Children's Health Insurance program, see Henry J. Kaiser Family Foundation, "Medicaid and SCHIP" (www.kff.org/Medicaid/index.cfm).

5. Richard G. Frank and Sherry Glied, "Changes In Mental Health Financing Since 1971: Implications for Policymakers and Patients," *Health Affairs* 25, no. 3 (May-June 2006): 601-13.

6. Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Program at a Glance," Fact Sheet 7235 (Washington: Henry J. Kaiser Family Foundation, May 2006) (www.kff.org/medicaid/upload/7235.pdf).

7. Bill J. Wright and others, "The Impact of Increased Cost Sharing on Medicaid Enrollees," *Health Affairs* 24, no. 4 (July-August 2005): 1106-116.

8. Willard G. Manning and others, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* 77, no. 3 (June 1987): 251-77.

9. Willard G. Manning and others, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment"; Joseph P. Newhouse, "Reconsidering the Moral Hazard-Risk Avoidance Tradeoff," *Journal of Health Economics* 25, no. 5 (September 2006): 1005–114; John Hsu and others, "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine* 354, no. 22 (June 1, 2006): 2349–359.

10. Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Program at a Glance."

11. John D. Klemm, "Medicaid Spending: A Brief History," *Health Care Financing Review* 22, no. 1 (Fall 2000): 105–12.

12. Lynn Etheridge, "Reagan, Congress and Health Spending," *Health Affairs* 2, no. 1 (Spring 1983): 15–24.

13. U.S. General Accounting Office, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, Report to the Committee on Finance, U.S. Senate (Washington: GAO, now named the Government Accountability Office, February 2004) (www.gao.gov/new.items/d04228.pdf).

14. Michael Bond, *Reforming Medicaid*, Policy Report 257 (Washington: National Center for Policy Analysis, 2003) (www.ncpa.org/pub/st/st257).

15. Sonya Schwartz, Shelley Gehshan, Alan Weil, and Alice Lam, "Moving beyond the Tug of War: Improving Medicaid Fiscal Integrity" (Portland, Me.: National Academy for State Health Policy, August 2006).

16. Teresa A. Coughlin and Stephen Zuckerman, "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues," Discussion Paper 02-09 (Washington: Urban Institute, June 1, 2002) (www.urban.org/url.cfm?ID=310525).

17. Deborah A. Freund and others, "Evaluation of the Medicaid Competition Demonstrations," *Health Care Financing Review* 11, no. 2 (Winter 1989): 81–97.

18. Robert Hurley and Sheldon Retchin, "Medicare and Medicaid Managed Care: A Tale of Two Trajectories," *American Journal of Managed Care* 12, no. 1 (January 2006): 40–44; Robert Hurley and Stephen A. Somers, "Medicaid and Managed Care: A Lasting Relationship?" *Health Affairs* 22, no. 1 (January–February 2003): 77–88.

19. Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Program at a Glance."

20. Louis F. Rossiter and others, "The Impact of Disease Management on Outcomes and Cost of Care: A Study of Low-Income Asthma Patients," *Inquiry* 37, no. 2 (Summer 2000): 188–202; Kenneth Patrick and others, "Diabetes Disease Management in Medicaid Managed Care: A Program Evaluation," *Disease Management* 9, no. 3 (June 2006): 144–56.

21. Centers for Medicare & Medicaid Services, "Medicare Pay-for-Performance Demonstration Shows Significant Quality of Care Improvement at Participating Hospitals," press release, May 3, 2005 (www.cms.hhs.gov/apps/media/press/release.asp?Counter=1441).

22. Institute of Medicine, Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs, *Performance*

Measurement: Accelerating Improvement (Washington: National Academies Press, 2006).

23. Calculations come from Henry J. Kaiser Family Foundation, “State Medicaid Fact Sheets” (www.kff.org/mfs/index.jsp?CFID=3234822&CFTOKEN=85265301).

24. Charles Milligan, Cynthia Woodcock, and Alice Burton, “Turning Medicaid Beneficiaries into Purchasers of Health Care” (Washington: AcademyHealth, January 2006).

25. John E. Reidel and others, “The Effect of Disease Prevention and Health Promotion on Workplace Productivity: A Literature Review,” *American Journal of Health Promotion* 15, no. 3 (January-February 2001): 167–91.

26. Alan Weil, “There Is Something about Medicaid,” *Health Affairs* 22, no. 1 (2003): 13–30.

27. Calculations from Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, “National Health Expenditure Data,” table 11, “Expenditures for Health Services and Supplies under Public Programs, by Type of Expenditure and Program, Calendar Year 2004” (www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf).

28. Marc A. Cohen, Nanda Kumar, and Stanley S. Wallack, “Long-Term Care Insurance and Medicaid,” *Health Affairs* 13, no.4 (Fall 1994): 127–39.

29. U.S. Government Accountability Office (GAO), “The Long-Term Care Partnership Program: An Overview,” GAO-05-1021R (September 9, 2005).

30. Vernon Smith and others, “Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey, State Fiscal Years 2006 and 2007” (Washington: Kaiser Commission on Medicaid and the Uninsured, October 2006).

31. See, for example, Jeffrey Crowley, “Medicaid Long-Term Services Reforms in the Deficit Reduction Act,” Issue Paper 7486 (Washington: Kaiser Commission on Medicaid and the Uninsured, April 2006).

32. Information on premium assistance programs is available at www.patoolbox.org.

33. Alice Burton and others, “State of the States: Finding Their Own Way” (Washington: AcademyHealth, January 2006).

34. Lynn Etheredge and Judith Moore, “A New Medicaid Program,” *Health Affairs* web exclusive, August 27, 2003: W3-426–W3-439.

35. See Avalere Health, “Evolution of State Health Information Exchange: A Study of Vision, Strategy, and Progress,” Publication 06-0057 J (Rockville, Md.: Agency for Healthcare Research and Quality, January 2006).

36. Kenneth E. Thorpe, “The Rise In Health Care Spending And What To Do About It,” *Health Affairs* 24, no. 6 (November-December 2005): 1436–445.