Opinion

Old Medicaid Is Gone; Expanded Medicaid Is Here to Stay

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WITH CONTROL OF BOTH HOUSES OF CONGRESS AND THE White House, many Republicans, as well as a large segment of the American public assumed Republicans would make good on their pledge to “repeal and replace” the Affordable Care Act—including its expansion of the Medicaid program to anyone below 138% of the poverty line. What soon became clear, however, is that the estimated losses by the Congressional Budget Office of 20+ million of the newly insured that would result from replacement legislation, along with the concerns of Republican governors and other state officials about the loss of the added Medicaid dollars that had been associated with the ACA, made “repeal and replace” politically untenable. Recent polling has also shown surprisingly strong support for Medicaid: 74% of the public holds a favorable view of Medicaid, including 37% who say they hold a “very favorable” view. A total of 61% say the program is working well for most low-income people and an even higher number—67%—say the program is working well for most low-income people in their state.¹ Another poll from 2015 found that two-thirds (64%) of Americans reported a connection at some point in their lives to Medicaid and a vast majority (87%) are against spending cuts to the program.²

The strong general support for Medicaid doesn’t mean that the public doesn’t recognize the need or desirability for some changes to the financing or structure of Medicaid. The same survey indicated that the public is very supportive for some changes—such as requiring states to impose work requirements for Medicaid beneficiaries (70% support) or requiring drug testing (64%). However, it is less supportive of other changes—such as reducing federal funding for the Medicaid expansion (35%) or for changing the funding to limit how much states get each year (35%).

There are some changes to the Medicaid program that may be easier to convince the public would improve the program than changing the

structure or financing. For example, Medicaid could begin requiring outcome metrics be provided by the states rather than focusing exclusively on process and procedural assurances. Most areas of coverage, such as Medicare or private-sector insurance, are gradually moving away from an exclusive focus on inputs and process to one that takes account of “value”—that is, the outcomes associated with specific care interventions relative to their costs. Although there continues to be more “talk than action,” with most payments to physicians still being made on the basis of fee-for-service reimbursement, increasing numbers of Medicare payments have at least some component in their payment that is related to “value.” The private sector is also focusing on outcomes and value-based payments to providers and sometimes the premiums or coinsurance payments charged for particular uses of care as well. Outcome metrics for Medicaid might include the incidence of low birth weight infants, the percent of deliveries that occur vaginally, immunization rates for two year olds, and so forth.

Another change to improve Medicaid that is likely to win public support is to have better coordination between Medicare and Medicaid for the small but very expensive population that is on both Medicare and Medicaid. Because the rules associated with Medicare and Medicaid differ substantially and the funding streams differ as well—all federal monies for Medicare versus a blend of federal and state monies for Medicaid—they have tended to operate as separate programs subject to separate reporting and process requirements. Providing for easier cooperation between the programs so that care could be more easily integrated could potentially improve the quality and reduce the costs of caring for this frail, elderly population. One challenge, aside from the different rules that govern each program, is that most of the savings will occur because of actions taken at the local level where care is provided but because of the way both programs are financed, most of the savings will accrue to the federal government. The federal government will need to share some of the savings that are produced as a result of local interventions or they are unlikely to happen.

There should also be an effort to reduce the administrative burden on states from Medicaid and to allow for more rapid innovation. While Medicaid is a highly flexible program through its use of waivers, getting a waiver request from the Centers for Medicare and Medicaid Services is an expensive and time-consuming process. Finding ways to expedite the waiver process would reduce the

cost and frustration states frequently experience when they try to innovate.

One past concern regarding Medicaid that has not been an issue thus far with the expansion states is the states' use of "creative financing" strategies to sharply reduce their share of Medicaid funding.³ In a 2014 report, the Government Accountability Office estimated that questionable state revenue represented 26% of the match funds. It hasn't been an issue with the expansion population because the federal government funded 100% of the costs of the expansion population from 2014 to 2016. That funding is now on a declining path to reach a 90% match by 2020. The interest in states finding ways to minimize their share of the Medicaid costs can be expected to increase as they are required to cover 10% of the costs of the expansion population, which for some states can be a sizable population. If there is an effort to move states to a single match rate representing a blend of the federal match rate for the base Medicaid population, which varies between 50% and 73%, and the 90% match for the expanded Medicaid population, that would provide an even greater incentive for states to find ways to reduce their share of the match.

One way to reduce the incentive for creative financing is a per capita cap. Not one that is designed to remove \$800-\$900 billion dollars from the program over a decade, as was proposed as part of the House American Health Care Act of 2017, but a program that keeps spending close to current predictions. Because the expansion and nonexpansion states currently receive such different amounts of federal Medicaid money with correspondingly different coverage rates, a baseline amount would have to allow for some adjustment to be made—either spreading the expansion funds across all 50 states or putting more federal money in. Another key issue, besides the baseline, is the rate of increase in funding that should occur. The rate of increase should approximate what an efficient state would need to spend (perhaps something between the consumer price index [CPI] and CPI-M, the medical CPI) and should be adjusted for the different populations covered under Medicaid—that is, the nondisabled population under age 65, the disabled population, and the dual eligible population.

Per capita caps got a bad reputation earlier in 2017 but it was the amount that was being removed from the program that should have been the focus of the public's ire—not the concept. Medicaid is now the only open-ended entitlement left in the federal government—at least

as long as IPAB (the Independent Payment Advisory Board) is on the books. It's time that Medicaid also changes.

References

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