Partnership for Medicaid

Recommendations to the National Commission on Fiscal Responsibility and Reform

October 20, 2010

The Partnership for Medicaid—a nonpartisan, nationwide coalition of organizations committed to the preservation and improvement of the Medicaid program—is pleased that President Obama appointed the National Commission on Fiscal Responsibility and Reform to investigate ways to improve our nation's fiscal situation and achieve long term fiscal sustainability. The Commission is charged with making specific recommendations to the President by December 1 to balance the budget by 2015. As advocates for health care providers, safety net health plans, counties and labor, we recognize the need to control deficit spending in order to protect future access to care for everyone in our country. To that end, we would like to help the Commission make constructive recommendations regarding the future of Medicaid.

While it is one of the federal government's largest programs, Medicaid has proven itself to be a cost-effective coverage option for low-income, vulnerable and special-needs populations. Despite disproportionately covering people with multiple chronic conditions, the Medicaid program boasts lower than average medical expenditures and lower overhead per person as compared to private coverage. The Affordable Care Act (ACA) builds upon Medicaid's vital role in the health care system by expanding the program to 16 million additional individuals at or below 133 percent of the federal poverty level by 2019. While the ACA expands Medicaid, providers will be squeezed by dual cuts to Medicare and Medicaid funding totaling more than $498 billion over ten years. The health care safety net is already stressed as state budgets continue to be cut. The low reimbursement rates that many state Medicaid programs pay providers (30 percent less than Medicare on average) reflect the already scarce resources available to states. An uncertain economic outlook which could wreak additional havoc with state budgets compounds this situation.

While Medicaid is a remarkably successful and durable program, it is not perfect. Members of the Partnership for Medicaid know firsthand that improvements must be made to streamline care and improve outcomes while lowering costs. In addition to expanding coverage, the ACA contains numerous delivery system reforms and other provisions that hold the potential to transform the delivery of health care in America while saving money in Medicaid and other federal programs. Congress and the administration should promote and invest in these delivery system improvements before additional cuts are suggested that could undermine the health care safety net.

The Partnership for Medicaid therefore offers two sets of recommendations: First, we recommend the Commission consider investing in and promoting a set of forward thinking options – many of which have their roots in the ACA – that hold the promise of improving Medicaid by lowering cost, ensuring access and promoting care quality. Second, we recommend the Commission bolster Medicaid's guarantee of access to care by maintaining eligibility, preserving covered benefits and strengthening provider payments.

Our specific recommendations are detailed below. These recommendations are not all unanimously endorsed by the undersigned, however, they offer multiple options for consideration by the Commission as you work to prepare your report.

Reducing Medicaid Cost Growth through Greater Integration, Coordination and Efficiency

Medicaid Payment Demonstrations – The Affordable Care Act authorized several demonstrations for state Medicaid agencies to innovate new models of accountable and value-based provider payments. Under the Accountable Care Organization (ACO) pilot program within Medicare and a similar pilot program for certain pediatric providers in Medicaid, the Secretary of the Department of Health and Human Services will be able to establish a shared savings program for certain groups of providers to be recognized as an ACO and share in cost savings above a certain threshold. This model will provide incentives to participating providers to become highly efficient and improve the quality of care they provide.

The Affordable Care Act also provides funding for states to create health homes for persons with chronic illnesses, which will allow state Medicaid programs to build on existing medical home programs developed to increase care coordination and manage high-risk beneficiaries. Furthermore, several programs focused on providing a medical home for children with complex conditions have shown that they can reduce health care costs while improving health outcomes. These programs, along with the demonstration for global and bundled payments, will allow states to establish innovative payment models without compromising care.

We urge the Commission to recommend that the Administration promote Medicaid Accountable Care Organizations. This could be accomplished through widespread use of Section 1115 waivers or by a legislative change allowing for Medicaid ACOs as part of state plans. Further, we urge the Commission to recommend that the Administration fully invest in the other payment demonstrations which show the promise of improving care quality and population health while limiting cost over time.

Care Coordination Initiatives – There is a growing consensus in the health care community that greater care coordination, particularly for vulnerable populations, not only increases care quality and access to care, but holds the promise of reducing health care costs. A recent study by the Milliman Research Report notes that the cost of failing to invest in care coordination for Mental Health/Substance Abuse patients alone may cost the system more than $300 billion annually.

The Community-Based Collaborative Care Networks (CCN) program, authorized by the ACA, provides the foundation for consortia of Medicaid providers throughout the country to effectively integrate and coordinate patient care to vulnerable populations. Many safety net providers and Medicaid health plans already strive to provide vulnerable patients with a full spectrum of high-quality, coordinated health care. Poor care coordination for people with chronic illnesses has contributed greatly to increases in overall health care spending in the past decade. Care coordination networks help reduce avoidable emergency room (ER) visits and uncompensated ER costs that jeopardize the financial viability of our health care system by providing their patients with a medical home.

Like CCNs, community-based health teams (CHTs) are improving patient outcomes and driving down health care costs in multiple states across the U.S. Congress recognized the positive impact of CHTs on health care spending when it included the concept in the ACA. CHTs leverage the patient-centered medical home model to support patient care teams, provide case management and streamline enrollment. The benefits of implementing the use of CHTs in the Medicaid program are only magnified when implemented in community-based collaborative care networks (CCN) settings.

These programs, and others like them, hold the promise of better coordination among Medicaid providers and a healthier Medicaid population. We urge the Commission to recommend that the President's budget fully invest in care coordination initiatives authorized by the ACA and that the Administration move swiftly to implement these programs.

Health Center Expansion – A longstanding example of the savings produced by utilizing care coordination is the decades-long record of federally-funded health centers. According to a recent analysis of Federal Medical Expenditure Panel Study (MEPS) data by the RCHN Community Health Foundation, health centers already save the national health care system $24 billion annually. Further, the analysis found that health centers save $1,262 per person through efficient delivery of needed care: health center patients have lower cost ambulatory care, less ER visits, and lower costs for inpatient stays when hospitalized than non-health center patients. As they expand to reach new populations, per the expansions in the Affordable Care Act, health centers will double the number of patients they serve, which will mean even greater savings to the system. A recent report by George Washington University indicated that the coming health center expansion could reduce health care costs nationwide by $122 billion between 2010 and 2015, including $55 billion in Medicaid savings, $32 billion of that attributable to federal Medicaid savings. Congress took a significant step towards expanding the health center model of care through the creation of the dedicated Health Center Fund. We urge the Commission to recommend that the President continue to support the Affordable Care Act's health center expansion.

Medicaid Managed Care – In addition to improving access to high quality health care for the underserved population, Medicaid managed care can provide significant savings in Medicaid to the states and the federal government. For decades, Medicaid health plans have provided predictable and controlled costs to state Medicaid programs through capitation and have experienced significantly lower payment error rates than fee-for-

service. Not every state has adopted Medicaid managed care, and there are several subpopulations of Medicaid beneficiaries who could benefit from the care coordination and case management provided by Medicaid health plans with proper consumer protections and adequate benefit structure. Effective Medicaid managed care plans should ensure choice of providers and access to appropriate specialists and provide adequate payments to providers. At the same time, one major impediment to the adoption of managed care is the potential loss of valuable supplemental payments for safety net providers, which under current law are tied to the fee-for-service payment system.

In a recent report from UnitedHealth Center for Health Reform and Modernization titled, *Coverage for Consumers, Savings for States: Options for Modernizing Medicaid*, the authors estimate that the federal government could save $57 billion over ten years from greater use of Medicaid coordinated care programs provided for both existing and expansion populations, with additional state savings of $36 billion. The report also concludes that the adoption of managed long-term care programs in Medicaid that substitute home and community-based care for care provided in nursing home settings could save an additional $140 billion over ten years. We urge the Commission to recommend that the Administration promote expanded Medicaid managed care as a cost-saving option and urge the creation of mechanisms to ensure that valuable supplemental payments for safety net providers are preserved in the context of Medicaid managed care.

Improved Coordination for Dual Eligibles – Among the most expensive of populations served by the Medicaid program are "dual eligibles" who receive benefits under the Medicaid and Medicare programs. According to a study by the Lewin Group in 2008, approximately 8 million Americans fall into this category and account for 40% of the nation's Medicaid spending and 25% of the nation's Medicare spending. The analysis from Lewin suggests that large-scale savings can be achieved in transitioning the dual eligible population into a fully integrated, capitated setting. Lewin found that the enrollment of dual eligibles into a capitation environment could generate a 15-year savings of more than $8 billion for Medicaid and more than $292 billion for Medicare, although savings would be less depending on the level of enrollment in the plans. We urge the Commission to recommend that the Administration pursue options to improve care coordination for the dual eligible population.

Pharmaceutical Savings Programs – Currently the 340B Drug Discount Program offers discounted outpatient pharmaceuticals to safety net providers that serve a disproportionate volume of uninsured and low-income patients. A full extension of the 340B program to the inpatient setting, i.e. allowing safety net providers, including mental health and substance abuse providers, to receive the same discounts for inpatient drugs as they do for outpatients drugs, will not only save safety net providers significant time and resources but will also save the federal government $1.2 billion over ten years through lower prices for Medicaid and Medicare drugs. We urge the Commission to recommend that the President work with Congress to extend 340B drug discounts to the inpatient setting of safety net hospitals.

Administrative Modernization – Updating antiquated information systems and streamlining administrative functions, while potentially carrying some nominal up-front

investments, would produce substantial long-term savings. The UnitedHealth paper mentioned above concludes that new technology and modern administrative processes could save the Medicaid program an additional $133 billion between 2011 and 2019. Medicaid data systems, which primarily focus on claims, should include information on quality and outcomes, allowing states to pursue initiatives like medical homes, ACOs, and pay-for-performance programs. Eliminating paper claims by requiring electronic data interchange for claims submission and payment would save $8 billion alone from 2011-2019 according to the UnitedHealth paper and would result in increased payment accuracy and quicker payment to providers. Electronic validation of claims prior to payment could end the "pay and chase" model of claims reconciliation without delaying payment. Enhanced coordination of benefits and data sharing between Medicaid and other government programs and private coverage would improve program integrity and reduce inappropriate payments. We urge the Commission to recommend that the Administration aggressively pursue administrative modernization in Medicaid.

Health Information Technology – The HITECH Act provides much-needed guidance and incentives for the adoption of electronic medical records by Medicaid providers, creating the infrastructure at the ground level that will be needed for interoperability across providers and programs. Making sure that safety net providers, including mental health and substance abuse and other public health providers, can access incentive funds and that the Medicaid program is fully integrated into health information exchanges is fundamental to the improved care delivery and outcomes envisioned in the broader effort. The UnitedHealth paper mentioned above estimates Medicaid savings of $22 billion from 2011-2019 from greater integration of Medicaid into Health Information Exchange efforts. We urge the Commission to recommend that the Administration continue to pursue incentives and policies for Medicaid providers and health plans to adopt advanced and interoperable health information technology.

Waste, Fraud and Abuse – The Affordable Care Act included many individual provisions that will identify, reduce, and discourage fraud in the Medicaid program. However, we believe more is needed to reduce waste, fraud, and abuse through a coordinated, systematic approach. Medicaid fraud and misuse of taxpayer dollars should not be tolerated. Efforts to combat fraud and abuse are often poorly coordinated, inconsistent, and not clearly communicated. The federal and state governments should coordinate efforts to combat fraud and bring more resources to monitoring and enforcement efforts to catch the crooks and bring them to justice. We urge the Commission to recommend that the Administration work diligently to reduce waste, fraud and abuse in Medicaid and that it be given necessary resources to do so.

Medical Liability Reform – The Congressional Budget Office in 2009 found that instituting comprehensive tort reform – including caps on non-economic and punitive damages, a statute of limitations, and joint-and-several liability – would reduce federal health care spending by about $41 billion over 10 years (in addition to $13 billion in additional tax revenues, for a $54 billion reduction in the deficit over 10 years). Beyond these cost implications, our system of medical malpractice has consequences for both patients and providers. A study in the Journal of the American Medical Association found that 42% of surveyed physicians in high-liability specialties restricted their

practices, including eliminating procedures prone to complications, such as trauma surgery. They also avoided patients who had complex medical problems or were viewed as litigious. Earlier this year, the Agency for Healthcare Research and Quality began funding seven state Medical Liability Reform and Patient Safety Demonstration Grants, with the twin goals of improving patient safety and reducing both medical errors and lawsuits. We urge the Commission to recommend that the President continue to investigate opportunities for medical liability reform that hold the promise of restraining cost while improving patient safety.

Preserve the Federal Guarantee of Medicaid Coverage and Access

The Partnership for Medicaid strongly urges the Commission to reject any potential cost-saving proposals that would undermine the health care safety net. We urge the Commission to:

Maintain Medicaid Eligibility Levels – Today, roughly 18 percent of the U.S. population is living in poverty. For a family of four with an income of approximately $22,000 a year (the federal poverty level) the option to pay as much as $10,000 a year for health insurance coverage is unrealistic. The Medicaid program is designed to help these vulnerable low-income populations. Limiting eligibility would seriously impede the ability of vulnerable, low-income Americans to access care before they become ill or their health problems escalate, causing greater utilization of care in higher-cost settings such as emergency departments. We urge the Commission to recommend that the President work to maintain Medicaid eligibility levels and retain the Medicaid coverage expansion included in the Affordable Care Act.

Preserve Covered Benefits – Medicaid is a unique program that provides coverage to many different populations with very different needs. Because of the different needs of the populations served, and their financial ability to access care, Medicaid's covered benefits are often different from the services covered by private insurance, especially for persons with chronic disabilities, including mental illnesses, and for children who are guaranteed to receive all medically necessary services. Eliminating certain covered benefits would reduce the availability of services for vulnerable populations; thereby threatening access to habilitative and preventive care that enables individuals to be productive members of society. We urge the Commission to recommend that the President work with Congress to preserve all benefits covered by the Medicaid program.

Strengthen Medicaid Provider Payments –Medicaid payment rates vary greatly from state-to-state. However, on average Medicaid only pays hospitals 89 cents to the dollar. In 2008, Medicaid hospital underpayments rose to $10.4 billion—an increase of nearly $8 billion since 2000. For physicians, Medicaid only reimburses on average 72 percent of the amount paid by Medicare for services. Medicaid payment shortfalls are even greater when compared to private insurance. As a result, many providers choose not to participate in the program. Lack of provider participation makes access to care difficult for beneficiaries and will present additional challenges under the Affordable Care Act's Medicaid expansion.

Although federal law requires health plans to be paid actuarially-sound rates, a recent GAO study questions the level to which states are actually complying with these requirements. Safety net providers strive to improve access to the full continuum of care for Medicaid patients but even these providers struggle to offer certain specialty services to their low-income Medicaid patients—for the provision of which they receive minimal reimbursement. If further cuts are made to provider payment rates, even fewer providers will continue to participate in the Medicaid program and millions of newly insured individuals will be unable to actually access care. We are pleased that Congress has authorized and funded the Medicaid and CHIP Payment and Access Commission (MACPAC) which will investigate and provide recommendations regarding Medicaid payment practices based on their effect on access to care. We urge the Commission to recommend that the President work with Congress to strengthen Medicaid provider payments.

Avoid Further Reductions in Disproportionate Share Hospital (DSH) Funding – In an effort to help pay for the cost of the coverage expansion, the ACA makes significant reductions to Medicaid DSH funding. By 2019, Medicaid DSH will be reduced by $14 billion. (Medicare DSH will decline by $22 billion.) Safety net hospitals currently rely on DSH funding to help cover the cost of caring for the uninsured; however, they also rely heavily on DSH funds to fill the gaps in payment for care provided to Medicaid beneficiaries. In addition to making up for the unreimbursed cost of care to Medicaid patients, DSH funds will continue to be necessary to pay for care to the 23 million remaining uninsured people in the country. This group includes those exempted from the individual mandate, the homeless and mentally ill and undocumented immigrants. We urge the Commission to recommend that the President and Congress take no action to further reduce Medicaid DSH funding and base further decisions about DSH funding on actual levels of uncompensated care once the Affordable Care Act's coverage expansion has taken place.

The Partnership for Medicaid appreciates the opportunity to engage with the Commission. We look forward to working with commissioners to discuss ways to make the Medicaid program more efficient while protecting our nation's most vulnerable people by ensuring access to high quality care.

AFL-CIO
Association for Community Affiliated Plans
Association of Clinicians for the Underserved
Medicaid Health Plans of America
National Association of Community Health Centers
National Association of Counties
National Association of Public Hospitals and Health Systems
National Council for Community Behavioral Healthcare
National Health Care for the Homeless Council