



April 13, 2011

A New Vision for Medicaid: Deploying the FLEX Strategy to Strengthen the Social Safety Net

*By Douglas Holtz-Eakin and Michael Ramlet**

Medicaid is broken. The program fails to deliver consistent, quality care to the neediest Americans and at the same time is bankrupting states and the federal government. Without comprehensive reform, the program will increasingly strain budgets, suffer financial collapse and fail in its role in the nation's social safety net. This paper lays out a new vision for Medicaid that strengthens the program through financial accountability, lean operations, ensured access and expanded state ownership (FLEX).

THE MEDICAID “FLEX” STRATEGY

Why is a reform strategy needed?

A reform strategy to strengthen the Medicaid program is a moral and fiscal imperative. Left unchanged, Medicaid will drain federal and state budgets, contribute to a growing national debt crisis, and fail as a social safety net for America's neediest citizens. States and the federal government have been operating without a strategic plan for Medicaid since the program's inception in 1966 with disastrous results.

Decades of short-sighted policy making has resulted in a program that fails its current participants and will not survive to the future. Its reimbursement and financing are riddled with loopholes and sweetheart deals. Consequently the current Medicaid program suffers from unsustainable reimbursement levels and inefficient program administration.

At its core the flawed federal-state matching formula has fueled runaway spending. Medicaid's current payment structure gives states a perverse incentive to spend with little incentive to save or innovate.

The FLEX Strategy

Medicaid reform is an imperative. Left unchanged, Medicaid will drain federal and state budgets, contribute to a growing national debt crisis, and fail as a social safety net for America's neediest citizens. To strengthen the Medicaid program, state and federal policymakers should deploy a long-term strategic plan that emphasizes:

Financial Accountability

- ✓ Federal block grants would put the program on budget and end the blank-check mentality
- ✓ State block grants would empower governors to make smarter investment decisions and encourage longer-term projects

Lean Operations

- ✓ Modernize Medicaid eligibility and enrollment systems with fraud detection technology
- ✓ Update payment systems to save money and support alternative payment models

Ensured Access to Care

- ✓ Leverage existing private insurance networks to improve access through managed Medicaid programs and commercial insurance
- ✓ Design state portals to offer Medicaid enrollees access to commercial insurance

Expanded State Ownership

- ✓ Implement long-term managed care
- ✓ Place dual eligibles in Medicaid managed care and extend the Medicaid drug rebate to dual eligibles enrolled in Medicare Part D

*Douglas Holtz-Eakin (dholtzeakin@americanactionforum.org) is President of the American Action Forum and Michael Ramlet (mramlet@americanactionforum.org) is Director of the Forum's Operation Healthcare Choice.

The federal government pays an average of 57 cents of every dollar spent on Medicaid.¹ Historically, this has led governors to recklessly expand Medicaid coverage during periods of economic growth, only to be forced to rapidly shrink the safety net during recessions when Americans need it the most. The lack of a sustainable long-term strategy for the Medicaid program was most recently apparent in June of 2010 when the federal government had to pass a \$26 billion emergency relief package to keep states solvent.²

Without a long-term reform strategy, the Medicaid program will accelerate the creation of a two-tiered hierarchy in the U.S. healthcare marketplace, with Medicaid participants trapped in a medical ghetto. As state and federal administrators look to control short-term costs and as providers increasingly refuse to serve Medicaid enrollees, the neediest Americans are at risk of being left behind in an increasingly expensive system for even the most basic medical care. Absent reform, Medicaid will not be able to deliver on its promise to provide a sturdy healthcare safety net for society's most vulnerable.

How does the FLEX strategy strengthen Medicaid for the long-term?

The FLEX strategy encompasses state and the federal government commitments to fiscal accountability, lean operations, ensured access, and expanded state ownership of the Medicaid program (FLEX). Together these guiding principles create the conditions for the type of Medicaid innovation that delivers higher quality and lower cost healthcare to the neediest Americans.

Adopting the FLEX strategy would establish a long-term commitment to improving the Medicaid program and put in place the type of aligned incentives for states that encourage savings and innovation through coordinated care delivery. This white paper outlines specific recommendations for states and the federal government to consider immediately.

Under the FLEX strategy, states will no longer face incentives to “game” the federal reimbursement system. Instead, they will be rewarded for new payment models and care delivery breakthroughs that foster higher quality, lower cost medicine. This state-led, bottom-up approach to reform marks a stark departure from the top-down, federal approach that has fueled spending and led to endless red tape.

How does the FLEX strategy address political opposition to Medicaid reform?

Political posturing by both parties has stood in the way of meaningful Medicaid reform for too long. Most recently this has taken the form of distorting the intentions and impacts of efforts by the nation's governors and the National Commission on Fiscal Responsibility to investigate the use of Medicaid block grants.

Critics of Medicaid reform measures, like block grants, often seek to vilify would-be reformers as intent on cutting services to the neediest Americans. Ironically, these attacks have at times been launched by the same policymakers who in other instances have recommended increased cost sharing for Medicaid enrollees and the elimination of voluntary Medicaid benefits.³ Ultimately, policymakers in both parties must recognize that the current menu of options for reforming Medicaid is too narrowly focused on limiting benefits, reducing reimbursement, and cutting enrollment.

The FLEX strategy addresses current political opposition to Medicaid reform by attempting to expand the toolbox for policymakers and shifting debate from contentious philosophical issues to proven management practices. By placing the Medicaid program on budget and increasing administrative autonomy, the FLEX strategy enables the American people to hold public leaders accountable for their management of the Medicaid program.

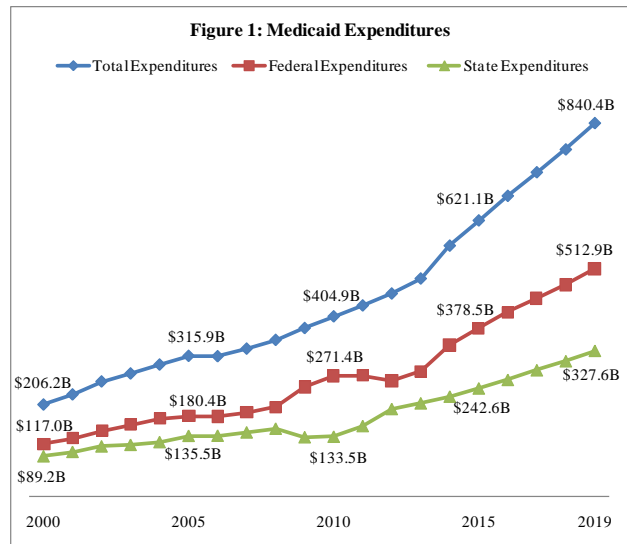
A clear, long-term strategic plan is needed for the Medicaid program. Through financial accountability, lean operations, ensured access, and expanded state ownership of the Medicaid program, the country can overcome political gridlock to strengthen the safety net for the most vulnerable citizens.

FINANCIAL ACCOUNTABILITY

Why is financial accountability important?

Medicaid is on a fiscally unsustainable path at both the state and federal level. This contributes to the nation's growing debt crisis, as well as threatening the continued existence of Medicaid itself. As shown in Figure 1:

- *Total Medicaid expenditures* for medical assistance and administration are expected to reach \$840.4 billion by FY 2019, increasing at a projected annual growth rate of 8.3 percent.⁴
- *Federal spending* on Medicaid is projected to reach \$512.9 billion by FY 2019, increasing at a projected annual growth rate of 7.3 percent.⁵
- *State spending* on Medicaid is projected to reach \$327.6 billion by FY 2019, increasing at a projected annual growth rate of 10.5 percent.⁶



How does a federal block-grant instill financial accountability?

Securing the Medicaid benefit by converting the federal share of Medicaid spending into a block grant would end the blank-check mentality in Congress and the executive branch. Members of Congress and the Administration would be forced to consider legislative and administrative actions that better align financial incentives for reducing fraud, streamlining program administration, and spurring care delivery innovation.

The FY 2012 House Budget Proposal passed by the House Budget Committee presents a viable option for structuring the federal block grant. Starting in 2013, the federal share of all Medicaid payments would be converted into block grants to be allocated to the states. The total dollar amount of the block grants would increase annually with population growth and with growth in the consumer price index (CPI-U). This proposal has been scored by the Congressional Budget Office as \$750 billion in savings over ten years compared to current federal Medicaid spending projections.⁷

By design, the block grant approach would make funding for Medicaid more predictable from a federal perspective, contributing to the long-term stabilization of the federal government's fiscal outlook and encouraging fiscal responsibility at the state level.

How can state block-grants incentivize savings and foster innovation?

States should benefit from negotiating Medicaid block-grants from the Federal government by gaining the financial incentives and regulatory autonomy necessary to carry out long-term Medicaid reform. The current federal waiver system is prohibitively time consuming and too costly for states to navigate. State

block-grants would empower governors to make smarter investment decisions and encourage longer-term projects that may have upfront-expenses but substantial future savings.

Rhode Island is a compelling example of how state block grants can infuse a sense of urgency into the Medicaid program. The state received approval in January of 2009 to operate the Rhode Island Medicaid program under an aggregate budget ceiling of \$12.075 billion through 2013.⁸ The approved Global Consumer Choice Compact Waiver established an expedited 45-day approval process for any changes to benefits or the Medicaid program; set new levels of care for determination of long-term care eligibility; allowed for benefits in any optional or mandatory program to be customized; placed a priority on preventative services; created a healthy choice account to reward healthy behavior; and implemented new purchasing strategies that focused on quality and competition.

The first 18 months of Rhode Island's global waiver have already yielded \$100 million in savings, without reducing Medicaid eligibility. The state projects that it will have saved \$146 million by June 2011 with an additional \$50 million gained through program integrity efforts and aggressively tracking fraud, waste, and abuse. Concurrent with the substantial savings, new expenditure growth in the Rhode Island Medicaid program has declined from over 8 percent to 3 percent in the past 18 months.⁹

Through state block grants, governors have the opportunity to build on Rhode Island's lead and begin to implement innovative Medicaid reform plans that address the short-term and long-term needs of their state.

LEAN OPERATIONS

Where can states and the federal government find immediate cost savings in the Medicaid program?

Medicaid program administration at the state and federal level is ripe for a cost-savings transformation. In 2009, the total administrative cost of operating the Medicaid program reached \$18.8 billion with the federal government contributing \$10.3 billion and states chipping in an additional \$8.5 billion.¹⁰

Currently, the cost of administering the program is only expected to grow. The Center for Medicare and Medicaid Services (CMS) estimates that the Patient Protection and Affordable Care Act (PPACA) will add \$26 billion in new administrative costs to Medicaid over the next decade, with \$14 billion to be paid by the Federal government and \$12 billion by states. By 2019, administration costs are expected to reach \$30.5 billion and continue growing at an annual rate of 5.2 percent.¹¹

This pace of administrative cost growth will prove unsustainable. Medicaid's improper payment rate is over 10 percent, more than three times the amount of waste that other federal agencies generate. This translates into an additional \$33 billion worth of annual expenses from poor program administration.¹²

How can states and the federal government achieve lean operations in the Medicaid program?

Modernize Medicaid Eligibility and Enrollment Systems – States should invest in improved technology and capabilities for determining Medicaid eligibility and tracking enrollment. PPACA's dramatic expansion of the Medicaid program in 2014 and the proposed launch of state health insurance exchanges will place substantial stress on administrative systems.

The structure of PPACA's insurance expansion creates a costly challenge for states to track individuals and families who are expected to move frequently throughout the year between Medicaid and the federally-subsidized state health insurance exchanges. The "churning" between Medicaid and state exchanges or other state insurance portals is estimated to impact more than 50 percent of all adults; this

includes 28 million Americans with family incomes below 200 percent of the federal poverty level.¹³ Accordingly, there will be a particular benefit to integrated systems that simultaneously track eligibility and enrollment in both programs.

Among the investments available to improve technological capabilities for determining Medicaid eligibility and tracking enrollment are:

- *Integrated Databases for Medicaid and State Portal Enrollment* – Combining enrollment data for both programs will reduce paperwork, staff overhead, and technology operating expenses.
- *Enrollment Data Management Systems* – Managing real-time enrollment data will inform better public policy decisions related to Medicaid benefit design and service delivery.
- *Predictive Modeling Analytics* – Adopting predictive modeling will allow states to identify high-cost beneficiaries and enroll them in aggressively managed, quality care programs.
- *Front-End Statistical Fraud Analysis* – Building statistical fraud analysis into eligibility and enrollment systems will empower states to better prevent and deter the estimated \$18.6 billion in annual improper Medicaid payments.¹⁴

Update Medicaid Payment Systems to Save Money and Innovate – States have the option to update payment systems to allow for electronic claims submission and processing. Electronic claims processing is essential for the entire healthcare system, McKinsey and Company estimates that more than half of the transactions between providers and payers, like Medicaid, are still paper-based. The current annual volume of 2.5 billion claims across the healthcare system leads to an estimated administrative waste of \$15 billion to \$20 billion per year in postage, item processing, and accounting.¹⁵

For state Medicaid programs, electronic processing is essential to efficiently and effectively capture an estimated \$18.6 billion in annual improper Medicaid payments.¹⁶ Using advanced statistical modeling fraud management programs can identify and investigate suspect electronic claims prior to Medicaid making a payment. This preemptive approach to combating fraud, waste and abuse is less invasive for medical providers, reduces staff overhead costs for states, and can better protect sensitive patient information.

In addition to the waste and fraud concerns, electronic claims processing will be required for any of the innovative healthcare payment reforms, like bundled payment and pay-for-performance. Governors and states interested in launching Medicaid provider pilots or encouraging state providers to pursue Accountable Care Organization designs should begin this initiative immediately.

ENSURED ACCESS TO CARE

Why is access a critical issue for the Medicaid program?

Medicaid coverage does not guarantee access to care. Increasingly individuals and families enrolled in the Medicaid program face barriers to receiving care from primary care physicians, specialists, behavioral health professionals, and other critical medical providers. The problem stems from fee-for-service (FFS) Medicaid reimbursements, which averaged only 72 percent of the rates paid by Medicare (Medicare rates are also well below the rates paid by private insurers).¹⁷ The unsustainably low reimbursement rate has led many primary physicians and specialists to stop accepting Medicaid enrollees. The problem is especially pronounced in rural areas where provider shortages present major public health concerns.

Unfortunately, the PPACA only exacerbates the access problem as Medicaid rolls are expected swell to more than 71 million beneficiaries in 2014.¹⁸ Left unaddressed, the negative impact will be felt

financially and from a public health perspective as Medicaid patients routinely receive lower quality care, delivered in the most costly care settings (emergency rooms, urgent care, etc):

- A June 2010 nationwide survey of physicians found that 54.5 percent of primary care physicians, 45.6 percent of medical specialists, and 49.3 percent of surgical specialists are no longer accepting new Medicaid patients.¹⁹
- In a separate 2010 survey of 1,800 emergency room physicians, 71 percent of respondents expect emergency visits to increase, and 47 percent anticipate conditions will worsen for patients.²⁰
- Increased overutilization of America's emergency departments by Medicaid enrollees could cost states, hospitals and physicians as much as \$35.8 billion over the next decade in unaccounted for expenditures.²¹

How can Medicaid ensure enrollees have access to care in the most appropriate care settings?

Medicaid must improve incentives for medical professionals to practice in underserved areas and to accept Medicaid enrollees. The best way to do this by leveraging existing private insurance networks through managed Medicaid programs and commercial insurance.

Expanding Medicaid managed care plans can mitigate access to care problems through in-network resources and the ability to negotiate differential rates by geographic area. In-network resources include both provider networks used by other lines of business, such as commercial insurance, as well as employed providers deployed in hard to serve areas.

Alternatively, states may seek to integrate Medicaid enrollees into state health insurance portals to improve provider access. Portals could be designed to offer Medicaid enrollees access to commercial insurance plans, which have more robust provider networks.

In either instance state policymakers would have additional policy options at their disposal to ensure Medicaid enrollees in their state have access to care in the most appropriate setting. The key is to empower states to innovate and learn from one another.

EXPANDED STATE OWNERSHIP

The key to welfare reform of the late 1990s was Congress's decision to grant states the ability to design their own systems. It is now time to grant states the same flexibility with regard to Medicaid. Improving long-term care management and care-coordination for dual-eligible populations stand out as two areas where expanded state ownership will lead to higher quality, lower cost medical care.

How can States improve long-term care management?

Reducing the anticipated budget costs for long-term care services will be critical to the overall sustainability of the Medicaid and Medicare programs. Medicaid has become the country's largest payer of long-term care services, funding approximately 50 percent of all long-term care spending and nearly two-thirds of all nursing home residents. Several policies could enhance the ability of Medicaid to prepare for the dramatic expansion of the long-term care market.²²

Medicaid would benefit from state administered managed long-term care programs that lower budget costs and allow more beneficiaries to stay at home. Traditionally, Medicaid pays doctors and nursing homes directly for individual services, but under long-term managed care, states could negotiate with health insurers a fixed monthly fee for each Medicaid patient. The fixed monthly fee includes all of the patient's costs, including physician and potential nursing home costs. Managed care companies would

then be responsible for using care coordinators to monitor patients to help ensure they receive the right care in the most appropriate setting.

Tennessee is an example where state administered managed long-term care addresses growing access concerns in the long-term care market. *USA Today* reports that in 2009, about 90 percent of Tennessee's Medicaid long-term care funding went to nursing homes, according to the state's Medicaid agency. As a result, there were long waiting lists for enrollees who wanted home and community-based services. But after Tennessee awarded managed long-term care contracts to three Medicaid health plans, those waiting lists shrank sharply.²³

Managed long-term care is growing more popular and should be encouraged by federal policymakers. Tennessee last year became the sixth state to require elderly and disabled beneficiaries to enroll in managed care plans. California plans to require its Medicaid long-term care enrollees to sign up for plans later this year. An additional 10 other states, including Florida, Maryland, New Jersey, and Rhode Island, are considering introducing or expanding the use of managed long-term care.

How can states improve care-coordination and reduce the cost of caring for dual-eligible populations?

Place dual eligibles in Medicaid managed care – Approximately nine million low-income seniors and disabled individuals are covered by both Medicaid and Medicare. The divided coverage for dual eligibles has led to poor coordination of care for this vulnerable population and higher costs to both federal and state governments. Giving Medicaid full responsibility for providing health coverage to dual eligibles and requiring that they be enrolled in managed care programs is likely to increase enrollee satisfaction as well as higher quality outcomes. Medicaid has a larger system of managed care than does Medicare and this would result in better care coordination and administrative simplicity. Medicare would continue to pay its share of the costs reimbursing Medicaid. Expanding state ownership in this area could save more than \$12 billion in the first 10 years.²⁴

Extend the Medicaid drug rebate to dual eligible in Part D – Additional savings could be gained from drug companies who are required to provide substantial rebates for prescription drugs purchased by Medicaid beneficiaries. By extending these rebates to Medicaid beneficiaries who are also eligible for Medicare and who receive prescription drug coverage through Medicare Part D, the federal government could save an additional \$49 billion over the next 10 years.²⁵

CONCLUSION

Medicaid is in dire need of a reform strategy. Left unchanged, it will contribute to a mounting federal debt crisis, endanger state budgets, deliver substandard care to current beneficiaries, and likely fail to endure as a safety net for future generations. Careful analysis of Medicaid suggests that a successful reform strategy should incorporate a commitment to financial accountability, lean operations, ensured access to care, and expanded state ownership of the Medicaid program. This FLEX strategy offers the opportunity for maintaining the social safety net with higher quality care and lower costs.



The American Action Forum is a forward-looking policy institute dedicated to keeping America strong, free and prosperous. The Forum produces real-time, fact-based, innovative policy analysis and solutions for policy makers and the public alike. Our mission is to promote common-sense, innovative and solutions-based policies that will reform government, challenge out-dated assumptions, and create a smaller, smarter government that will serve its citizens better.

Operation Healthcare Choice is the Forum's public policy center focused on promoting high-value healthcare and higher quality health insurance that expands consumer choice. Operation Healthcare Choice experts conduct research, offer commentary, and develop reforms that reduce the Patient Protection and Affordable Care Act's intrusion on private sector and individual freedom while eliminating its burden on the economy.

References

¹ Paul Ryan, "The Path to Prosperity," *House Committee on the Budget*, April 5, 2011

² Robinson E, "States of Crisis for 46 Governments Facing Greek-Style Deficits," *Bloomberg News*. June 25, 2010.

³ Secretary Kathleen Sebelius, "Medicaid Cost-Savings Opportunities," *Department of Health and Human Services*, February 3, 2011.

⁴ Office of the Actuary, "[2010 Actuarial Report on the Financial Outlook for Medicaid](#)," *Centers for Medicare and Medicaid Services*, December 21, 2010, Accessed on February 20, 2011.

⁵ Office of the Actuary, "[2010 Actuarial Report on the Financial Outlook for Medicaid](#)," *Centers for Medicare and Medicaid Services*, December 21, 2010, Accessed on February 20, 2011.

⁶ Office of the Actuary, "[2010 Actuarial Report on the Financial Outlook for Medicaid](#)," *Centers for Medicare and Medicaid Services*, December 21, 2010, Accessed on February 20, 2011.

⁷ Paul Ryan, "The Path to Prosperity," *House Committee on the Budget*, April 5, 2011

⁸ Grace-Marie Turner, "Rhode Island Global Consumer Choice Compact Medicaid Waiver: A National Model for Medicaid Reform," *Galen Institute*, December 2010.

⁹ Grace-Marie Turner, "Rhode Island Global Consumer Choice Compact Medicaid Waiver: A National Model for Medicaid Reform," *Galen Institute*, December 2010.

¹⁰ Adapted from Office of the Actuary, "2010 Actuarial Report on the Financial Outlook for Medicaid," *Centers for Medicare and Medicaid Services*, December 21, 2010, Accessed on February 20, 2011.

¹¹ Adapted from Office of the Actuary, "2010 Actuarial Report on the Financial Outlook for Medicaid," *Centers for Medicare and Medicaid Services*, December 21, 2010, Accessed on February 20, 2011.

¹² Paul Ryan, "The Path to Prosperity," *House Committee on the Budget*, April 5, 2011

-
- ¹³ Benjamin D. Sommers, Sara Rosenbaum, “Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges,” *Health Affairs*, February 2011.
- ¹⁴ Kay Daly, “Improper Payments: Progress Made But Challenges Remain in Estimating and Reducing Improper Payments,” *Government Accountability Office (GAO)*, April 22, 2009.
- ¹⁵ LeCuyer, Nick and Shubham Singhal, “Overhauling the U.S. Health Care Payment System,” *The McKinsey Quarterly*, June 2007.
- ¹⁶ Kay Daly, “Improper Payments: Progress Made But Challenges Remain in Estimating and Reducing Improper Payments,” *Government Accountability Office (GAO)*, April 22, 2009.
- ¹⁷ Zuckerman S, Williams A, Stockley K, “Trends in Medicaid Physician Fees, 2003-2008,” *Health Affairs*, 28, no.3 (2009).
- ¹⁸ Office of the Actuary, “[2010 Actuarial Report on the Financial Outlook for Medicaid](#),” *Centers for Medicare and Medicaid Services*, December 21, 2010, Accessed on February 20, 2011.
- ¹⁹ “Medicare/Medicaid Acceptance Trends Among Physicians,” *AmeriMed Consulting*, June 2010, at <http://amerimedconsulting.com/home/wp-content/uploads/press/pdf/AmeriMedTrendTracker-2010.pdf> (Accessed on February 20, 2011).
- ²⁰ “ER Docs Predict Jump in Emergency Room Visits,” *U.S. News and World Report*, May 17, 2010.
- ²¹ Douglas Holtz-Eakin and Michael Ramlet, “Healthcare Reform and Medicaid: Patient Access, Emergency Department Use, and Financial Implications for States and Hospitals,” *American Action Forum*, September 2010, available at http://americanactionforum.org/files/HCR_Medicaid.pdf (Accessed on February 20, 2011).
- ²² “[The Medicaid Commission Final Report and Recommendations](#),” *Bipartisan Commission on Medicaid Reform*, December 29, 2006
- ²³ Phil Galewitz, “States Turn to Private Insurance Companies for Managed Care,” *USA Today*, February 21, 2011.
- ²⁴ “The Moment of Truth,” *The National Commission on Fiscal Responsibility and Reform*. December 2010.
- ²⁵ “The Moment of Truth,” *The National Commission on Fiscal Responsibility and Reform*. December 2010.