Medicaid’s Visibility

Despite covering more than 60 million individuals at a combined state and federal cost of $420 billion in 2011, Medicaid remains poorly understood and appreciated by the general public and federal policymakers. It is truly the nation’s health care safety net, yet it remains in the shadow of Medicare for a variety of reasons, including the heterogeneity of its beneficiaries and the wide variation in program design from state to state.

Unlike Medicare, which is generally understood as a program for the elderly, Medicaid’s impact is truly “birth to earth.” Medicaid pays for more than 40 percent of all births in this country and for the majority of long-term services and supports. It is also the largest funding source for practically all expensive, specialty services such as HIV/AIDS treatment and mental/behavioral health. It covers the entire spectrum of children and adults with physical, developmental and intellectual disabilities. This makes Medicaid hard to simplify or categorize.

Also unlike Medicare, Medicaid’s program design can vary widely from state to state. Some state programs cover practically the entire population in capitated managed care arrangements, while others have almost no managed care. Some states have expanded coverage for residents with relatively high income levels, while in other states, working families can only be covered at miniscule income levels, and childless adults have no access to the program, regardless of income.

Challenges

Despite all the state variation, one common theme unites the directors: the desire to provide the best possible health care to their beneficiaries within the constraints of often crushing budgetary pressures. These two goals, of improving health care and reducing costs, often can be diametrically opposed, and this lies at the heart of the challenge of administering Medicaid today.

Medicaid directors face multiple challenges in administering the program. These can basically be categorized into short term, intermediate and long term. While general statements may apply to most states, there are always outliers and exceptions.

Short-term Challenges

In the short term, states are still struggling with the repercussions of the state revenue collapse that started in 2007. The past few years have seen states facing multiple consecutive budget windows in which 5, 10, 15, even as much as 25 percent reductions in spending are commonplace.

These budgetary challenges do not come with easy solutions. While the American Recovery and Reinvestment Act provided more than $100 billion in direct relief to beleaguered state Medicaid budgets, that funding is now gone. As a result, state spending on Medicaid is expected to increase by nearly 50 percent from 2010 to 2012, according to the Centers for Medicare & Medicaid Services actuaries.

The traditional tools states have used to weather budgetary challenges are poorly suited to deficits of this magnitude. Traditionally, states needing to make significant budgetary reductions in Medicaid have looked to cuts in eligibility, services and reimbursement rates, as reducing any of those three categories generally leads to less spending, at least in the short term.

Federal law, specifically the maintenance of effort provision contained in the Affordable Care Act, however, prohibits states from reducing eligibility levels or coverage in any way. While the merits of this restriction can be debated, it undeniably limits state options to reduce costs.
Similarly, as states look to reduce reimbursement rates as a means of achieving short-term Medicaid savings, they are challenged by the fact that Medicaid is the least generous payer for everything within the health care system. From prescription drugs and nursing home beds to hospitalizations and physicians, Medicaid's baseline rates are generally so low that significant savings are difficult to achieve from reducing reimbursement rates alone. For example, the average state's payment rate for primary care physicians is about 70 percent of the Medicare rate, which in turn is roughly 70 percent of what the private market pays.

Finally, there is limited ability to achieve significant savings through eliminating or reducing benefits. The so-called optional benefits within Medicaid can be categorized one of two ways: those that can be cut with little impact to beneficiary's health, such as podiatry, adult dental, vision or chiropractics, and those that simply cannot be cut without severely impacting the health care safety net, such as prescription drugs or long-term services and supports. Unfortunately, there’s simply not enough savings to be found in cutting the first category and cutting the second is generally unthinkable.

**Intermediate Challenges**

Unfortunately, at the same time that states are struggling to balance their budgets, they also are planning and preparing for the fundamental changes the Affordable Care Act will bring to Medicaid. While the law contains many components, the two primary impacts on states will be the largest expansion in the program’s history, scheduled to begin Jan. 1, 2014, and the fundamental overhaul of how Medicaid eligibility works and the resulting changes to the eligibility, claims process and information systems currently in place.

The expansion will bring an estimated 17 million individuals into Medicaid, on top of its current coverage and growth trends. While this newly eligible group will be 100 percent federally funded in the beginning, the state exposure to costs increases gradually over the next decade. The other key factor will be absorbing the so-called “woodwork effect,” as the 13 million adults and children currently eligible for Medicaid but not enrolled begin to show up in the system. The Affordable Care Act provides no enhanced federal match at all for this population, and depending on demographics, it could represent a cohort significantly sicker, and therefore more expensive, than the general expansion population.

Further complicating this effort will be the necessity to address the challenges of providing access to the newly insured population. Not only will Medicaid be facing huge increases in beneficiaries, but tens of millions of individuals will have newly subsidized private coverage through the insurance exchanges. Reimbursement rates will have to be sufficient to attract the appropriate levels of providers in both programs, but no amount of reimbursement will be able to summon providers from thin air where they currently do not exist.

Another near term challenge will be Congressional efforts to reduce the federal deficit by reforming entitlement programs. While it is clear that some form of Medicaid, Medicare and Social Security reform is necessary, Medicaid directors worry that such efforts could have unintended consequences. Medicaid directors are concerned that Congress may see the simplest approach to saving federal dollars is to shift costs to the states without addressing any of the underlying structural barriers to improving health care. Efforts to reduce or eliminate provider taxes or simply reduce every state’s federal matching rate could have the effect of eliminating tens or hundreds of billions of dollars from the system without reducing any of Medicaid’s current obligations or entitlements.

**Long-term Challenges**

The final challenge is one of sustainability. Regardless of the fate of state cost-containment efforts, federal deficit reduction efforts or the Affordable Care Act, the future of Medicaid rests on two separate trend lines: the expected growth in state revenues and the continued reliance of an aging nation on Medicaid for the entirety of its long-term care financing.

Aside from unpaid, informal caregiving and out-of-pocket expenses, Medicaid is by far the dominant funding source for the nation’s long-term care bills. As the population needing services grows—100,000 dual eligibles are added to the rolls every month, so too does Medicaid’s obligations. While states have made significant strides in rebalancing the system to include a whole spectrum of non-institutional care options, they also have succeeded in massively increasing the number of people served and reducing the sense of urgency for any other payer to step in and provide relief. This is unsustainable in the face of states’ historic capacity to finance the program.

Over the past 30 years, state revenues have grown on average by 6.5 percent per year, while Medicaid’s
growth has been about 7 percent. This slow growth has led to Medicaid’s taking almost 50 years to become close to 25 percent of the average state budget. Once the economy improves, however, reliable forecasts project Medicaid to grow at more than 7 percent, with state revenues stabilizing around 4.5 percent. The increasing disparity between the growth in state revenues and the growth in Medicaid enrollments poses the greatest threat to the program’s sustainability that we have ever seen.

Solutions
In the short term, cuts in program spending are inevitable. In the long term, however, fundamental program reform is equally inevitable. Medicaid directors are seizing the opportunity to turn the battleship of cost and quality in the U.S. health care system around. This will involve completely rethinking the delivery system and the incentives inherent in the fee-for-service payment model. The future of Medicaid is in managed care, although this will include a full spectrum of models, ranging from fully capitated for-profit managed care entities on one end to an in-house, managed fee-for-service model using health homes or medical homes on the other. But there is no question that the current incentives in the system which deliver quantity as opposed to quality must end.

While the Medicaid program, which is ultimately 56 different state and territorial programs, is perhaps not the ideal lever for fundamentally rethinking the entirety of the U.S. health care system, it is the lever we have and the one we will use. Most importantly, the state Medicaid budget crisis brings a sense of urgency to this issue that is significantly greater than that faced by any other payer or entity.

The National Association of Medicaid Directors’ goal is to help its members as they steer the nation’s largest health insurance program through difficult and uncertain times. While these obstacles seem insurmountable, it is our goal to help equip the directors with the tools and the support they need to mount sustained challenges to the challenges that lie ahead.

NAMD History
The National Association of Medicaid Directors is the only organization in the country that represents each of the 56 state and territorial Medicaid programs. The association was incorporated in January 2011 with the goal of giving the nation’s state Medicaid directors a stronger collective voice and a more robust platform from which to share best practices and help each state build a stronger Medicaid program.

While Medicaid directors have been working in states since the creation of the program in 1965, they were represented for decades by a larger umbrella group, the American Public Human Services Association. They shared equal billing with a variety of state social services agencies, such as Temporary Assistance for Needy Families, child welfare and Supplemental Nutrition Assistance Program or SNAP, formerly called food stamps. While state Medicaid directors had a home in that organization, few felt it was sufficiently focused on supporting them and their issues, thus the movement toward independence began to take shape.

The need for this change for the Medicaid program also was driven by several external factors, including its growing importance in political discussions at both the state and the federal level, its inexorable growth in terms of the number of people covered by the program and total expenditures, and the practical aspect of Medicaid’s movement away from being a welfare program in favor of a more mainstream health insurance program.

The executive committee laid the groundwork in the summer of 2010 to formally withdraw from the American Public Human Services Association and began the process of achieving independent status. The National Association of Medicaid Directors was formally created by January 2011 as a stand-alone 501(c)(3) and a formal affiliate of the National Governors Association.

Vision
The new association was created with the primary goal of creating a more powerful, effective organization to better serve its members. This is especially critical as states struggle through difficult budgetary times, prepare for the implementation of the Affordable Care Act and address other challenges to the program’s sustainability, both at the state and federal level.

The National Association of Medicaid Directors’ vision is to ensure the voices of all state Medicaid directors are being heard. Only then can the needs of all state Medicaid directors be met. This will require building consensus. While that may not be easy, it is necessary to effectively influence the development of federal legislation, as well as regulations and other forms of guidance from the administration.

But the association will not focus entirely on policy development or federal advocacy. In recog-
nizing that not every challenge can be resolved at the national or federal level, the association also will play a strong role in developing technical assistance and best practices to educate and inform all states. Medicaid is so large and complex that even veteran directors will be challenged by the multitude of reforms anticipated in the Affordable Care Act. The association aims to help all directors become more efficient and effective, utilizing tools such as timely analysis of federal developments, member-to-member networking and knowledge development, as well as issue briefs highlighting promising practices and lessons learned.

NAMD Structure

The association created a formal committee structure to help guide both its internal policymaking process and inform the best practices work. Every director is a member of one of four standing committees: Eligibility and Access, Health Information Technology and Systems, Care Management and Integration, and Delivery System and Payment Reform. These committees meet regularly and are not only the convening area for internal discussions key to the program’s future, but also the focal point for external conversations about Medicaid’s role in the broader health policy and political landscape.

The work of the four committees has been robust, producing comprehensive analysis and consensus comments on a number of key federal regulations on managed care, pharmaceutical pricing, and long-term services and supports, as well as working extensively with the Centers for Medicare & Medicaid Services to guide implementation of the Affordable Care Act, including the conversion to the new Medicaid eligibility rules and the interface with the health insurance exchanges.

The full membership convenes twice annually, at a spring state-only meeting and a fall conference that welcomed almost 850 attendees in its inaugural year. These events offer the members opportunities for robust peer-to-peer learning and sharing of best practices.

About the Author

Matt Salo was named executive director of the National Association of Medicaid Directors (NAMD) in February 2011. The newly formed association represents all 56 of the nation’s state and territorial Medicaid Directors, and provides them with a strong unified voice in national discussions as well as a locus for technical assistance and best practices.

Matt formerly spent 12 years at the National Governors Association, where he worked on the Governors’ health care and human services reform agendas, and spent the five years prior to that as a health policy analyst working for the state Medicaid directors as part of the American Public Human Services Association. Matt also spent two years as a substitute teacher in the public school system in Alexandria, Virginia, and holds a B.A. in Eastern Religious Studies from the University of Virginia.