



## **Medicaid at Fifty**

*Remarks given June 14, 2015 at the Academy Health Annual Research Meeting in Minneapolis, MN.*

“Where others celebrate a birthday, from a state lens this is more like the golden anniversary of a sometimes rocky but nonetheless longstanding marriage between the state and federal governments. It wasn’t a shotgun wedding – states accepted the proposal, although the dowry was mighty tempting! But there was not a long courtship and certainly no prenup. No time or opportunity to discuss how to pool the money and who’d pay for what; no time to talk through how big the family would be and, of course, no discussion about who would care for their parents as they aged.

But Medicaid was always there even as the family grew and changed. When the AIDS epidemic hit and private insurers were imposing benefit limits and refusing coverage, Medicaid was there. When Medicare requires persons with disabilities to wait two years for coverage, Medicaid stepped in; Medicaid catches those who spend down on care and have no place to turn, helps schools pay for services to children with special needs and has long been the major payer of long term care services.

But like any long marriage, there have been ups and downs, good times and bad. And like the negotiations in any marriage, the Medicaid pendulum swings between more state initiative and more federal control, between different political and policy philosophies.

Today, observing the choices states make regarding Medicaid expansion, many note the swing in states to more conservative control. Today, 31 Governors are Republican, and 30 Legislatures are controlled by Republicans. It’s true that in recent history there has been a more even split in state-level party control. But take a look at 1965, when Medicaid was enacted, then 33 Governors were Democrats, and 32 Legislatures were controlled by Democrats. Democrats had a slightly stronger hold in State capitols than Republicans enjoy today. History shows that party control is only one variable in the choices states make about Medicaid.

The questions of interest to policymakers change some as the political pendulum swings. To be sure, too often the plural of anecdote is policy – a challenge for researchers seeking evidence.

But it would be a mistake to draw too many conclusions based on the party in control. Many issues transcend party lines. Most Governors at some point raise concern over the cost growth of Medicaid. That concern only grows as the program does. Indeed some of the states whose leaders today most vocally oppose expansion and to establishing a state based exchange under the ACA, are participating in other ACA reforms. Fueled largely by CMMI funding, 33 states are now engaged in comprehensive reforms to restructure payment and delivery through SIM grants; eight are working with the safety net and the Delivery System Reform Initiative Program, eight are experimenting with financial incentives to Medicaid beneficiaries to test whether they can achieve behavioral changes and improve health and 12 are administering demonstration programs to better serve the dual eligibles. Of the 21 states that have not expanded Medicaid, 10 have embraced at least one of these ACA- related initiatives. And while states resist the rising costs of the program, 60percent of those costs are for spending on optional programs.

States are expanding their use of Medicaid managed care and covering more people with disabilities and nearly every state is engaged in medical homes, often the foundation for new ACO models. Community health workers, accountable communities and other new initiatives abound.

Interest in how best to coordinate health care, housing and social services has never been higher yet that challenges traditional Medicaid payment rules. What payment models work? What's the ROI of delivery system reforms? In this period of reform, Medicaid's role in a changing health care system invites researchers' inquiry. There are several questions that could benefit from your work.

### **1. Medicaid – Stepchild or Partner in a Multipayer family?**

The lines have begun to blur between public and commercial payers. As Medicaid has grown so has its use of managed care contracted to commercial health plans. Of the 29 states that expanded Medicaid, 6 did so with a private option. Using Medicaid funds to purchase private coverage and Montana will soon join their ranks. Sixteen state governments have created exchanges purchasing commercial insurance. The new Medicaid managed care regulations call for a closer alignment between public and commercial purchasers, alignment that is needed, as well, to address churning as ACA beneficiaries move among subsidy programs. Importantly, SIM grants are engaging multi-payers in moving from fee for service to value. In states like Connecticut and others, work is underway to create a single set of quality measures for all payers.

Conversely, on the commercial side too, lines are beginning to blur as the ACA reinforces the defined benefit in the individual market- an essential health benefit, no pre-existing condition exclusions, no lifetime limits. And while insurance mandates are anathema to the industry, 37

states now require coverage for autism, 34 for nutrition supplements, 20 for hearing aids, 18 for newborn screening. Sounds a bit more like Medicaid than products in the old non-group market.

State Medicaid programs are increasingly engaged in a multi payer world and considering, as the private option Medicaid expansions demonstrate, how certain Medicaid beneficiaries might be served in a commercial product. But many of the newly eligible may have disabilities. Can the nascent movement to change the offerings in the individual market move far enough to address those needs? Or might there be enhanced payments, buy-ins or wraparounds to assure Medicaid is there to fill those gaps? Could the 1332/super waiver option provide new opportunities?

## **2. Medicaid – Is it taking more than its fair share of the family budget?**

This, of course, is an old question with a new urgency.

In an era of Medicaid expansion –with more enrollment of those previously eligible but not enrolled, state budgets will feel the pinch. Even when states are only responsible for 10 percent of costs, those are real costs for states whose structural deficits endure and who have not fully recovered from the great recession. As of mid- June only 25 states had enacted budgets, caught up in debates about taxes, the ongoing and unresolved costs of public workers pensions, crumbling infrastructure, education and health care and yes Medicaid.

In this environment as Medicaid covers 1 in 3 children and 1/2 of all births, as expansion brings more low wage workers into the program, and with a growing population of aged and persons with disabilities states are increasingly major health care purchasers and need to do more than look at multi-payer payment reforms and new public-private options.

They need help in the challenges of health care costs. Even the most conservative states continue to support Medicaid for the most vulnerable yet it is precisely those populations who drive spending growth. For at least 30 years states have struggled with the costs of those dually eligible for Medicaid and Medicare and now a federal demonstration promises some movement. But for states, it's the spending on persons with disabilities that accounts for more state money that dual eligibles in Medicaid. Much work is underway on integrating behavioral health and primary care –will it work? Less attention is given to those with severe and persistent mental illness and those with intellectual and developmental disabilities (IAD)– what works, what strategies provide quality affordable care? Arkansas, for example, has plans to create a health home for IAD, will it work? As the nation's nursing home infrastructure ages and seniors seek even more alternatives for home and community based services what research will help inform state policy?

### **3. Do we need to renew the vows?**

After 50 years there's a lot to untangle and a lot of baggage. The complexity and variation of the populations Medicaid serves necessarily brings complexity to the system. And as states experiment and the federal government provides more funding to fuel those experiments, managing the program grows more challenging. It's fair to say the investment in Medicaid's infrastructure –its administration- has not kept pace with its growth. State elected officials are reluctant to grow the size of government. While they often do so willingly to tackle fraud and abuse, fueled by higher federal match, less attention has been given to what it takes to run a 21st century Medicaid program. The recent investments to streamline eligibility and improve IT systems are an important step but more needs doing. And as the challenges of managing the Medicaid program and its many waivers, contracts and population grows, the call for simplification grows too with many Governors again raising the clarion call for more flexibility. It's a double-edged sword – waivers provide flexibility but each brings its own set of requirements. Block grants, per capita caps and 1332 super waivers raise again old questions about how the program is best run. It's a marriage of financial co-dependency-one party needs the other -and as its costs continue to grow, we may need some marriage counseling to thoughtfully examine what works and doesn't and to think about Medicaid's future with new eyes. Step one to such a discussion is a clear definition of expectations – how can flexibility and accountability be balanced? What must every Medicaid program achieve and how will we measure its success? What evidence do we have to document what works? Can we find a new way to negotiate the budget and identify how to provide meaningful, transparent and consistent data about the program? States and the federal government addressing those big questions together, can strengthen, not destroy, the marriage, and sustain it for many years to come.”