

Cover Story

Medicaid reform time again

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Pa. Gov. Ed Rendell

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Pa.'s Medical Assistance program is in trouble again. Declining federal dollars, increasing health care costs, and growing enrollments – up by 100,000 Pennsylvanians in the coming year – are straining the program as never before.

Last year an unexpected boost, in the form of surplus funds from tax receipts, allowed the Pennsylvania General Assembly to restore about \$200 million of the original \$500 million in proposed cuts. This year, policymakers must again grapple with solutions to a looming Medicaid shortfall. The medical community and other stakeholder organizations believe that the state's current Medicaid program structure is unsustainable, that mere fiscal tinkering will not fix a broken system, and that major structural reform is required.

Reform proposals confront the issues of program sustainability, fairness and practicality, while their political viability remains an open question. Stakeholders' Medicaid reform proposals engage several facets of the problem, including:

- Shoring up Medicaid provider reimbursement.
- Increasing and reallocating program resources.
- Fundamentally restructuring the program.
- Containing its drug costs.
- Shoring up state coffers by reducing the number of uninsured.
- Slowing the accelerating costs of long-term care.

Spiraling Costs and Rolls

Since 1990, per capita Medical Assistance spending in Pennsylvania has increased 180 percent, the fifth largest increase in the country. Some \$4.5 billion in state funds, in conjunction with an additional \$10 billion in federal funds, currently cover the 1.85 million Pennsylvanians who receive some form of Medical Assistance – nearly 15 percent of the Commonwealth’s population, according to data compiled by the Pennsylvania Medical Society (PMS). The two fastest growing areas in the Commonwealth’s budget, compared to the 2002-03 fiscal year, are Medical Assistance for health care (enrollment up 21 percent) and Medical Assistance for long-term care (two-thirds of Pennsylvania’s nursing home residents receive Medical Assistance). Neither trend is about to reverse itself, as the demographics point to an increasing need for services, particularly among the state’s growing numbers of elderly. The state’s Medicaid enrollment is expected to grow another by 21 percent by 2015, according to a study cited by John G. Lovelace, Vice President, Medical Assistance Programs for UPMC Health Plan.

In his budget address on February 8, Governor Rendell restated his goals that no one currently receiving Medicaid benefits would lose them, that services for children would be retained, and that service demand be met. The 2005-06 budget calls for expansions in eligibility for health coverage for

children, for senior prescription drug coverage, and for adults covered in the Adult Basic program. It proposes no other changes to the program's eligibility or benefit structure.

"There is no budget shortfall per se," said Jim Hardy, Acting Deputy Secretary for Medical Assistance Programs. "We were challenged in putting together the budget year because of the loss of federal funding."

In the face of last year's \$1.6 billion budget shortfall, the administration acknowledged the need to broaden the discussion about a system overhaul. The objective was to hear both short- and long-term solutions to balancing funding and services. The administration and Department of Public Welfare (DPW) recently launched a "Listening Tour," receiving testimony from stakeholder groups throughout the state – from physicians to hospitals to consumers – on proposals for long-term changes that would put the program on firmer financial footing.

Stakeholders believe that sustainable solutions must look beyond annual budget pronouncements. "The challenges confronting Medicaid cannot be separated from the challenges of meeting the needs of the uninsured, addressing the health needs of an aging population, and finding ways to constrain overall health care costs," said Carolyn F. Scanlan, President and CEO of the Hospital & Healthcare Association of Pennsylvania (HAP).

Shoring Up Provider Reimbursement

Provider groups have long maintained that public health insurance fails to reimburse the cost of care adequately, and thereby erodes the system's ability to sustain delivery of that care. When Medicaid or any public program pays less than 100 percent of the cost of care, that unreimbursed cost is passed along as higher prices for commercial insurers and others, which ultimately results in higher premiums for employers and individuals – a "back-door tax."

The debate needs to reveal what the general

population is paying to cover the uninsured and underinsured, including those receiving Medicaid, said Scanlan. A Lewin Group study commissioned by HAP last June reported that Medicaid currently pays 85.7 percent of the actual cost of inpatient care and 54 percent for outpatient care, while the PMS said that Pa.'s Medicaid pay rate for physicians ranks between 43rd and 47th in the nation, and reimbursement for office visits hasn't risen since the 1980s. The Pennsylvania Health Care Association states that nursing homes relying solely on Medicaid reimbursement are losing five cents on every dollar.

HAP complains that the proposed budget not only reduces state hospital reimbursements by \$68.8 million (medical education, community access fund, and "supplemental" payments), but the lost federal matching dollars push the total to nearly \$150 million.

"Last year the Administration targeted Medicaid cuts in the proposed budget, but the legislature ultimately restored most of those cuts after the public and elected officials successfully demonstrated the negative impact of those cuts on patients and the economy," Scanlan said. "HAP offered a number of longer-term approaches to help get Medicaid program costs under control. I am disappointed that we are 'back to the future,' cutting hospitals that provide health care for the vulnerable, when more viable approaches should be explored."

Hardy counters, "We are increasing hospital rates, nursing home rates and Medicaid managed care rates by four percent. We are eliminating two supplemental payment programs for hospitals and reducing supplemental inpatient disproportionate share payments by 50 percent. We believe as we expand coverage to previously uninsured consumers through the CHIP and Adult Basic program there is a reduced need for these payments. The changes to the DRG system are cost neutral. We are also re-vamping another supplemental payment pool for hospitals that see a disproportionate share of Medicaid and uninsured consumers in an outpatient setting to insure that the money goes to the hospitals that need it the

most. The change to this pool will not result in decreased funding levels."

Increasing and Reallocating Resources

Stakeholders raise four possible ways of increasing the dollars going into the state's beleaguered Medicaid program: create new revenue streams or find untapped ones in the state budget to apply to Medicaid, streamline state bureaucratic processes, draw additional federal dollars to state programs, and fundamentally restructure the way the Medicaid program's care is paid for.

Governor Rendell claims that the Pa. Department of Public Welfare (DPW) saved \$16 million last year by more effectively identifying and collecting reimbursement for health care costs owed from private insurance companies. An additional \$8 million in savings resulted from the identification and denial of fraudulent claims submitted to the Medical Assistance program. In 2006-07, the governor is calling for more aggressive efforts to reduce waste, fraud and abuse, calling specifically for an additional \$5.5 million by ensuring that other insurers pay for the health care costs of Medical Assistance recipients when they have an obligation to do so, i.e., employers who hire people on Medical Assistance must provide them insurance as they would other new employees, rather just let Medicaid continue to pick up the tab.

In terms of creating new state revenue, PMS, HAP, the Medical Assistance Advisory Committee (MAAC), and UPMC *for You*, Inc. – a not-for-profit Medicaid managed care organization – all call for initiating a tax on chewing tobacco and raising taxes on other tobacco products. Some call for additional taxes on alcohol and "junk" food as well.

Several organizations see streamlining bureaucratic processes as an area for potential savings. UPMC *For You* calls for coordinating overlapping health and social welfare programs like Head Start and mental health/mental retardation programs, re-examining eligibility criteria and removing non-qualified people from the rolls, and improving the accuracy of contact

information collected at the County Assistance Offices so that enrollees are easier to find. HAP calls for evaluating the regulatory structure to eliminate unnecessary mandates and duplicative reporting, and to reduce the administrative burden of managing the program. The MAAC calls for an expansion of the Department of Public Welfare's (DPW) efforts to obtain Medicare payment for services wrongly denied by Medicare but paid for by Medical Assistance, according to Yvette Long, a member of the MAAC and its consumer subcommittee.

Attracting new federal dollars and aligning state and federal programs are cited by stakeholders as ways to stanch some of Medicaid's bleeding. The MAAC, for example, calls for using potential revenue enhancement from the Medicare Part D prescription drug program to shore up long-term care. HAP believes that Adult Basic might be administered in such a way as to enable federal financial participation. Maintaining assessments on the premiums for Medicaid managed care organizations would continue to draw federal money to the state.

Fundamental Restructuring Proposed

Two organizations, PMS and the seven-member Pennsylvania Coalition of Medical Assistance Managed Care Organizations, are advancing more fundamental changes to the way Medicaid is administered in Pennsylvania. PMS proposes a "defined contribution" plan, where recipients are given a specified dollar amount to apply to health care services, while the MCO coalition believes that their HealthChoices program, currently in effect in three areas of the state, ought to be expanded statewide.

The current Medical Assistance program in Pa. is a "defined benefit" plan, under which the federal government mandates 16 different kinds of service for all state Medical Assistance programs, such as inpatient and outpatient services, childhood vaccines, prenatal care, and rural health clinic services. Pa.'s offerings are more generous, with 26 categories of service available to all who are eligible – including 10

optional benefits such as prescription drugs, diagnostic services and eyeglasses.

By contrast, PMS's defined contribution overhaul to the reimbursement system aims to cover more people with more individualized services while keeping provider reimbursements fair, according to Dennis Olmstead, PMS chief economist and vice president of the Division of Practice, Economics and Payer Relations.

"Better management and coordination of patient care especially related to chronic diseases combined with patient incentives to decrease utilization should provide additional dollars in the system to pay providers a realistic payment amount," said Olmstead.

PMS's plan would give a consumer a predetermined amount of money to choose, with the help of a state-paid counselor, health benefits that best fit his or her need, while providers are selected based on the chosen plan, and plans compete on benefit packages and providers. The plan could then be phased in by patient population.

"The defined contribution plan is an attempt to limit the open-endedness of the current system where recipients can seek or receive as much care as they want," said Olmstead. "It would not limit access to care, but incentivize activities like healthier lifestyle, proper care for obesity and diabetes, and healthy decision-making."

The model for the program is the Federal Employee Health Benefit Plan (FEHBP) that provides health care coverage to federal employees, and PMS points to defined contribution demonstration programs in several states, such as one announced in Florida in January, in which Medical Assistance recipients select their own coverage and may earn enhanced benefits by demonstrating healthy lifestyle changes and preventive care. Or, the recipient could use Medical Assistance funds to purchase traditional employer-based insurance, similar to a plan already available in Pennsylvania, the Health Insurance Premium Payment Program, says Olmstead.

The defined contribution idea faces resistance because of potential confusion for consumers and providers, and because the concept would introduce benefit caps, varying by the plan selected, according to Robert I. Field, Ph.D., MPH, J.D., Director of the Health Policy Program, University of the Science, Philadelphia, and senior fellow of the Leonard Davis Institute of Medical Economics. Managing a pool of money and selecting appropriate care levels, even with the assistance of paid counselors, could prove difficult for consumers, many of whom are elderly, he said, adding that "The level of computer sophistication needed for the consumer choice program put forth by PMS makes it a problem logistically and politically."

"We need to wait and see what happens with the Florida pilot," said Scanlan. "We haven't supported defined contribution in part because of the potential cap on benefits, and what that might mean for catastrophic care. Secondly, phasing it in county-by-county may work well for physicians, but it is problematic for a hospital system. If a hospital serves seven or eight counties, it creates seven or eight different sets of Medicaid rules."

Olmstead says that the cap set by Florida will be exceeded only rarely, and that a "catastrophic overlay" at the upper limit ensures that nobody goes without care. He states that initial reports show the Florida experiment to be very popular with Medical Assistance recipients, including the elderly.

A less sweeping structural reform proposal is being pushed by Pa.'s Medicaid MCO coalition, composed of seven of the state's HealthChoices plans, which administer the mandatory capitated managed care program for Medical Assistance recipients.

HealthChoices is now mandatory in three zones: Southeast, Southwest, and Lehigh/Capital, while DPW cancelled a planned statewide expansion of HealthChoices in 2003, and in 2005 began phasing in a preferred provider alternative – ACCESS Plus – in the remaining 42 counties. The program links recipients with a primary care provider or clinic that

provides case management and coordinates their care.

The seven MCOs commissioned The Lewin Group to compare the HealthChoices and fee-for-service models, focusing on cost-effectiveness, impact on access, quality of services, and services for people with special needs. The report, released last May, stated that managed care organizations outperformed fee-for-service from a cost standpoint – holding cost increases to seven percent, versus ten percent in the fee-for-service model – while the report recommended expanding the full-risk capitation model statewide because of the efficiencies it could produce. Expanding HealthChoices statewide could produce more than \$100 million in savings, according to testimony delivered last Nov. by Daniel J. Hilferty, president and CEO of Keystone Mercy and AmeriHealth Mercy Health Plans, who noted that the Rendell administration stopped plans to expand HealthChoices statewide.

Interpretations differ as to whether and how much the MCO plans actually save. PMS is lukewarm about the concept, noting that mandated managed care initiated in the mid-nineties slowed utilization to some extent, but managed care plans' profits and administrative costs continued to increase and to take away funds from the actual delivery of health care services.

Containing Drug Costs

The debate about prescription drugs has shifted since last year, when the focus was on trimming benefits in the least painful way, with preferred drug lists, increased co-payments and the like.

This year a new idea is up for discussion: the new Medicare Part D Low-Income Subsidy Program, and how to allocate any savings that result.

Pennsylvanians of limited income who are 65 and older can receive assistance in paying for prescription drugs through the PACE and PACENET programs, funded by the lottery. The 2005-06 state budget assumes that 80,000 dual-eligible PACE recipients – those eligible for both Medicare and Medicaid –

would qualify for the federal program, resulting in cost savings of \$94 million to the lottery fund.

The state and many stakeholder organizations are encouraging people who are dual-eligible to apply for Part D. Recipients, they say, will not notice any difference in their coverage, but the federal government would presumably pay for something the state has thus far funded. And the state is looking for ways to include more people in Part D. Says the Governor's mid-year budget briefing, "The Rendell administration continues to work with the U.S. Department of Health and Human Services to determine how best to integrate the 210,000 remaining PACE/PACENET recipients into the standard Medicare Part D prescription drug program."

How those anticipated savings would be applied is another question, and the issue of prescription drug costs is a sensitive one.

Stakeholders like MAAC's Yvette Long and Alan G. Rosenbloom, president of the Pennsylvania Health Care Association (PHCA) – representing long-term care facilities – favor using the funds for long-term care, while others favor increasing provider reimbursements.

Rendell's proposed 2006-07 budget calls for creating a new benefit called PACE Plus Medicare, to cover the gap in Part D coverage known as the "donut hole." Annual drug purchases exceeding \$2,250 but less than \$5,100 are not covered by Part D, while PACE Plus would cover those costs for all low-income seniors. Said Governor Rendell in his budget address, "Our PACE Plus package is by far the most generous and comprehensive supplement to the federal program in the nation."

The scramble for how to spend the Part D windfall may be premature, though, as the federal government can figure out what the states would have paid and ask for reimbursement. "Under the so-called *clawback* provision, the federal government plans to charge the states for what it views as its portion of drug benefits for the dual-eligible," said Hardy.

"While it's true that in the past we paid for those drugs, we now have a new federal program [Part D] that is covering it. For the first time the states are being required to subsidize a federal benefit. Some states are considering litigating in federal court: we are watching closely."

Governor Rendell acknowledged in his budget address that Pennsylvania will be required to pay the federal government \$348 million in 2006 for Medicare Part D.

Reducing the Number of Uninsured

Most stakeholder organizations interviewed expressed concern about the rising number of uninsured in Pa., estimated at about 1.4 million of the state's 12 million people – about 133,000 of them children – and the financial drain to the health care delivery system of providing uncompensated, or *undercompensated* care. As public insurance is poised to expand in the state, the private insurance market is contracting, potentially nullifying overall cost gains.

Rendell's proposed 2006-07 budget calls for extending health insurance to cover an additional 15,000 uninsured children under a new Cover All Kids program, which would offer subsidized at-cost insurance to parents who meet income guidelines. The budget also calls for adding \$8.7 million in Community Health Reinvestment Funds to the Adult Basic program to cover 21 percent more low-income working adults than in 2005-06.

Reflecting a national trend, Pa.'s rate of employer-sponsored coverage is eroding. Between 2000 and 2004, employment-based health coverage declined from 63.6 percent to 59.8 percent nationally, in part because fewer employers offer coverage, while the larger factor has been employees electing not to participate in employer health plans because the costs are too high, according to Alwyn Cassil of the Center for Studying Health System Change, a health policy group in Washington, D.C.

Health care stakeholders watched with interest in

January as the Maryland legislature overrode the governor's veto of a bill requiring organizations with more than 10,000 employees to spend at least eight percent of their payroll on health benefits or contribute to the state's insurance fund for the needy. In Pennsylvania, a less sweeping version, HB 1460, now in the House Insurance Committee, seeks to enhance employer participation through increased employee health insurance or contribution to the Adult Basic program.

"We all share the responsibility for the uninsured," said Scanlan. "We need some equitable combination of employer coverage, government coverage and individual responsibility, and the debate needs to be about that."

"While the Maryland decision was symbolic more than real, it certainly focuses attention on the issue of employers who don't pay what's perceived as a fair share of health costs," said Field. "The larger issue may be with smaller companies – those who employ 50 people or less. All employers need an economical way and some incentive to insure their employees."

Containing Long-Term Care Costs

Stakeholders agree that any long-term Medicaid cost-control solution must address long-term care costs in a fundamental way. About 70 percent of Medical Assistance resources are used to care for the 37 percent of recipients who are elderly or disabled, according to PMS data.

Reducing costly nursing home occupancy is one approach being piloted in ten Pa. counties, in programs allowing eligible recipients to receive health care services at home or in the community. The number of Pennsylvanians receiving home and community-based long-term care has doubled in the past three years, from 12,000 to 25,000 people, according to a Lewin Group study, while Rendell's 2006-07 budget proposal calls for expansion of community-based care to an additional 2,800 people.

However, the hoped-for effect of reduced nursing

home admissions has not materialized. To the contrary, nursing home admissions have risen during the past three years from 53,000 to 55,000, and the acuity of residents' conditions has also increased, yet Medicaid reimbursements declined 1.6 percent last year, according to Rosenbloom. "With Pennsylvania nursing home occupancy at 91 percent, there's not a lot of excess capacity. In fact, there's substantial need," Rosenbloom added.

The problem will only intensify. The Lewin Group study estimates that the demand for long-term care will rise 17 percent from 2002 to 2015. According to U.S. census data, as Pa. ranks second in the nation in the percentage of residents over 65, a group currently comprising 16 percent of the state's population and expected to reach 21 percent by 2025. The fastest growing age group in the state comprises people 85 and older. That rapidly growing population of the very-old necessitates a hard look at how long-term care will be delivered in the future, either in a facility or in a home/community setting

Since 2000, nursing homes have been able to cross-subsidize Medicaid under-funding with Medicare dollars. Fears are that this "Medicare/Medicaid hydraulic" cannot be sustained, as current national legislation calls for a decrease in federal Medicare subsidies for nursing homes, while piggybacking state Medicaid cuts on top of that decrease could cause some nursing homes to close, said Rosenbloom.

"If we think long-term care expenditures by private entities and the government are high now, wait 15 years," said Scanlan. "Utilization by sheer numbers will drive expenditures even higher. We think taking long-term care as part of Medicaid in a stand-alone program may have some merit. But that must be done at federal level."

Another fiscal patch may be to tap the assets of elderly persons who are not poor, and the MAAC calls for rules to tighten transfer of assets for those seeking nursing home care through Medical Assistance. Says PMS' Olmstead, "Some of the increased costs are driven because the middle class

sees Medicaid as a way to allow the state to pay for long-term care." PMS also calls for tax incentives for employers and the healthy young to be able to buy long-term care insurance. Scanlan believes that a robust private market for long-term care insurance is probably a good partial-fix, and putting in some government incentives might encourage people to buy it.

Rosenbloom also sees long-term care insurance as only a partial fix. "The shift toward long-term care insurance will be slow going. To the young, it's an afterthought. To the old, it will be unaffordable to protect \$50,000 or \$100,000 in assets. It won't get far unless it's an employee benefit. But if you give a tax break to employers like you do with health insurance, it would become an enormous drain on tax revenues decades before it becomes a drain on the system."

Rendell's 2006-07 budget calls for "an extensive study of long-term living demand and supply over the next 20 years to understand how the long-term living industry should look in the future." Rosenbloom agrees that the real need is to look at programs that can make long term care services and nursing homes into a growth industry and integrate them into the larger community, making them attractive to investors and payers alike.

"At the end of the day, Medicaid is in the same boat as Medicare and Social Security," said Rosenbloom. "We are aging as a society too rapidly, given the way the programs are currently designed. Adjusting over a period of years may be potentially painful but not catastrophic. In long-term care, we have a time window to create the program of the future."