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Medicaid Block Grants and Medicaid Performance

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IP-2-2012
March 2012

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Executive Summary

Medicaid has expanded rapidly since its inception in 1965. Its financial structure, in which the federal government matches state spending, rewards Medicaid spending. The incentives are so dysfunctional that states have increased the cost of health care in order to increase the federal matching funds that they receive. The program is badly in need of structural reform that provides incentives to economize on the use of health care and to find new, and less costly, ways to deliver it.

An obvious reform is to block grant Medicaid funds to the states. With almost 60 million people enrolled, state expenditures on Medicaid have increased from 0.2 percent of total state tax revenues in 1966 to an estimated 21 percent in 2005. In FY 2010, Medicaid surpassed elementary and secondary education as the largest component of total state spending. ObamaCare will add at least 18 million people to Medicaid rolls. Without reform, some states will see Medicaid spending increase by as much as 50 percent in 10 years.

From 1974 to 1984, Medicaid eligibility was reserved for the truly sick who could not support themselves. In 1975, just 10 percent of the U.S. population was enrolled in Medicaid. By 2008, 19 percent of the U.S. population was enrolled in Medicaid. The program grew from financing 17 percent of births in 1985 to financing an estimated 40 percent of births in 2009.

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In the time since its passage, Medicaid's focus has shifted from providing care for those who were ill and destitute to providing coverage for essentially mothers and children. To the extent that Medicaid's shift in focus from caring for the vulnerable poor to covering the essentially healthy has contributed to a decline in the quality of Medicaid health care for those most dependent on it, block grant reform gives states the opportunity to refocus Medicaid spending on those most in need of help.

Whether Medicaid's massive coverage expansions have improved health or simply replaced private spending with public spending remains an open question. While the destitute with acute or chronic health conditions do appear to benefit from Medicaid, researchers have been unable to document health improvements resulting from the coverage expansions that occurred in the late 1980s and 1990s. There is some evidence that recent Medicaid/SCHIP expansions, and their focus on covering otherwise healthy children, have substituted public spending for private spending.

Block grants would also bring much needed change to Medicaid's dysfunctional spending culture. Medicaid's matching fund finance encourages state officials and local interest groups to divert state spending to health programs that maximize federal matching funds, often leading to suboptimal patterns of spending. The Aid to Families with Dependent Children entitlement program, which also depended on federal matching funds, had similar problems. In 1996 it was replaced with the Temporary Assistance for Needy Families block grants. Given a specific amount of money to spend, states no longer worried about maximizing matching funds. They used the more flexible block grants to concentrate on reorganizing their welfare programs to better suit the needs of those enrolled in them. New and innovative programs were developed, a million children moved out of poverty, and welfare caseloads fell by over 60 percent.

Medicaid's matching fund finance encourages state officials and local interest groups to divert state spending to health programs that maximize federal matching funds, often leading to suboptimal patterns of spending.

Antiquated federal Medicaid rules dictate that Medicaid recipients pay little or nothing for their health care with the result that they have little incentive to either economize on their use of health care or find less costly ways to receive it. If block grants encourage states to mimic successful private health care delivery reforms, and those reforms reduce spending on acute care by just 4 percent

per year, annual spending would fall by $9.5 billion. If a third of Medicaid recipients of home health care volunteered to participate in a consumer-directed program and spent just 10 percent less—a reasonable proposition given that pilot programs have produced savings of up to 20 percent—Medicaid expenditures could be reduced by another $2.5 billion a year.

Other possible benefits from eliminating matching fund finance include lowering the cost of uncovering Medicaid fraud, thus making policing Medicaid fraud more attractive to states, and removing a significant incentive for states to inflate the price of health care by imposing health care taxes that increase federal matching funds. Administrative cost savings are also possible.

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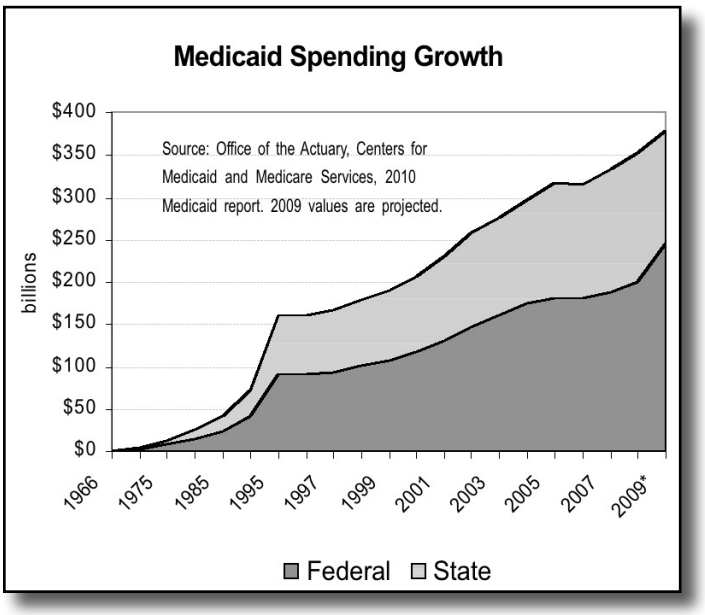
A number of Medicaid experiments suggest that there are specific program reforms that can both reduce expenditures and improve health. Consumer directed experiments suggest that cost falls and quality improves when Medicaid recipients can choose to hire their own personal care attendants. Indiana's POWER accounts seek to promote wise health care use by changing the incentives faced by people enrolled in public coverage. Rhode Island has developed a needs-based system to determine the safest and least restrictive care setting for people in need of long-term care with the result that it was able to eliminate waiting lists for long-term care and move 93 people from nursing homes to home care.

Introduction

Governments at all levels are facing severe fiscal stress, and Medicaid is the largest and fastest growing publicly-funded health program in the United States. State and federal authorities have had little success in controlling Medicaid expenditures with conventional reforms, and changing it from an entitlement program to a block grant program is now under discussion.

This Issue Paper explores how transforming Medicaid into a block grant program offers the promise of improving patient care and restraining the growth in program costs. It provides a brief overview of Medicaid, describes the dysfunctional incentives that have made the program fiscally unsustainable, and discusses the evidence suggesting that block grants could improve outcomes by changing those incentives. Specific Medicaid reforms that have simultaneously reduced state expenditures and improved health are highlighted.

Figure 1

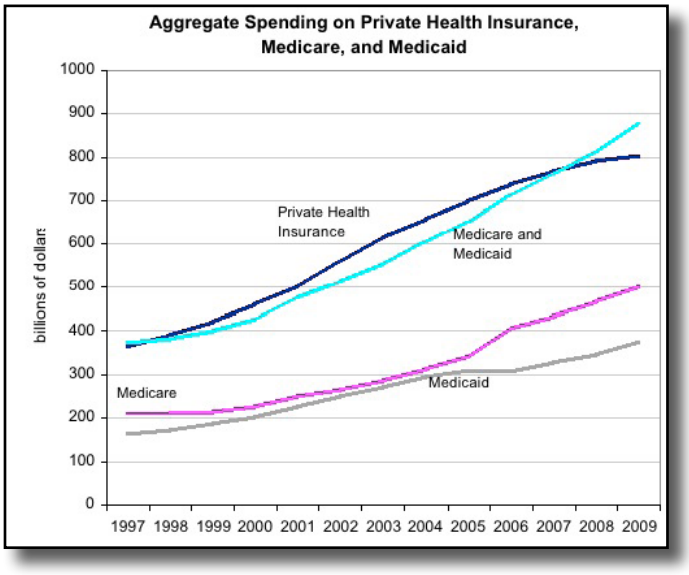


At present, Medicaid is an open-ended program in which the federal government matches all state spending on federally allowed Medicaid services. Federal Medicaid rules constrain state ability to reshape settled patterns of spending in line with local needs and medical progress. Matching fund financing vitiates both state and federal incentives to control expenditures. Each extra dollar in state

spending on local Medicaid services results in at least two dollars of revenue for the local health services sector. This creates numerous interest groups that favor increased Medicaid spending at the state level in the private sector, among non-profit groups, and in state bureaucracies. Funding Medicaid with matching funds increases political resistance to program change. As a result, Federal spending on Medicaid has risen rapidly. It was $271.4 billion in 2010, and is projected to be $512.9 billion by FY 2019.

Though federal authorities have allowed a laundry list of reforms seeking to limit Medicaid expenditure by centralizing decision making—including mandatory managed care, targeted expansions of primary care, various programs experimenting with different types of coordinated delivery mechanisms, preferred drug lists, disease management, and the diversion of the mentally ill to monopoly mental health providers—they have approved far fewer reforms seeking to engage beneficiaries in the management of their own health care.

FIGURE 2



This shortcoming is unfortunate, as private sector experiments with novel insurance plan designs and decentralized consumer driven health care have produced estimates suggesting that people with an incentive to manage their own health care can voluntarily reduce third party expenditures by 4 to 15 percent.

In 2009, Medicaid spent $237.9 billion on acute care. If copying successful private sector models reduced spending by just 4 percent per year, annual expenditures would fall by $9.5 billion. In 2008, Medicaid averaged about $8,440 per year on home health services for each of its 8,694,000 disabled recipients. If a third of the recipients volunteered to participate in some kind of consumer-directed home health program and spent just 10 percent less—a reasonable proposition given that pilot programs have produced savings of up to 20 percent—Medicaid expenditures could be reduced by $2.5 billion a year. Results from the RAND Health Insurance Experiment suggest that these estimates may be conservative. To those enrolled, Medicaid closely resembles RAND's free health care plan. The Experiment showed that free care produced per capita expenses 45 percent higher than the expenses generated by people on a plan with a 95 percent coinsurance rate up to a deductible equivalent to about $4,000 in 2011 dollars.[1]

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Changing Medicaid financing from matching funds to block grants would benefit the federal government by eliminating the incentive that encourages states to maximize health spending in order to capture Medicaid matching funds. It would benefit states by insulating them from federal efforts to condition the way that states deliver health care, and would allow them to efficiently deliver benefits by varying their health subsidy programs to fit the needs of those who depend upon them.

A Brief Overview of Medicaid

Originally designed in 1965 as a narrow categorical assistance program to pay for the medical expenses of people who could not work to support themselves, Medicaid covered the aged, the blind, and dependent children.[2] Before Medicaid, local government, charities, and community hospitals cared for the indigent with a variety of programs tailored to local circumstance.

On paper, Medicaid offered much broader health coverage. Patients paid nothing for services. In 1982, the maximum deductible was set at $2.00 per month per family. Copayments for services were limited to 5 percent of their price, with a maximum charge of $3.00. Many services and populations are exempt from any payment.

States that decided to join Medicaid agreed to pay for certain medical services for certain groups of people. In return, the federal government agreed to match at least 50 percent of state payments for Medicaid eligible services with federal funds. Federal matching funds were also made available for a variety of optional populations and services.

State Medicaid plans must cover seven specific groups of people. The groups are defined by various combinations of age, health condition, and income. States have the option to cover any combination of nine optional populations. There are 13 mandatory service categories that must be covered, and states have the option to add any combination of 17 optional services. Five of the optional service categories—prescription drugs, behavioral health services in some format, durable medical equipment, optometry, and home- and community-based services—are covered by all 50 states.[3]

States have some flexibility to determine eligibility, enrollment processes, the amount of services provided within specific service categories, provider payments, and how their State Children's Health Insurance Programs will integrate with their Medicaid plans. States can further vary their programs by applying for federal Medicaid waivers. The waivers allow states to use their Medicaid populations to test policy innovations, to limit individual provider choice for people enrolled in Medicaid, and to provide long-term care services in community settings.

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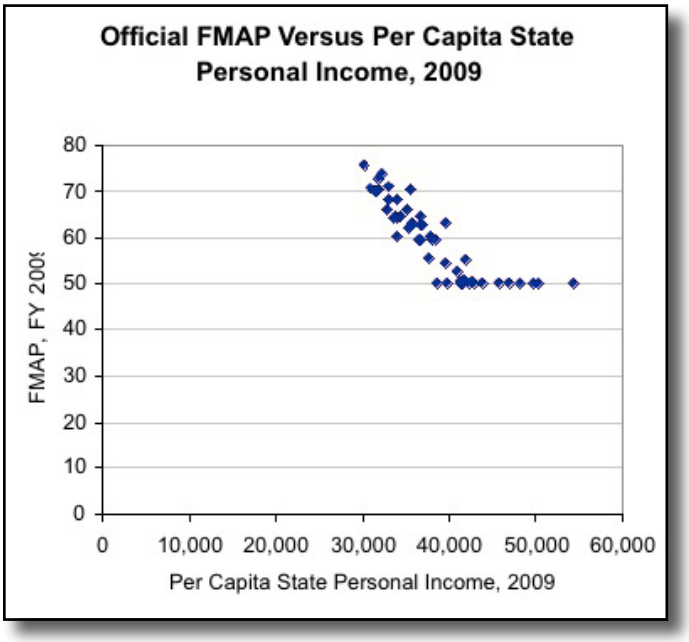
Waiver awards, state spending differences, and state choices of optional and mandatory populations and services combine to ensure that no two states have exactly the same Medicaid program. In 2001, Medicaid payments to a physician for performing an appendectomy ranged from $160 in New York to $799.87 in Nevada.[4] As of July 2007, maximum annual income Medicaid eligibility thresholds for a family of three with one working parent ranged from $3,360 in Louisiana to $47,232 in Minnesota.[5]

In theory, the federal government bears a higher fraction of the Medicaid burden in poorer states. In 2011, federal matching fund rates ranged from a minimum of 50 percent in higher income states to 74.73 percent in Mississippi.[6] The official formula for calculating federal Medicaid matching rates compares state personal incomes to average U.S. incomes. As Figure 3 shows, the theoretical federal Medicaid match declines with state per capita personal income, bottoming out at the minimum 50 percent.

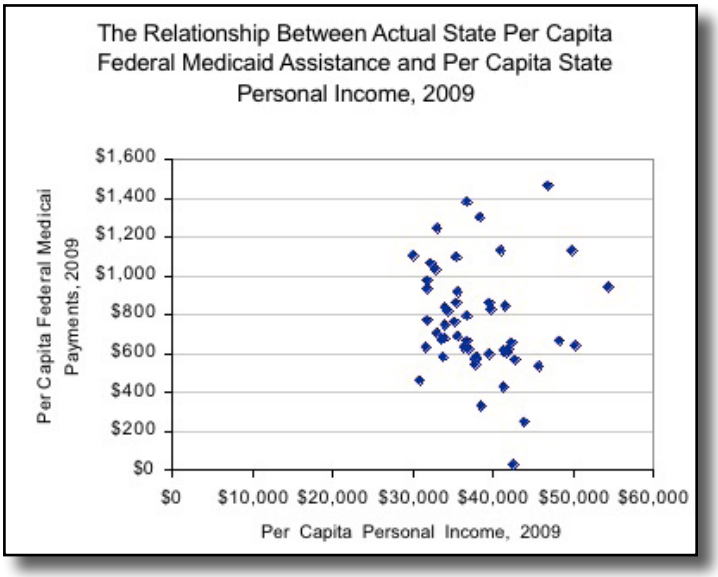
FIGURE 3



In practice, there is at best a tenuous relationship between state personal incomes and the size of the federal match. In 2007, Helms showed that matching funds create "a negative relationship between the per-capita amount of federal funds flowing to the states and the amount of poverty in the states—that is, as a general tendency, the poorer the state the less federal money that state receives."[7]

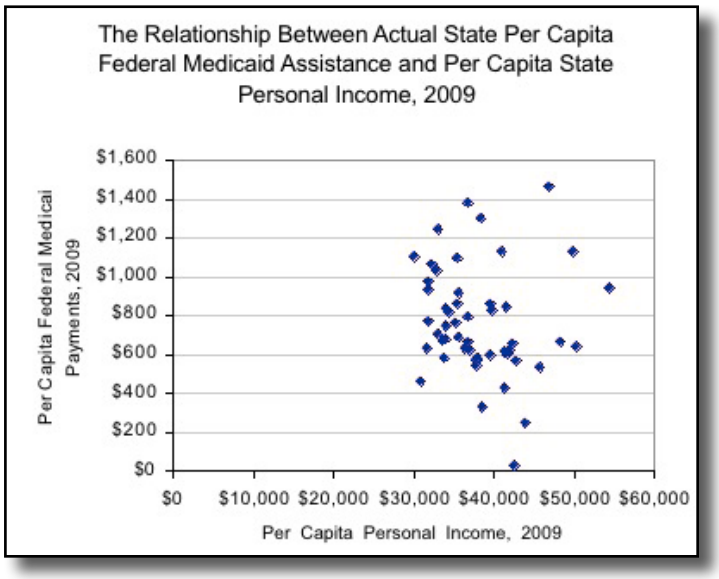
Not only can the wealthier states afford to spend more on Medicaid, the open-ended process of obligating the federal government to match what the state chooses to spend creates an incentive for states to increase Medicaid spending relative to all other priorities. When a state is forced to cut budget expenditures, the FMAP [federal medical assistance percentage] procedure gives the state an incentive not to cut matched expenditures relative to unmatched state expenditures. With a minimum matching rate of 50 percent, a state would have to cut total Medicaid expenditures by $2 in order to cut state expenditures by $1, thereby foregoing $1 in federal funds. This incentive results in a ratchet effect in state Medicaid budgets, since Medicaid expenditures tend to rise in times of plenty but are rarely reduced when states must cut back.[8]

FIGURE 4



Using 2009 data, Figure 4 shows that the relationship between actual per capita federal Medicaid payments and per capita state income remains tenuous at best. Figure 5 plots the difference between the official Medicaid matching percentage and the actual percentage of state Medicaid expenditure paid for by the federal government in 2009 as a function of state per capita personal income. In every case, the federal government pays for a larger fraction of state Medicaid programs than the official matching formula would suggest. Further, there is a very slight positive correlation between state per capita personal income and the percentage of a state's Medicaid program paid for by the federal government.

FIGURE 5



In FY 2010, the federal government paid 67 percent of total Medicaid costs. From October 1, 2008, to December 31, 2010, Congress increased the federal Medicaid matching percentage by 6.2 percent plus a factor reflecting state unemployment. States were not eligible for the increase if they responded to the recession by trimming Medicaid eligibility in any way. The increased match likely boosted Medicaid spending during the recession, reducing the estimated additional federal cost of the new health care law that required the federal government to pay 100 percent of the state cost of its mandated Medicaid expansions for the first five years.[9] Certain Medicaid health information technology programs also required by the Patient Protection and Affordable Care Act (PPACA) were awarded a 90 percent match.[10]

The PPACA will add at least 18 million people to the Medicaid rolls. Though the federal government will pay 100 percent of the cost of the new Medicaid enrollees mandated by the PPACA, it will not pay for new enrollees who were previously eligible for Medicaid, had not signed up, and may feel compelled to do so by PPACA's individual health insurance mandate.[11]

At present, Medicaid coverage is retroactive for several months and people often do not sign up until they need health care. In 2005, scholars estimated that roughly 25 percent of the uninsured, almost 11 million people, were eligible for public coverage but not enrolled.[12] If these people formally enroll as a result of the individual mandate, a leading Cato Institute economist estimates that some states could see Medicaid expenditures increase as much as 50 percent in 10 years.[13]

What Drives Medicaid Expenditures?

Factors that make Medicaid health spending rise more quickly than private sector spending include coverage expansions, administrative complexity, and dysfunctional incentives. After a general overview of Medicaid expenditure history, this section discusses each of those expenditure drivers in more detail.

Table 1

Real Per Capita Health Care Spending Growth in Medicare, Medicaid, and All Other Sectors.

	Medicaid	Medicare*	All Other	Total
1975 to 1990	5.4	5.4	4.8	5.1
1990 to 2005	3.8	3.3	3.1	3.4
1975 to 2005	4.6	4.4	4.1	4.2

* Estimates for Medicaid do not include 2005. Estimates are adjusted for growth in the number of beneficiaries in Medicaid and Medicare, for age composition in the case of Medicare, and for caseload composition (the proportion of beneficiaries who are children, elderly, or disabled) in Medicaid. [14]

As shown in Table 1 Medicaid expenditures have grown more rapidly than private sector expenditures. In inflation-adjusted dollars, total Medicaid spending increased by 247 percent between 1975 and 2008.[15] Spending has increased despite the fact that state Medicaid programs generally reimburse physicians at much lower rates than the private sector and receive preferential prescription drug pricing.

With almost 60 million people enrolled, Medicaid surpassed elementary and secondary education as the largest component of total state spending in FY 2010. State expenditures on Medicaid have increased from 0.2 percent of total state tax revenues in 1966 to an estimated 21 percent in 2005.[16]

About 64 percent of Medicaid funds are spent on the aged and disabled. The fraction spent on the aged has fallen, from about 36 percent of spending in 1975 to 21 percent of spending in 2008, as has the fraction of spending on adults, which fell from 36 percent of program spending to 21 percent. That decline has been offset an increase in the share of spending directed to the disabled, which grew from 26 to 43 percent of program costs, and children, who grew from 18 to 19 percent of program costs.

Spending on the disabled increased by 487 percent, spending on the aged grew by 100 percent, and spending on children grew by 274 percent. Changes in the spending totals are reflected in changes in the spending composition. Payments to nursing homes, which accounted for more than 76 percent of all Medicaid payments in 1975, are now roughly 59 percent of program expenditures. Inpatient hospital costs, which were 4.7 percent of expenditures in 1975, peaked at 12.4 percent in 1983 and fell to 3.1 percent in 2008.

Though states and the federal government often blame recessions and rising health care for rising Medicaid enrollment and expenditure, their impact is difficult to estimate. Even though unemployment grew from about 5 percent in 1973 to almost 11 percent in 1982, Medicaid enrollment was flat in the late 1970s and early 1980s. The tenuous connection between Medicaid enrollment and unemployment is unsurprising given that people who become unemployed are not necessarily eligible for Medicaid, that the unemployed are not necessarily newly uninsured, and that people who are newly uninsured may not apply for Medicaid if they do not immediately need health care.

Medicaid reimbursement rates are set by states and are often unresponsive to general medical care price increases.

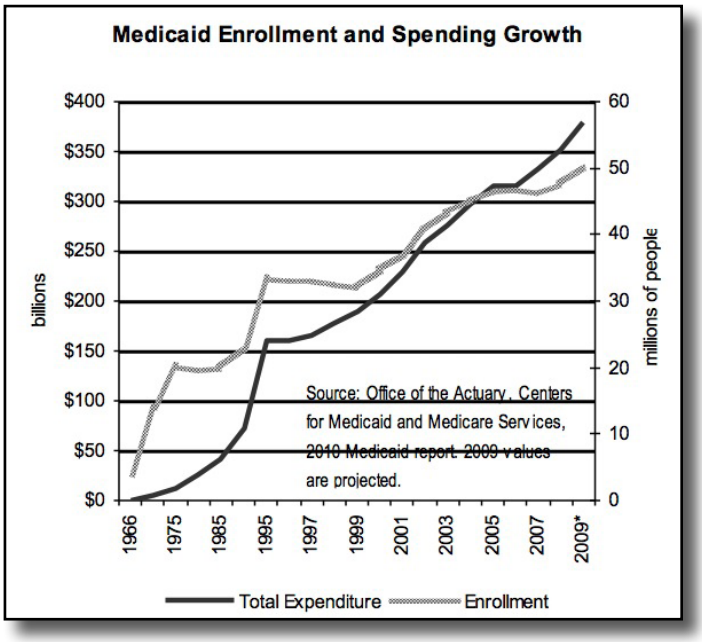
Medicaid reimbursement rates are set by states and are often unresponsive to general medical care price increases. Some Medicaid facilities are insulated from general health care cost drivers through special limits on malpractice awards, generous loans and grants, and membership in federal programs that provide significant discounts on medical products. Some facilities also receive cost-based

reimbursement that is set by federal law and is generally much more generous than that offered to other providers.

Coverage

In 1975, just 10 percent of the U.S. population was enrolled in Medicaid. By 2008, the figure was 19 percent. From 1974 to 1984, Medicaid eligibility was tied to the low income levels required for welfare assistance, and Medicaid enrollment was stable at roughly 20 million people.[17] Enrollment of people with higher incomes expanded rapidly after 1990, driven by what Sardell and Johnson (1998) describe as a period of "intense activity by a number of institutions and advocacy groups that were defining problems in the area of child health and advocating solutions to them."[18] Activists succeeded in shifting Medicaid's focus from providing chronic and acute care for the very poor to providing coverage for all.

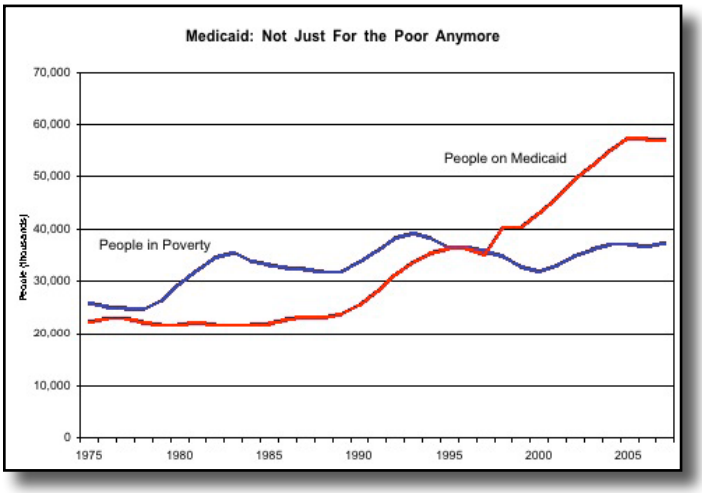
Figure 6



As successively higher income groups became eligible, Medicaid expanded rapidly. While the number of aged grew by about 532,000, the number of disabled grew by 6,230,000, the number of adults by 8,417,000, and the number of children by 18,473,000. In 2005, University of California researchers Gilmer, Kronick, and Rice estimated that almost all of the newly enrolled children came from families with incomes between 100 and 200 percent of the federal poverty level.[19]

Expressing Medicaid eligibility as a percentage of the federal poverty level obscures the expansion of Medicaid eligibility to the middle class. In 2009, an estimated 40 percent of U.S. families had incomes below about $48,000, roughly 262 percent of the federal poverty level. Because younger people tend to have lower incomes, higher income eligibility has significantly increased the proportion of U.S. births financed by the program. In 1985, Medicaid financed 17 percent of births. In 2009 it financed an estimated 40 percent.[20] In New York State, where the estimated median income was $56,000 in 2008, Medicaid covers healthy children from all families making less than 400 percent of the federal poverty level, or up to $73,240 for a family of three.[21] In many states, income verification is rudimentary.

Figure 7



Whether the coverage expansions have improved individual health or simply replaced private spending with public spending is an open question. The people covered by original Medicaid, the very poor with acute or chronic conditions, do appear to benefit from Medicaid coverage.[22] It is worth considering whether the higher income people added to its rolls actually benefit, and in fact may have previously paid for most of their own health care, because it raises the possibility that Medicaid rolls could be trimmed without harmful effects.

The campaign to provide coverage for pregnant women in the 1980s is the most intensively studied Medicaid expansion. Asserting that coverage would improve birth outcomes and child health by increasing prenatal care, advocates succeeded in

adding mandatory coverage for pregnant women with family incomes below 133 percent of the federal poverty level to the list of Medicaid benefits. Coverage for women up to 185 percent of the federal poverty level was added as an optional benefit.

Researchers have been unable to document significant health benefits from this expansion. Though a duo of Harvard scholars rated the campaign as "one of the most prominent health policy initiatives during the latter part of the 1980s and 1990s,"[23] they found little or no substantive improvement in birth outcomes in either California or South Carolina. The Urban Institute's Embry Howell reported that while expanding Medicaid for pregnant women to higher income groups expanded the amount of prenatal care received, the evidence that it improved birth outcomes was weak.[24] In a later review, a team of scholars concluded that the Medicaid expansions were associated with "very small and statistically insignificant changes in prenatal care use, birth weight, and incidence of low-birth weight."[25]

Even if expanding Medicaid coverage had clearly improved health, it is not clear that spending more to provide coverage for pregnant women was the best use for the money.

Even if expanding Medicaid coverage had clearly improved health, it is not clear that spending more to provide coverage for pregnant women was the best use for the money. Economists Helen Levy and David Meltzer note that more focused spending on things like setting up inner-city health clinics or expanding screening programs for hypertension might have provided more benefit.

Medicaid already substitutes for private long-term care insurance coverage for an estimated two-thirds of the income distribution.[26] A 1996 study found that people enrolled in the 1987 to 1992 eligibility expansion were much more likely to have had private insurance than people originally covered by the program, that the rise in Medicaid coverage over this period was "roughly commensurate with a decline in private insurance coverage," and that "increases in the eligibility of family medical spending for Medicaid coverage significantly lower the probability of worker insurance coverage."[27]

Medicaid reform efforts need to distinguish between the destitute and those with higher incomes and to consider that some segments of the population will never sign up for insurance plans and might be better off using services provided by public providers on an as needed basis. Given that Medicaid lacks the co-pays and deductibles that inhibit excessive use of medical services in private sector health insurance, and that it offers a more extensive array of benefits, coverage programs that merely substitute Medicaid for private insurance could end up increasing overall health expenditure.

Administrative Complexity

Medicaid is a categorical grant-in-aid program, one that provides a certain kind of aid to anyone who fits into a certain category. One major problem with categorical grants is that it is difficult or impossible to shift funds to a program that does work if the original plan fails to work as intended. A second major problem is that innovation has changed the way health care is delivered, and Medicaid's program design has often had a difficult time accommodating those changes. Because those who originally receive money for providing various services are almost certain to be opposed to having it taken from them, categorical programs often evolve by spawning new categorical programs designed to fix known deficiencies. This both keeps current recipients happy and corrects previous oversights. The problem is that the web of programs rapidly becomes costly, complex, ineffective, fragmented, difficult to evaluate, and resistant to change.

One major problem with categorical grants is that it is difficult or impossible to shift funds to a program that does work if the original plan fails to work as intended.

Categorical programs grafted onto Medicaid over the last 45 years range from the 1967 Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program to PACE, an optional Medicaid adult day-care program added in 1997. Each comes with its own rules, rights, obligations, and reporting requirements. Among other things, EPSDT has been used as a way to legally compel mental health screening to "increase Medicaid-financed

mental health."[28] As is so often the case, there is surprisingly little evidence demonstrating EPSDT's cost-effectiveness. PACE now serves about 0.03 percent of the Medicaid population.[29] In 2009, it was one of 10 federally-funded, managed long-term care programs for the elderly offered in New York State,[30] and each of the 10 programs has its own administrative requirements.

Decades later, considerable uncertainty remains about many of Medicaid's administrative innovations, including its encouragement of managed care. Duggan found that "the switch from fee-for-service to managed care [was] associated with a substantial increase in government spending" in California with no discernible improvement in health.[31] In 2006, the State of Colorado concluded that managed care increased rather than reduced its Medicaid expenditures. Many other centrally-managed, federally-sanctioned, expenditure control initiatives in disease management, prescription drug formularies, telemedicine, and nurse visiting programs have added to administrative costs while generating inconsistent results.

Medicaid's Dysfunctional Incentives

Medicaid's structure encourages exuberant spending in virtually every segment of the program. Its problems start with individuals, who pay almost nothing for their health care and have little incentive either to economize on their use of it or to seek less costly ways to receive it.

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At least some Medicaid adults use the emergency room because it is convenient and costs no more than a regular physician visit. Though total annual U.S. emergency department visits doubled between 1997 and 2007, visit rates for adults with private insurance, those covered by Medicare, and those without health insurance remained constant. Visit rates for uninsured and privately insured children fell while visit rates for Medicaid children remained constant and visit rates for adults with Medicaid coverage increased from 693.9 to 947.2 visits per 1000 enrollees, accounting for most of the increase.[32] When Oregon implemented $50 co-pays on emergency department visits under a Medicaid waiver in 2003, utilization rates fell 18 percent and visits leading to hospitalization fell 24 percent.[33]

Because they spend other people's money, individual Medicaid recipients have relatively little incentive to detect and deter fraud. Common problems include charging for medical, transportation, and home health care services that were never delivered, charging for a more expensive service or good than was delivered, using ambulance transportation when it is unnecessary, and charging twice for the same treatment. Experts estimate that abuse accounts for 10% of Medicaid spending.[34,35]

Medicaid's spending problems are exacerbated by its matching fund finance. States benefit from federal Medicaid money only if they spend it, reducing their incentive to spend wisely. Matching funds make state fraud control relatively more expensive. If a state anti-fraud program spends one dollar to reduce fraudulent Medicaid spending by two dollars, the net gain to the state from reducing fraud is one dollar. With a 50 percent match rate, the two dollar reduction in Medicaid spending means the state loses a dollar of the matching federal funding and its net gain is zero. The same is true of the federal government. Its successful anti-fraud Medicaid expenditures lose state matching funds for favored federal Medicaid initiatives.

States benefit from federal Medicaid money only if they spend it, reducing their incentive to spend wisely.

Matching fund finance also may affect state efforts to verify eligibility. In response to strong evidence that states were adding illegal aliens to their Medicaid rolls, the federal Deficit Reduction Act in February 2006 required states to demand proof of citizenship as a condition for Medicaid enrollment. In 2007, the number of non-disabled adults and children enrolled in Medicaid declined for the first time since 1996. Given the financial rewards for maximizing Medicaid enrollment, it was not surprising that groups serving Medicaid beneficiaries were strongly opposed to the new ID requirements.

Because groups intent on maximizing Medicaid funding have an incentive to overstate the health needs of a particular population, matching fund finance makes reliable information on a state's actual health needs much more difficult to obtain. Non-profits, local governments, and state executive departments may support suboptimal health programs simply because they maximize Medicaid matching funds.

At present, Medicaid coverage is retroactive for several months and people often do not sign up until they need health care.

As of February 2011, 46 states collected some kind of provider tax, fee, or assessment on physician, therapist, hospital, home health, imaging, managed care, prescription drug, and nursing home.[36] States also tax hospital beds, gross retail prescription sales, and health insurance claims. In at least one state, legislators sought to hide their behavior by making it illegal to list the tax on hospital bills.

Provider taxes increase the cost of health care faced by private citizens while increasing the flow of funds to state Medicaid programs. If a hospital bill costs $10,000, and the match rate is 50 percent, a state Medicaid program pays $10,000 to the hospital and collects $5,000 from the federal government. The net cost to the state of $5,000. If the state enacts a 5 percent provider tax on all hospital bills, it pays the hospital $10,500. It collects $5,250 from the federal government and $500 from the hospital for a net cost to the state of $4,250. If the state then promises to put part of the $750 gain into a slush fund used to subsidized favored hospitals or Medicaid clinics, the clinics and the hospital association will support the tax increase, even though the tax raises the cost of hospital care for sick people by 5 percent.

In Colorado, the provider tax on hospital bills transferred substantial amounts of money from the hospitals patronized by the privately insured to those owned by the state. Thanks to the provider tax, the University of Colorado Hospital enjoyed net new funds of almost $3.9 million. Denver Health Medical Center reaped an additional $17.9 million. In contrast, Douglas County's Sky Ridge Medical Center lost $2.8 million. Littleton and Porter Adventist Hospitals lost more than $2.4 million each.[37]

Medicaid's ability to command below-market pricing for pharmaceuticals has also raised health care costs. In some cases, state Medicaid programs have considerable market power because they purchase a large fraction of the total production of a particular drug. When this happens, drug manufacturers must raise their list prices in order to make up for the lost revenues created by Medicaid's below list pricing. For each 10 percent increase in Medicaid's market share, everyone else's average prescription price increases by 7 to 10 percent.[38]

As lower-income people tend to be especially sensitive to the price of health care and health insurance, taxes and subsidy programs that raise the cost of health care likely increase the number of uninsured. This in turn increases the support for those who call for government to provide ever more generous Medicaid "coverage."

How Block Grants Can Change Medicaid for the Better

The Hoover Commission first proposed block grants in 1949 as an administrative reform, "a system of grant … based upon broad categories–such as highways, education, public assistance, and public health–as contrasted with the present system of extensive fragmentation."[39]

The Hoover Commission first proposed block grants in 1949 as an administrative reform, "a system of grant … based upon broad categories–such as highways, education, public assistance, and public health–as contrasted with the present system of extensive fragmentation."

In 1981, the Omnibus Budget Reconciliation Act combined 80 federal programs into nine block grants including Preventive Health and Health Services, Alcohol, Drug Abuse, and Mental Health Services, and Maternal and Child Health Services. Though federal agencies maintained oversight responsibilities, their activities changed from detailed review of proposed programs to ensuring that state plans for using federal money were complete and complied with statutory requirements. Because the block grants were based on a statutory formula, federal agencies lost the ability to allocate grant funds to favored applicants, establish program priorities, and set requirements.[40]

The block grants clearly reduced administrative overhead. Texas reported that the 22 days needed to prepare its request for federal funding under the previous categorical program was reduced to three days by The Low-Income Home Energy Assistance Block grant. Michigan experienced a 10 percent reduction in reporting for the funds consolidated under the Alcohol, Drug Abuse, and Mental Health Services block grant because one report replaced the 16 that were previously required. Pennsylvania estimated that reduced federal reporting would save the state $5.2 million. Florida expected to save $1 million a year by eliminating certain applications previously required by federal programs.

The block grants clearly reduced administrative overhead. Texas reported that the 22 days needed to prepare its request for federal funding under the previous categorical program was reduced to three days by The Low-Income Home Energy Assistance Block grant.

Interest groups were generally less satisfied with the 1981 block grants than were state officials, possibly because the groups felt they could lose funding as state officials moved funds from federal priorities to those they felt better served their state's needs.

In 1996, the Aid to Families with Dependent Children entitlement was replaced with the Temporary Assistance for Needy Families block grants. The program gave people an incentive to work. States no longer worried about maximizing matching funds. They used their newfound flexibility to concentrate on reorganizing their welfare programs to better suit the needs on the ground and meet their new budget targets. A million children moved out of poverty as work effort increased, and caseloads fell by over 60 percent.

The switch to TANF block grants created a generally positive effect on employment, earnings, and income.[41] As states reworked benefit structures to reward work, funds were shifted from cash assistance to programs that provided child care, housing, transportation, and education. Block grants encouraged the development of completely new networks of local non-profits, state offices, employers, and community colleges. New and innovative career ladders and work opportunities were also developed.[42]

Opponents of Medicaid block grants generally argue that the grants will reduce Medicaid spending and thus automatically harm health. They also claim capped funding puts states at risk when health care costs rise.

A 2011 Kaiser Family Foundation Issue Brief explains that a block grant will end Medicaid's "coverage entitlement" and assumes that the result will be to reduce coverage. Inexplicably, the report also claims that reducing coverage will "not reduce underlying program costs."[43] The brief asserts that Medicaid is an efficient program because its per capita expenditures have grown more slowly than those in the private sector over the last decade. The slow per capita growth is probably the result of recent enrollment expansions heavily emphasizing healthy children.

In a 2004 discussion of the success of block grants for welfare reform, Brookings Institution experts showed that the arguments marshaled against ending the welfare entitlement were every bit as apocalyptic as those marshaled against ending the Medicaid entitlement. They conclude that the welfare block grant reform worked because it was predicated on a simple and correct proposition ("poor families are better off employed than on welfare") and that the "dire warnings" produced by advocates of the status quo--that states would abuse federal funds, abandon the poor, and drastically cut welfare spending—did not come to pass.[44]

The case for Medicaid block grants is predicated on a similarly simple proposition: when people spend what they think of as their own money on their own health care, they spend less and get more than if they spend other people's money.

The case for Medicaid block grants is predicated on a similarly simple proposition: when people spend what they think of as their own money on their own health care, they spend less and get more than if they spend other people's money. None of the existing critiques explores what might happen if states treated federal block grants as their own money, were free to change Medicaid spending patterns, alter the program's

incentive structures, or focus more resources on those most in need of help.

Medicaid Reforms that Work

At current levels of health care utilization, most Americans can economize their use of health care without harming their health provided they economize voluntarily, they have the freedom to economize as they see fit, they face reasonable incentives to do so, and providers are free to accommodate consumer demand.

In the private sector, switching to policies that have lower premiums but require people to spend more of their own money on routine care appears to reduce expenditure by 4 to 15 percent in the first year.

In the private sector, switching to policies that have lower premiums but require people to spend more of their own money on routine care appears to reduce expenditure by 4 to 15 percent in the first year. It reduces annual expenditure growth rates by 3 to 5 percent thereafter.[45] The RAND Health Insurance Experiment showed that cost-sharing reduces health expenditures both by the poor and by the more comfortably circumstanced, with similar health outcomes for both groups. Free care improved poor people's health slightly, primarily because free physicals found unsuspected cases of high blood pressure. It also slightly increased the likelihood that people would obtain corrective vision lenses and have better periodontal health.

In Medicaid, results from the 1999 to 2003 Robert Wood Johnson Foundation's Cash and Counseling experiments showed that Medicaid recipients given a budget to hire the people who provide personal care in their homes do better than when Medicaid agencies control the provision of care. Consumer direction reduces rates of unmet need, theft, and injury, and though individuals purchased fewer hours of attendant care overall, they were more satisfied.[46]

Although Cash and Counseling was designed to be budget neutral, expenditures in Arkansas increased by 28 percent. The state had set Medicaid payment rates so low that workers were unobtainable in some parts of the state and Medicaid recipients were unable to obtain services. The wage flexibility allowed by Cash and Counseling enabled them to purchase the care to which were entitled.[47] Assuming that Medicaid pays only for services necessary to preserve the long-term health of recipients, the increased expenditure should result in a long-term improvement in health and a consequent decline in expense.

In the second year of the experiment, Medicaid beneficiaries in Cash and Counseling spent fewer days in nursing homes and had fewer home health therapy visits. Despite the initial increase in Arkansas, Dale and Brown concluded that consumer-direction is likely to have a "modest" impact on "total Medicaid costs" in the short run but might offset this by generating savings in other long-term care services. Overall, Cash and Counseling improved the amount and quality of paid personal assistance.

Indiana: Changing Incentives to Promote Wise Health Care Use

Indiana's Healthy Indiana Plan (HIP) has sought to change the incentives faced by people enrolled in public coverage. Participants, people earning less than 200 percent of the federal poverty level ($21,660 for an individual or $44,000 for a family of four), have a choice of three health plans. They must make monthly contributions to their POWER accounts if their income is above the poverty level. Everyone has a $1,100 deductible. The deductible is funded by the POWER account.

Indiana's Healthy Indiana Plan (HIP) has sought to change the incentives faced by people enrolled in public coverage.

The state subsidizes lower-income members so that the total amount deposited in the POWER account over a 12-month period equals the $1,100 deductible. If necessary, the state will finance the deductible over 12 monthly payments because the full $1,100 is available in the POWER account on the first day of coverage. Provided participants have received required preventive care, any POWER account contributions remaining at the end of the year can be used to reduce next year's premiums. The plan covers $500 in preventive care services and there are no co-pays except for a $25 charge for non-emergency use of emergency rooms.[48]

HIP retention rates have been higher than in Indiana's regular Medicaid program. Less than 3 percent of members left because they failed to pay monthly contributions.[49] Of those who enrolled in the first six months, 36 percent had POWER account funds to roll over, and 71 percent of them had met the preventive care requirements.[50] Preliminary indications suggest that emergency room use has declined despite the fact that early enrollees may have had more medical problems than average.[51] The program, like all 1115 waivers, is designed to be budget neutral. No information is yet available on how this particular structure affects overall expenditure.

Rhode Island: Exploit Block Grant Flexibility to Right-Size Care

Rhode Island has been experimenting with a Medicaid block grant since January 2009. Its early results suggest that block grant flexibility can be exploited to reduce Medicaid expenditures while improving care. In exchange for much more flexibility in its Medicaid program, Rhode Island agreed to a $12.075 billion limit on all federal matching funds through 2013. In 2010, the second year of the new program, state Medicaid spending was $1.34 billion below the budget neutral target of $2.4 billion.[52]

Rhode Island has been experimenting with a Medicaid block grant since January 2009. Its early results suggest that block grant flexibility can be exploited to reduce Medicaid expenditures while improving care.

Though Rhode Island Medicaid still has federal cost sharing, it sought flexibility in order to focus on patients as people with diverse needs. As a result of a meticulously planned transition, in which the state worked closely with non-profit and advocacy groups to develop its intake and case management systems, in its first two quarters of operation it managed to eliminate waiting lists for long-term services. It also moved 93 people from nursing homes to home care.

Rhode Island developed a needs-based system to determine the safest and least restrictive setting of care for people needing long-term care. It provides homemaker services, minor home modifications, respite care, and physical therapy for people for when such care would delay nursing home placement.

Unlike traditional Medicaid, the Rhode Island experiment requires able-bodied people to contribute towards their health coverage Under Rite Care, families with incomes between 150 and 185 percent of the federal poverty level ($33,075 to $40,792 for a family of four) pay $61 a month, families with incomes between 185 and 200 percent of the federal poverty level ($40,792 to $41,000 for a family of four) pay $77 a month, and families with incomes between 200 and 250 percent of the federal poverty level ($41,000 and $55,125) pay $92 a month. Under Rite Share, families eligible for employer health insurance pay the same premiums, but the state pays all or some of the employee's cost to purchase employer provided health insurance.

Colorado: Change Incentives to Empower the Individual

In Colorado, disabled Medicaid recipients worked closely with state Medicaid officials to develop the Consumer Directed Attendant Support Services (CDASS) pilot program. CDASS was unique in both its incentive structure and in the freedom that it gave participants.

The program began in 2002. In its first two years, beneficiary health improved and spending was 21 percent under budget. CDASS was similar to Cash & Counseling program in that Medicaid officials determined how much attendant care an individual needed, set an annual budget, and deposited the funds with a fiscal agent. Recipients hired and fired attendants, and set hours, wages, and the terms of employment.

In its first two years, beneficiary health improved and spending was 21 percent under budget.

Budgets were allocated on an annual basis. If CDASS participants had money left over at the end of a year, they shared the savings with the state on a 50-50 basis. Before CDASS, Medicaid contractors sent attendants to homes and billed the State. Since Medicaid beneficiaries never saw the bills, the State did not know whether an attendant had actually shown up and done satisfactory work. After CDASS, the people paying

for the services knew exactly what they were getting. With their health care at stake and a share in any savings, CDASS participants had a low tolerance for fraud or incompetence.

Options for the Future

The current Medicaid program is fiscally unsustainable. It operates as a fragmented collection of overlapping specialty programs and waivers coordinated by administrative rules of daunting cost and complexity that discourage attempts to provide individualized health care for beneficiaries. Federal rules and matching fund finance means that all program participants spend with abandon because they are spending other people's money.

Block grants can change Medicaid incentives by eliminating matching fund finance. States satisfied with their current Medicaid program could continue it without change subject only to having to meet a negotiated budget. States that think they could do better by building new programs tailored to their citizens' needs would be free to try something else. They could copy Rhode Island, which used its newfound flexibility to provide individualized care and held its 2010 Medicaid to $1.34 billion, almost a $1 billion less than its cost neutral target.[53] Colorado saved 21 percent by giving Medicaid beneficiaries a budget, a 50 percent stake in any savings, and the freedom to employ attendants on their own terms. In Indiana, POWER accounts that roll over and reduce fees next year appear to have improved retention, increased receipt of preventive care, and reduced emergency room use.

Reforms that change incentives by giving individuals an incentive to spend wisely, and that give states flexibility in return for an end to unlimited federal matching funds, have produced promising results.

Conventional reform efforts have failed because they have added to Medicaid's complex rules without addressing its dysfunctional incentives. Reforms that change incentives by giving individuals an incentive to spend wisely, and that give states flexibility in return for an end to unlimited federal matching funds, have produced promising results. Making Medicaid a block grant program would allow states to build on that promise.

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