CHA Policy Positions for Medicaid Reform

Background

CHA believes that Medicaid is a program in need of progressive, carefully thought out, forward-thinking bipartisan reform—reform that is driven first and foremost by the vital needs and best interests of the populations it serves, and not by a budgetary target.

Jointly funded by the federal and state governments, Medicaid is a vital entitlement and health care safety net for our nation's most vulnerable populations: low-income families, the elderly, and those with chronic, disabling health problems. These populations rely heavily on the enduring commitment of the Catholic health ministry, a mission which has been and continues to be a vital, binding fabric that keeps our nation's safety net whole.

Today, Medicaid reaches approximately 52 million persons, more than Medicare or any other health insurer in the country. Medicaid is the primary source of health and long-term care assistance for one in six Americans, accounting for 20 percent of our nation's spending on health care. Medicaid also pays for approximately one-third of all births and 60 percent of all nursing home care in this country.

Stresses on both federal and state budgets have put Medicaid squarely in the budget cutter's eye. CHA and many other health care organizations have lobbied against cutting Medicaid, though it appears Congress will be forced to find $8 billion in Medicaid savings over the next five years.

The policy positions below have been developed in full recognition of Medicaid reform proposals recently issued by the Secretary of DHHS, the National Governors' Association, the National Conference of State Legislatures, and the newly formed Medicaid Commission. The latter is charged with issuing recommendations to address both short-term Medicaid savings (issued September 1, 2005) and fundamental reform of the program (due by December 31, 2006).

CHA Policy Positions on Current Medicaid Proposals

CHA believes it is possible to improve on the efficiency with which Medicaid dollars are spent, in a manner that ***does no harm*** to those covered, both in terms of eligibility and services covered.

- **Maintain Limits on Beneficiary Cost-Sharing**—CHA supports an enhanced patient role in assuming responsibility for staying healthy and using Medicaid services appropriately, by providing them with the information, education, and medical care oversight needed to achieve this worthy goal. Multiple studies consistently show that increased Medicaid cost-sharing for low income *beneficiaries results in lowering enrollment and driving beneficiaries away from needed services.* **As such, CHA opposes proposals calling for increased beneficiary cost-sharing for individuals at or below 200% of the Federal Poverty Level.** Such proposals are ill advised, and do not offer a viable savings option—in fact, studies show that health care costs are increased when patients lose eligibility or delay getting needed care before a crisis develops. In the long run, keeping patients well is the best solution, not only saving states money, but also avoiding the cost shift to providers and other payers that higher co-pays would generate.

- **Reduce Medicaid Drug Costs—**There is widespread consensus that Medicaid spends too much for drugs, with payments by states to pharmacists based on an artificially inflated manufacturers' average wholesale cost. This overpayment problem is detailed in a series of recent Congressional Budget Office reports. With Medicaid outpatient drugs costs increasing about 15% annually over the last few years, totaling about $30 billion in 2004 (about 10% of total federal Medicaid budget), the NGA, Medicaid Commission, and Congress all believe Medicaid drug costs can and must be reduced. This can be achieved through lowering acquisition costs to states, as well as increasing the level of drug manufacturer rebates. Another option for obtaining drug savings would be for Congress to extend the Section 340B (of the Public Health Service Act) Drug Pricing Program to inpatient drug purchases made by qualified disproportionate share hospitals, which serve a large volume of Medicaid and uninsured patients. A significant portion of the savings that these hospitals receive would be passed through to Medicaid, effectively reducing Medicaid costs by at least $100,000 million per year.

  Such cost-conserving approaches in no way harm beneficiary access to needed medications, and in fact can produce savings to help improve service/coverage in other parts of the Medicaid program. **CHA thus supports reduction of Medicaid drug costs as a primary approach for achieving Medicaid savings.**

- **Protect Access to Medicaid Long-Term Care Services for Low and Medium Income Elderly—**According to a May 2005 issue brief by Georgetown University's Long Term Care Financing Project: "There is little evidence that large numbers of the elderly are planning their estates for the purpose of gaining easy access to Medicaid in the event they need nursing home care. There is no evidence that they use transfers to significantly shift cost burdens to Medicaid, and little evidence that those who do transfer sizable assets gain eligibility for Medicaid." A September 2005 Government Accounting Office report on assets transfers use to obtain Medicaid long-term care coverage likewise found little evidence of abuse. CHA has concerns about the impact proposals to change the penalty and look back periods for assets transfers might have on the frail elderly and individuals truly in need of Medicaid long term care services. Instead, **CHA recommends a careful review and retooling of laws governing trusts and estates and to close loopholes which lead to artificial impoverishment by wealthy individuals for the sole purpose of gaining Medicaid coverage.**

- **Maintain the Federal Share of Medicaid Payments to States—**HHS's proposals to reduce states' use of intergovernmental transfers and to place caps on state Medicaid administrative costs cannot be supported by CHA, as the impact would only be to shift costs to already financially strapped states, potentially harming beneficiaries by forcing states to reduce eligibility and/or services. The end result would be higher numbers of uninsured and patients who have higher morbidity and mortality, ultimately costing all taxpayers more in the long run. **It is essential, however, that HHS ensure that 100 percent of federal matching monies obtained by states through intergovernmental transfers be used solely for Medicaid purposes. CHA thus opposes changes in federal policy which would reduce the level of federal Medicaid matching funding provided to the states.**
- **Medicaid Waiver Approval/Reapproval Processes—**CMS's processes for initial approval and reapproval of waivers should not create barriers to states pursuing innovative approaches to Medicaid service expansion, delivery, efficiency, and quality. New waiver requests that duplicate successful, proven waiver programs in other states should receive expedited CMS approval. For reapprovals, a waiver which has operated successfully for several waiver cycles should be converted into a state plan amendment. With the proviso that ***waivers are not used to reduce the numbers of individuals or services covered prior to waiver implementation,*** **CHA supports helping states stretch Medicaid resources further by streamlining CMS's requirements for Medicaid waiver approvals and reapprovals.**