

Medicaid Everyone Can Count On

Public Choices for Equity and Efficiency

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Introduction: Public Choice and State Roles

Premise

- We currently give states considerable power in the Medicaid program.
- But the outcomes of their choices lead to substantial and troubling variation across states in how a given household, middle income taxpayer, or high income provider are treated.
- We need to rethink what “we” are trying to do, and not just prescribe. We must give attention to voter-taxpayers.

Rationales for state roles and their discontents

- States could be just Napoleonic *departements* carrying out edicts from Paris. Uses rules.
- But Medicaid gives them roles in deciding eligibility, benefits, state tax finance, and provider payment. Uses incentives.
- Because states differ, decisions may (though not must) turn out differently. Is this desirable?

How Not to Think about Medicaid

- Kaiser news story last week on Medicaid for able bodied adults.
- “They should go on Medicaid but it should pay doctors better.”
- But state plans set provider payment to achieve their (taxpayers’) goals, given their matching rate.
- So it is foolish/destabilizing just to opine.

How to think about what states will and should do

- State choices well explained by a public choice model: they do what the median voter wants, and that demand varies with taxpayer income, % poor people, and South dummy.
- Good reason #1: Lab of democracy
- Good reason #2: Some states want more than others.
- Troubling reason #3: Geographic dimension in caring for the poor: our poor first, then elsewhere in US, and maybe then the world.

The Medicaid premise

- If left alone, help for deserving poor would be inadequate in all states and inequitable across states. So there is federal matching to get/help states to do more.
- If state demands vary, programs to make outcomes more uniform must also vary.
- The optimal federal (rest of country) matching rate (FMAP) should fall as state demand rises.

Medicaid practice

- Matching rate is high for poorer states but not enough. And it is lower for richer states but not low enough.
- No adjustments for other preference parameters.
- So we end up with beneficiaries, taxpayers, and docs all doing better in richer non-Southern states.

Why this produces discontents

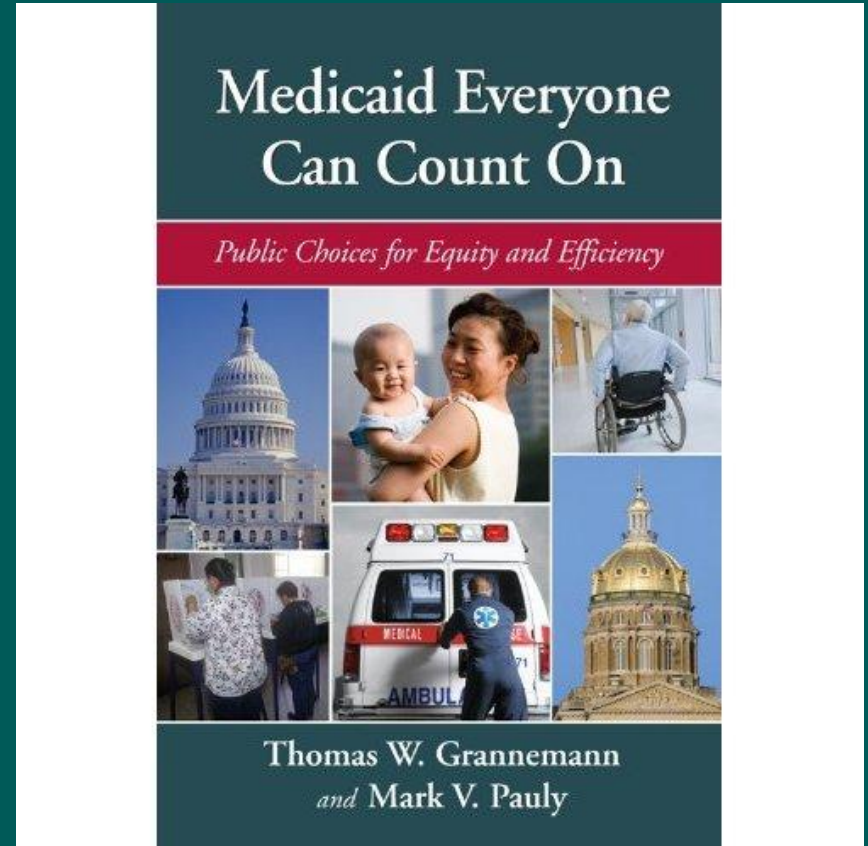
- Taking high spending as given means offering less generous incentives for more spending to richer states. This makes them mad because they feel their good deeds are being punished (but they were not more virtuous, just more lucky).
- Taking high spending as given means offering less generous incentives for more spending to non-Southern states with stronger tastes for helping. Their good intentions are being taken advantage of to keep federal cost down.

An example: Policy dimensions going forward: current eligibles

- We first need to decide how much equality we want.
- Matching (Jefferson) or orders (Napoleon) could either produce near equality—do we care about the ends or the means?
- Lower federal match for rich states for current eligibles and raise it for poor states.
- A compromise that allows state preferences: EBEB.

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Keys to Understanding Medicaid

Keys 1: Financing Care for the Poor in a Democracy

- Medicaid was made in America
- Medicaid depends on altruism, not solidarity
- Medicaid reflects public choices
- Medicaid is tied to the U.S. health care system
- Medicaid spending is unequal among states

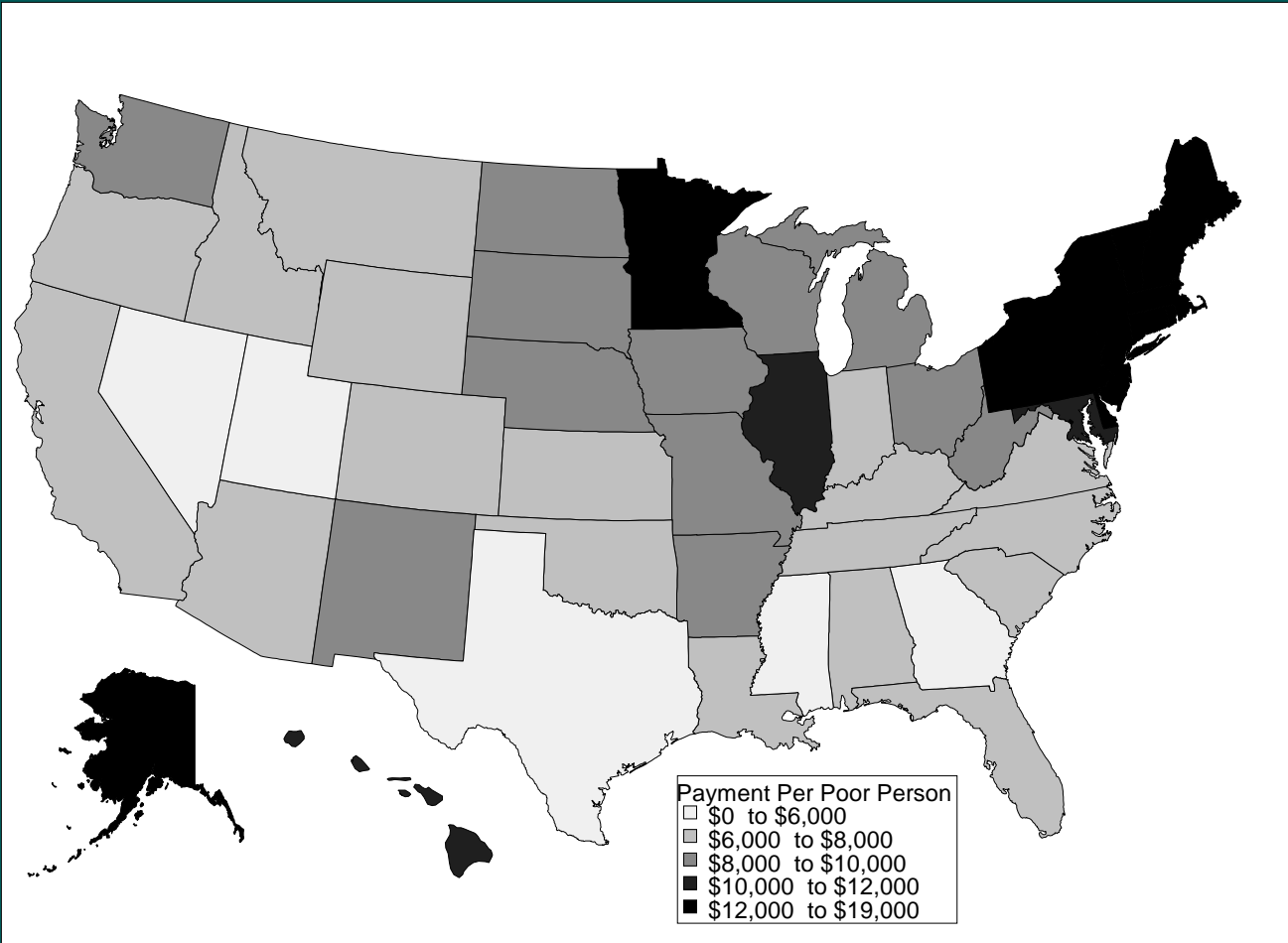
Keys 2: Medicaid's Roles in Our Health Care System

- Medicaid is both expenditure and revenue
- Medicaid's roles change over time
- Medicaid embodies a set of implicit promises
- Medicaid promises, and associated principles of equity, efficiency, and democracy, provide a framework for enlightened policy making

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Making and Meeting Promises to the Poor

Medicaid Spending per Poor Person



Barriers to Access

**Perhaps the greatest impediments to access under Medicaid are the more limited eligibility and coverage in the lower-benefit states – mostly lower-income states in the South and the West.
(p. 119)**

Achieving High-Value Care

We will never have a cost-effective system if we do not consider costs as well as effects in making treatment choices, but as a nation we have not yet agreed on reasonable criteria for defining value or for denying coverage for uncostworthy care. (p. 80)

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Making and Meeting
Promises to Voter-Taxpayers

Accounting for Voter Preferences

Medicaid financing allows for decision that express voter preferences for the program at both national and state levels. One just needs to get the program parameters set to reflect these preferences correctly. (p. 147)

EBEB Matching rates

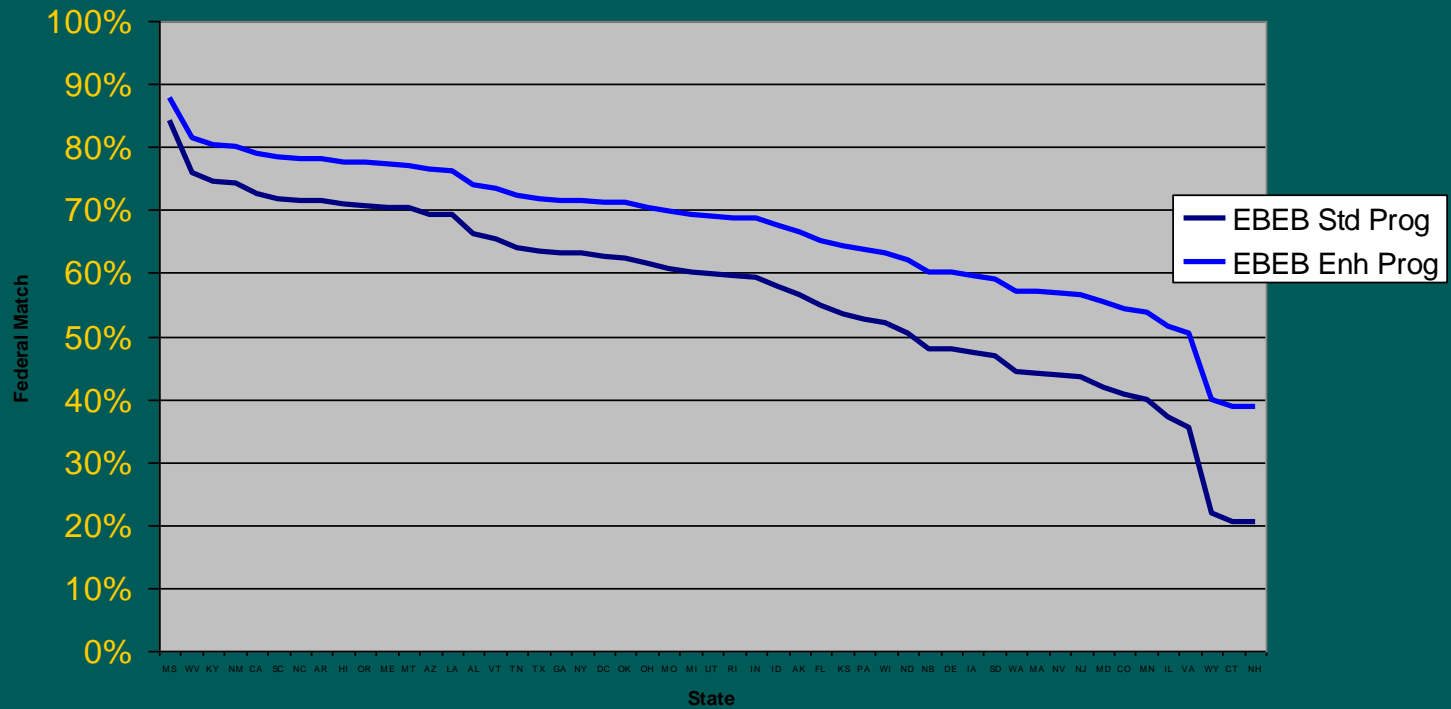
“Equal burden for equal benefit” is a method for computing Medicaid matching rates that are equitable for both taxpayers and the poor. Ideally such rates should enable each state to provide the same level of real benefits as each other state by spending the same fraction of taxpayer income on its share of benefits. (p. 329)

EBEB Input Parameters

- **Aggregate fiscal capacity** (e.g. taxpayer income, adjusted for cost of living)
- **Fixed percent** – share of fiscal capacity measure to be devoted to state share
- **Number of poor** – (e.g. below FPL)
- **Standard benefit** – (e.g. average payment per poor person)
- **Medical prices** – (e.g. index of input prices)

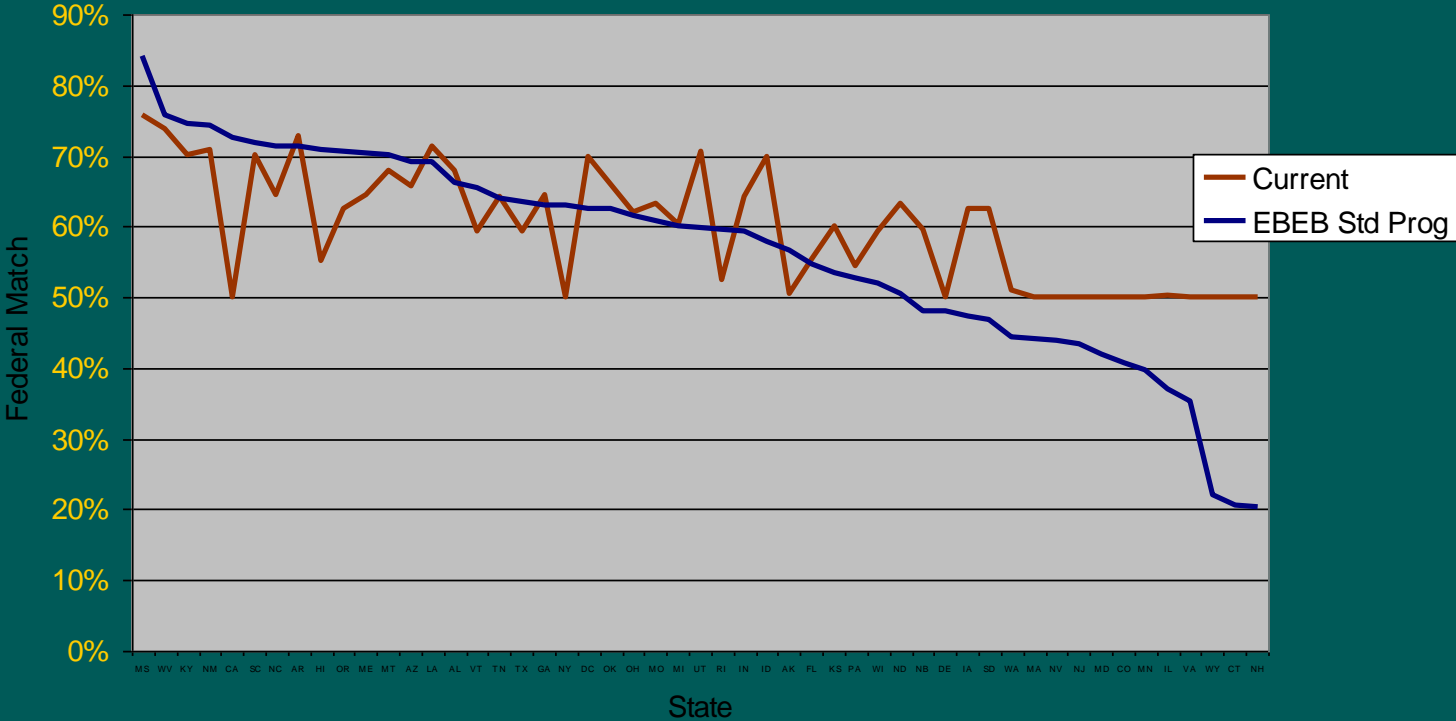
EBEB Matching Rates

Comparison of EBEB Basic and Enhanced Matching Rates



EBEB Compared to Current FMAP

Comparison of EBEB with Current FMAP Matching Rates



Countercyclical FMAP Adjustments

- **Three-part solution**
 - **Part 1:** EBEB Matching rates better reflect needs and ability of states to contribute to costs
 - **Part 2:** Timely updates through regression-based projections and interim payments
 - **Part 3:** Federal and State Medicaid trust funds

(p. 174-175)

Accountability

Taxpayers have two administrative “friends”, the claims-based payment system and upper payment limits. ...Where either of these protections is not effectively applied – most often with DSH, other supplemental payments, captive state-dependent providers, or services without enforced cost limits – accountability is at risk.

(p. 195)

Provider Taxes

- **So long as they do not affect federal matching payments... Provider taxes are neither more nor less pernicious than low Medicaid payments *as a way to balance state budgets*. They are only a problem when combined with... payment provisions that allow providers to escape accountability for delivering specific services to covered individuals at reasonable cost. (p. 181-182)**
- **However, federal policy makers should question what support they are willing to provide to states that choose to undo with tax policy what the Medicaid program is attempting to accomplish with payment policy. (p. 183)**

Provider Fraud

- **Medicaid provider fraud has long been a problem, reflecting the difficulty of monitoring activities of providers, particularly those who operate largely out of the public view. (p. 190)**
- **Provider exclusion is an underused tool that could be applied more broadly. (p.192)**

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Promises to Providers –
Payment Policies and
Strategies

State Payment Strategy

- **Having a rational, realistic, an well-thought-out provider payment strategy is a central part of any well-formulated state Medicaid plan. (p. 200)**
- **We suggest policy makers seek to pay what is needed to obtain the level of access desired by voter-taxpayers for Medicaid patients. (p. 232)**

Why Low Medicaid Payment?

- **Health care markets can be viewed as “payer-segmented” .. Medical care providers accept different rates for similar services. (p. 216)**
- **State motivations for low payment: Monopsony market power, temporary imbalance in financing, general system cost control. (pp.216-217)**

Can Medicaid Shift Costs?

- **A “hydraulic” model seems to imply that pushing down on public sector hospital payment rates automatically pushes up private insurance rates – that costs are shifted from one payer to another.**
- **But a hydraulic system only works when it is a closed system with no leakages. (p. 219)**

Effects of Low Payment

- **The hospital very likely has more flexibility in raising or lowering its costs than it does in influencing rates it is able to obtain from private payers. (p. 220)**
- **With hospitals, all patients are affected by reduced quality or intensity of services (p.221.)**
- **Professional providers may reduce program participation. (see pp. 228-231)**

Who benefits from low payment?

- **The federal government is the primary beneficiary of state Medicaid low-payment strategies. (p. 213)**
- **We see no sense in which existing costs are shifted to private payers; in fact, the consequence of lower payment is that system costs are lower, though... the private insurers will end up paying a larger share of the reduced total. (p.223)**

Inequities in Payment

- Payment differs by setting and provider type
 - OPD, FQHCs vs. physician offices
 - OPD vs ASC
 - Provider-based vs. independent practice
 - Urban vs. rural classified hospitals
 - IPPS vs. CAH, SCH, RRC, Children's hospitals

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Promises to the Near Poor – CHIP and Fiscal Federalism

On extending benefits up the income distribution

- **The value to state taxpayers of extending benefits to households that are definitely not poor (even if they are not well off) is apparently low. (p. 287)**
- **The fact that enhanced federal matched rates were needed and provided for CHIP suggests the fall off is steeper for state taxpayers than for federal-voter taxpayers who are apparently willing to take on a greater share of the cost to extend benefits to children. (p. 287)**

Conclusion

Things to Change

- The matching rate structure – to EBEB-based
- Add countercyclical adjustments
- Extend and standardize federal eligibility
- Phase out DSH and other supplemental payments
- Permit more state cost containment efforts
- Change structure of federal health care subsidies (continuity of subsidy)

Advice to Policymakers

- **Manage Medicaid promises**
- **Base policy on principles**
- **Use federal financing and provider payment as tools**