Your Medicaid Matters: Serious Threats from Capitol Hill

Presented by
Joseph C. Isaacs, MSPH, FASAE, CAE
Vice President, Public Policy
United Spinal Association

January 26, 2012
Your Medicaid Matters: Serious Threats from Capitol Hill

This webinar is gratefully made possible with kind support from the following sponsors:
To Raise Questions or Share Your Comments

To Ask A Question or Make a Comment
Please Type It in the “Ask A Question” Box

If we don’t get to your question, we will do our best to follow up with you after the webinar.
Summary of What We Will Discuss on Today’s Webinar

1. Why Medicaid matters?
2. What is driving federal policymaker actions to cut Medicaid support?
3. What cuts have been proposed and how are they harmful to you?
4. What alternative approaches to savings are available without undermining needed care?
5. What messages should we send to policymakers about preserving Medicaid?
Why Medicaid Matters:

What’s at Stake?
What is Medicaid?

- A $400 billion federal - state health care financing partnership providing coverage to 67 million low income people in the U.S.
- Health care benefits for poor or near poor children, expectant mothers and families
- Basic health care and long-term care services and supports for people with disabilities and low-income seniors
Medicaid Accounts for Nearly One-Fifth of All Health Coverage and Personal Health Care Expenditures in the U.S.

Health Coverage

- Employer-Sponsored Insurance: 49%
- Medicaid: 16%
- Medicare: 12%
- Private Non-Group: 5%
- Uninsured: 17%

Total = 309 million

Health Spending

- Private Health Insurance: 34%
- Medicaid: 17%
- Medicare: 23%
- Other Private Funds: 8%
- Consumer Out-of-Pocket: 14%
- Other Government Programs: 4%

Total = $2.6 trillion

Federal Medicaid Match By State
FY 2012

NOTE: Rates are rounded to nearest percent. These rates will be in effect Oct. 1, 2011 – Sept. 30, 2012.
Medicaid is the largest source of federal revenue to states, contributing to local business activity and jobs.
Medicaid has many roles in our nation’s healthcare system and safety net.

**Health Insurance Coverage**
- 29 million children & 15 million adults in low-income families;
- 15 million elderly and persons with disabilities and 20% of all those with severe disabilities

**Assistance to Medicare Beneficiaries**
- 8.9 million aged and disabled, of whom 3.4 million are disabled under age 65 — 21% of all Medicare beneficiaries

**Long-Term Care Assistance**
- Pays for 40% of all LTC costs;
- Covers 1 million (or 70%) of all nursing home residents;
- 2.8 million in community

**Veterans and Military and Medicaid**
- VA-Medicaid dual enrollees comprise 10.2 % of VA’s annual patient load or about 612,000;
- Medicaid covers 1 in 12 military children and 1 in 9 with special needs

**Working People with Disabilities**
- Medicaid Infrastructure Grants and Medicaid Buy-In promote higher employment rates in more than 2/3 of states
Mandatory Medicaid Services

- Inpatient hospital services, excluding services for mental disease
- Outpatient hospital service
- Federally qualified health center services
- Rural health clinic services (if permitted under state law)
- Laboratory and x-ray services rendered outside a hospital or clinic
- Nursing facility services for beneficiaries age 21 and older
- Physician services
- Certified pediatric and family nurse practitioner services (when licensed to practice under state law)
- Nurse mid-wife services
- Medical and surgical services of a dentist
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services
- Family planning services and supplies
- Home health services for beneficiaries who are entitled to nursing facility services
- Pregnancy-related services as well as postpartum care for 60 days
Optional Medicaid Services

-- Ambulance services
-- Certified Registered Nurse Anesthetist
-- Chiropractor services
-- Clinic services
-- Critical access hospital services
-- Dental services
-- Denture services
-- Diagnostic, Screening and Preventive services
-- Emergency hospital services in non-Medicare participating facilities
-- Eyeglasses
-- Hearing Aids
-- Hospice care
-- Inpatient Psychiatric care for under age 21*
-- Institutions for Mental Disease for age 65 +*
-- Intermediate Care Facility services for Developmentally Disabled (Mentally Retarded)*
-- Medical equipment and supplies*
-- Medical and remedial care by other licensed practitioners, e.g., psychologists
-- 1915(i) Home and Community Based Services*
-- 1915(j) Self-directed Personal Assistance Services (cash and counseling)*
-- 1915(k) Community First Choice (CFC) Option*
-- Non-emergency medical transportation services*
-- Nursing facility services for under age 21
-- Optometrist services
-- Personal care services*
-- Podiatrist services
-- Prescription drugs*
-- Primary care case management
-- Private duty nursing services
-- Program of all-inclusive care for the elderly (PACE)
-- Prosthetic and Orthotic devices*
-- Rehabilitation Therapy Services*
-- Religious non-medical healthcare institution and practitioner services
-- Respiratory care for ventilator dependent beneficiaries
-- Speech, hearing and language disorder services*
-- Targeted case management

* Services of particular importance to those with severe disabilities.
Those with disabilities and the elderly account for the bulk of Medicaid spending.

**Enrollees**
- Total = 67 million

**Expenditures**
- Total = $400 billion

NOTE: Percentages may not add up to 100 due to rounding.
SOURCE: KCMU/Urban Institute estimates based on data from FY 2008 MSIS and CMS Form-64, 2010.
Medicaid Plays a Crucial Role for Medicare Beneficiaries

- Paying Medicare cost-sharing (co-payments, deductibles and premiums)
- Paying for Services not covered by Medicare
  - Non-skilled Long-term Supports and Services
  - Nursing facility care
    - Private pay rate ~ $75,500 avg./yr (semi-private)
    - Home and community-based care
    - ~70% Medicaid spending for Medicare beneficiaries is for long-term care
  - Dental services
  - Vision services
  - Hearing services
  - Transportation services

Source: www.medicareadvocacy.org
Copyright © Center for Medicare Advocacy, Inc.
Dual Eligibles Account for Nearly 40% of Medicaid Spending

Medicaid Enrollment

- Adults: 25%
- Other Aged & Disabled: 10%
- Children: 50%
- Duals: 15%

Est. Total = 67 Million

Medicaid Spending

- Non-Dual Spending: 60%
- Long-Term Care: 27%
- Medicare: 6%
- Other Acute: 2%
- Prescribed Drugs: 0.4%
- Dual Spending: 39%

Est. Total = $400 Billion

Medicaid higher per-enrollee spending is driven by disability and long-term care.

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2007 MSIS and CMS64 data.
Medicaid Long Term Care Expenditures

**1995 Estimated Medicaid Long-Term Care Expenditures = $49 Billion**
- Nursing Facility: 61%
- Home Health: 19%
- Personal Care: 6%
- ICF-MR: 4%

**2007 Estimated Medicaid Long-Term Care Expenditures = $101 Billion**
- Nursing Facility: 47%
- ICF-MR: 12%
- Personal Care: 10%
- Home Health: 4%

Source: Burwell, B., Sredl, K., and Eiken, S. Medicaid expenditures for LTC services, 1995-2007. HCBS.org. *HCBS = home and community-based services; ICF-MR = intermediate care facilities for the mentally retarded*
HCBS Spending As % of Medicaid Long-Term Care Spending by State

So what’s the problem?

What is motivating the current assaults by policymakers on Medicaid spending?
The driving forces behind current proposals to cut Medicaid.

- It’s the economy, stupid!!!
- Record federal budget deficits and national debt.
- Population is aging and poorer, raising questions about entitlement programs’ sustainability.
- Many more people on Medicaid due to economic downturn.
- Resistance to new tax revenues has forced heightened pressure on spending cuts.
- Opposition to health care reform and expanding Medicaid further.
Medicaid is the States’ fastest growing expenditure.

State Medicaid Spending Has Grown Faster Than Other Major Categories

<table>
<thead>
<tr>
<th>State Spending per Capita</th>
<th>1989 (in 2009 Dollars)</th>
<th>2009</th>
<th>Growth Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Spending</td>
<td>$3,218</td>
<td>$5,038</td>
<td>57%</td>
</tr>
<tr>
<td>Medicaid Spending</td>
<td>$364</td>
<td>$1,065</td>
<td>192%</td>
</tr>
<tr>
<td>Elementary and Secondary Education Spending</td>
<td>$754</td>
<td>$1,092</td>
<td>45%</td>
</tr>
<tr>
<td>Higher Education Spending</td>
<td>$385</td>
<td>$526</td>
<td>37%</td>
</tr>
<tr>
<td>Corrections Spending</td>
<td>$102</td>
<td>$170</td>
<td>66%</td>
</tr>
<tr>
<td>Transportation Spending</td>
<td>$324</td>
<td>$391</td>
<td>21%</td>
</tr>
</tbody>
</table>

Note: Categories shown constitute roughly 60 percent of state spending.
Source: Author’s calculations based on the 1990 and 2009 state expenditure reports from The National Association of State Budget Officers and population estimates from the U.S. Census Bureau.

Table 1 • WM 3243 heritage.org
Since the recession, Medicaid has added more than 20 million enrollees.
The number of those in need of Medicaid has been the primary driver of spending growth since the recession.

Average Annual Growth 2007 - 2009

- Total Spending: 7.5%
- Enrollment Growth: 5.3%
- Spending Per Enrollee: 3.8%

SOURCE: Urban Institute, 2010. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Expenditures exclude prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.
Medicaid annual spending per capita has grown far slower than private health spending per capita.

Spending Growth 2000-2009

- Total Medicaid Per Capita: 4.6%
- National Health Expenditures Per Capita: 5.9%
- Monthly Premiums for Employer Sponsored Coverage: 7.7%

Medicare, Medicaid and Social Security Will Be Nearly Half of All Federal Spending in 2021

Outlays Under Current Policies, as a Percent of GDP, 2021

- Net interest, 4.2%
- Other program spending, 8.2%
- Medicare, 3.6%
- Medicaid, 3.0%
- Social Security, 5.3%

Source: Center on Budget and Policy Priorities based on data from the Congressional Budget Office.
Current Policies Are Not Fiscally Sustainable Without Additional Revenues

Source: CBPP projections based on CBO data.
Medicaid is being attacked at both the state and federal levels.

What specific cuts are being proposed and what harm can they do?
States have already begun curtailing their Medicaid expenditures.

- Raising your cost-sharing responsibility – higher co-payments;
- Reducing payments to physicians, hospitals, nursing homes, home health providers, etc.;
- Expanding patient enrollment in Medicaid managed care plans; and
- Limiting benefits, especially among optional services such as home- and community-based services and supports.
Attacks at the Federal Level Have Potential for Far Greater Damage

- **Bipartisan Deficit Reduction Panels:** Proposed *targeted Medicaid cuts* of $100-375 billion over 10 years.

- **Global Spending Caps:** Would limit all federal expenditures based on arbitrary percentage of nation’s GDP. Federal Medicaid spending cut by $547 billion over 10 years.

- **Converting Medicaid into a Fixed Payment Block Grant Program:** Approved in the House and rejected in the Senate, proposal would fundamentally alter Medicaid structure and cut Federal program spending $1.4 trillion over 10 years and by nearly half by 2030. Enrollment would drop by 31-44 million.
What are the alternatives?

Can savings be achieved and new revenues be identified to preserve Medicaid without hurting people?
Other approaches to achieving Medicaid savings without sacrificing needed care.

1. Rebalance the federal Medicaid payment formula and plan requirements to emphasize lower cost home- and community-based services and supports (HCBSS) and assistance with non-medical functional needs. *

- Ease HCBSS (Section 1915) State Waiver Acquisition
- Promote “Community First Choice Option” incentives to states
- Encourage states to use new “Balancing Incentive Program”
- Make available more “Money Follows the Person” grants
- Expand Consumer-Directed Personal Assistance
- Support expansion and training of Direct Care Provider Pool

* Lewin Group attributed significant savings to emphasis on home- and community-based services and supports in 2011 study of Rhode Island Medicaid program.
Other approaches to achieving Medicaid savings without sacrificing needed care.

2. Improve care coordination for Medicare-Medicaid “dual eligible” enrollees in “managed” long-term services plans.

Such systems must adhere to strict principles and requirements, ensuring:

- Patient rights protections and due process.
- State system preparedness and phased-in introduction.
- Adequate provider networks and access to specialists.
- Continuity and integration across the care continuum.
- Transition to more home- and community-based services.
- Strong government oversight and quality management.
- Stakeholder involvement at all stages of development.
Other approaches to achieving Medicaid savings without sacrificing needed care.

3. Make available Medicaid’s discounted pharmacy pricing to dual eligibles and low income Medicare Part D enrollees.

- Medicaid pharmacy rebates are not available to those who are enrolled in Medicare
- Medicare Drug Savings Act of 2011 would change this*
- Requires drug companies to offer Medicaid discount pricing to dual eligibles and low income Medicare Part D enrollees
- Federal savings of $112 billion over the next ten years **

* S.1206 and H.R. 2190 introduced by Senator Rockefeller (WV) and Rep. Henry Waxman (CA) respectively.
** Estimate by Congressional Budget Office.
Making Our Voices Heard

What messages should we send to policymakers about preserving Medicaid?
Our Messages to Congressional Policymakers and the White House

1. My Medicaid matters! Its services and supports are a lifeline for millions with severe disabilities to more healthy and productive independent lives in our homes and communities. *

2. Cutting Medicaid hurts people. It is an efficient program that has grown out of genuine need and is fulfilling its historic purpose.

3. We’re all concerned about our economy, but the burden of deficit reduction and ever-rising health care costs should not be placed on the shoulders of those most vulnerable.

4. Medicaid’s current structure is effective and arbitrary cuts will merely shift costs to the states, healthcare providers and beneficiaries and contribute to hurting local business and jobs. **

---

* In 1999, U. S. Supreme Court ruled in *Olmstead v. L.C. and E.W.* that the "integration mandate" of the ADA requires public agencies to provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

** Families USA Study (June 2011): For every $1 cut from Medicaid, almost $4 of business activity is reduced. A 5% cut in Medicaid would cause large states -- NY, CA, PA, FL, OH, IL, NC, MI and MA -- to lose nearly 144,000 jobs and other states to lose many as well.
Our Messages

5. The government can achieve cost savings without undermining Medicaid’s coverage, finances and service delivery.
   - Advance home health and community-based services and supports use over more costly institutional long-term care.
   - Expand Medicaid managed care for dual eligibles with strict oversight and patient protections to improve care coordination and achieve efficiencies.
   - Give dual eligibles Medicaid’s discount drug pricing.
   - Intensify efforts to reduce fraud and abuse accounting for billions of dollars in Medicaid and Medicare overpayments each year. *

* Medicare and Medicaid made an estimated $23.7 billion in improper payments in 2007. These included $10.8 billion for Medicare and $12.9 billion for Medicaid. (U.S. Office of Management and Budget, 2008)
Our Message Is The General Public’s Message

6. Consistently, 60 to 70% of Americans polled support Medicaid and do not want to see benefits cut.*

To achieve this, we need a more balanced approach to financing Medicaid, combining cost savings and new revenues.

* 2011 polls conducted by the Pew Research Center and the Kaiser Family Foundation.
Thank you very much. I welcome your questions.

If you would like to download a copy of this presentation, it will be posted soon on United Spinal Association’s website at:

www.spinalcord.org
To Raise Questions or Share Your Comments

To Ask A Question or Make a Comment Please Type It in the “Ask A Question” Box

If we don’t get to your question, we will do our best to follow up with you after the webinar.
Schedule of Future 2012 Webinars

- **February 29** – “Push for More - Getting the Wheelchair that Works for You”
- **March 29** – “Medicare Restricts Your Access to Quality Care, Equipment Services” *
- **April 26** – “No, you can’t get that!”- Addressing Wheelchair & Accessory Denials
- **May 31** – “Disabled and Seeking Employment – Is the government helping you adequately?” *
- **June 25-26** – *Roll on Capitol Hill Conference and Congressional Visits and Awards* **
- **July 26** – “Are you ready to learn more about being an advocate? Are you ready to make a difference?”

* Part of “Roll on Capitol Hill” preparation series.