Perspectives
ON TEXAS PUBLIC POLICY

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Senate Health and Human Services Committee
Medicaid – Improving Care and Cutting Costs

Testimony by C. Patterson, Director of Research
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The Texas Public Policy Foundation would like to thank members of this committee for its work to resolve one of the state's most important challenges – improving the quality and reducing the costs of Medicaid. We appreciate the invitation to provide testimony about research we published in September; copies of this report will be distributed with a written version of my testimony and are available on the Internet at http://www.texaspolicy.com/pdf/2004-09-medicaid.pdf. *Medicaid And The Uninsured* is the first of a series of reports that the Foundation plans to release over the next 6 months examining alternatives for reforming Medicaid.

Medicaid is becoming Texas' top fiscal priority, superseding the position that public education has held for decades. Consuming an ever greater share of the state budget, sharply rising costs of Medicaid undermine the ability of taxpayers to sustain this essential program for the neediest of Texans and now competes with other important state programs for limited resources. Traditional reforms have proven unequal to the task of achieving long-term savings, and today, the sustainability of Medicaid depends on comprehensively changing the way care is delivered and services are paid for, and creating incentives for recipients to increase the efficiency of Medicaid dollars.

Long-Term Care

Reforming Medicaid must begin with long-term services for the elderly and persons with disabilities. As described in our report *Medicaid And The Uninsured,* care for the elderly and persons with disabilities account for a disproportionate share of Medicaid expenses. Although only 20 % of Texas Medicaid recipients represent the aged and persons with disabilities, services for this population account for 62 % of Medicaid spending. Services for this population are also primarily responsible for increasing Medicaid costs; nationally 60 % of the growth in Medicaid spending was incurred by services rendered to the elderly and disabled.

Our report suggests two alternatives for long-term care that offer promise for Texas – expanding

411 Brazos St., Ste. 99
Austin, TX 78701
512-472-2700
Fax 512-472-2728
www.TexasPolicy.com

the state's Cash and Counseling program and introducing Team Delivery Care.

1. Cash and Counseling Program. Pilot Cash and Counseling programs offer evidence that a consumer-directed approach to personal assistant services for the elderly and persons with disabilities can both reduce Medicaid costs and improve the quality of care. Funded by the U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation in 1995, large-scale programs established in Arkansas, Florida and New Jersey provide a cash benefit to Medicaid-eligible individuals to use in hiring care-givers and purchasing goods and services (including transportation, assistive technologies, home and vehicle modifications, and respite care).

   In Arkansas and New Jersey, the allowance was determined by "cashing out" of a consumer's care plan and, in Florida, participants received an allowance based on their Medicaid claim history. All three plans provided counseling and fiscal assistance services that helped recipients develop and monitor spending plans and uses. In two of the three programs, goods and services cost less than planned. In the one program surveyed, participants indicated "dramatic improvements" in the quality of life and medical outcomes were at least as good as traditionally-delivered care and some outcomes were improved.

   In several important ways, these programs differ from the consumer-directed program for personal assistant services that Texas recently implemented. Texas (i) has committed limited resources for outreach/education; (ii) relies on traditional agencies for administrative and fiscal services; and (iii) utilizes federal waiver authority that is limited to home and community-based services – barring employment of relatives, forbidding direct cash management, and limiting consumer direction in personal assistant services (such as transportation, assistive technologies and modification of home and vehicle).

2. Team Delivery Program. Team delivery programs also offer promise for cutting costs and improving care for the chronically ill, frail elderly, and persons with disabilities. The most successful programs, two pilot programs in Massachusetts, realize savings of 15-20 % by preventing adverse medical outcomes that often result in hospitalization. Patients report increased independence, greater access to services, and improved care. Team delivery programs provide comprehensive, holistic health care, managing every aspect of care for twenty-four hours a day, seven days a week. Integrating acute and long-term care, specialized primary care networks provide team-based care for patients in the home. Successful programs are based on prepaid, risk-adjusted financing, integrated Medicare and Medicaid funding, and flexible combination of acute and long-term services.

   In several important ways, Team Delivery Programs differ from the STAR+PLUS program developed by Texas (which integrates acute and long-term care in a managed care delivery system, emphasizes home delivery, coordinates care, and uses some degree of risk-adjusted financing). Texas has not received waiver authority to (i) integrate Medicaid and Medicare funding; and (ii) most importantly redesigned the delivery of care to the provider level but instead assigned control and coordination of care to health maintenance organizations (which leads to fragmented care without commitment of health care providers).

Comprehensive, Systemic Reform

To achieve long-term savings and ensure the sustainability of Medicaid, Texans must look beyond the current system and comprehensively change the delivery and payment for care. A new framework must be developed that expands the role of private insurance in meeting health care needs of the poor, creates incentives for more efficient and effective utilization of health care services, and relies on competition to control costs and improve the quality of care. Over the upcoming months, the Foundation will publish reports detailing specific proposals for market-based reforms.

Important Considerations

We would be remiss not to remind this committee that all Medicaid reform must be sensitive to two issues:

- Crowd-Out. Because Medicaid provides richer benefits than are offered by most insurance procured through employers, the substitution of state-subsidized care for private insurance ("crowd-out") is a growing problem. In Texas, Medicaid enrollment rises as enrollment in private health care coverage falls. Nationally, a 50 % rate of crowd-out is associated with growing Medicaid enrollment, according to a study published by the National Bureau of Economic Research. It is important for state policies to recognize the relationship between Medicaid expansion and crowd-out, establish specific calculations of the problem, and strengthen policies to reduce "crowd-out."

- The Uninsured. There are widely-held misperceptions that Medicaid is both the cause of and solution for Texans who lack health care coverage. Some claim that efforts to reduce Medicaid costs have bolstered the uninsured population and predict that expanding Medicaid enrollment will shrink it. Stable numbers of Texas' uninsured population over the past decade disproves the contention that changes in Medicaid and CHIP enrollment shrinks or expands the uninsured population. In fact, a growing body of well-designed research finds no evidence of any relationship between government-subsidized health care and the uninsured. It is important for state policy to recognize that Medicaid reforms cannot address the problem of un-insurance.

Urgent Need for Reform

Texas and nearly half of the 50 states anticipate shortfalls in Medicaid spending for the current fiscal year, and this shortfall will grow increasingly severe annually as costs and enrollment rise. To solve this problem, the choices are clear. Policymakers can slash other government services such as public education, raise the state tax burden with disastrous economic consequences, or enact cost-control measures.

Recommendations:

- Secure a federal waiver to allow full integration of Medicaid and Medicare funding streams
- Secure federal waivers to expand consumer-directed services to transportation, assistive technologies, employment of family, and modification of home and vehicles
- Integrate acute and long-term services on a provider, instead of an insurer, level
- Establish a Team Delivery Model for acute, long-term care that coordinates resources and financing
- Expand reliance on non-traditional agents for administrative, fiscal, and health services
- Allocate resources to outreach and education to increase participation in consumer-directed programs
- Create incentives for Medicaid recipients to enroll in managed and consumer-directed care programs
- Establish a pilot program for sending Medicaid funding as a block grant to local communities
- Strengthen strategies to eliminate waste, fraud, and abuse
- Expand premium assistance for implementing a benefit phase out rate for Medicaid
- Establish a long-term plan for transitioning the state's Medicaid program into private sector health care

Resources:

- *Medicaid and The Uninsured* by Beau Egert, Texas Public Policy Foundation, September 2004 (http://www.texaspolicy.com/pdf/2004-09-medicaid.pdf)
- *Using Market Forces To Control Texas Medicaid Costs And Improve Health Outcomes* by Dr. Michael Bond, Texas Public Policy Foundation (to be released in early 2005)

The Facts

- Medicaid is an entitlement program – Texas must provide medically necessary care to all eligible individuals.
- Health and human services represent 34 % of the total state budget for 2004 – Medicaid accounts for three-quarters of the state's health and human services budget.
- $17 billion is the total projected amount to be spent by Texas on Medicaid in 2004 (all funds including the Disproportional Share Hospital Funding).
- Medicaid is jointly financed by state and federal government – the federal share for 2004 is 60.22 %.
- 2,951,945 Texans received Medicaid-funded services during 2002.
- 1 out of 9 Texans received Medicaid in January 2004.
- 59 % of Texas Medicaid recipients are children, but they account for 25 % of Texas Medicaid spending.
- 20 % of Texas Medicaid recipients are the aged and disabled, but they account for 62 %of Medicaid spending.
- The elderly and disabled accounted for almost 60 % of the national growth in Medicaid spending from 2000-02.
- Over one-third of Texas' Medicaid population is enrolled in some form of managed care.
- 28 States, including Texas, anticipate shortfalls in Medicaid spending for the current fiscal year.
- Medicaid will bankrupt every state if spending is not controlled, according to some health care analysts.
- Direct Medicaid costs are expected to nearly double within the next 3 years.
- Increases in Texas Medicaid spending have demonstrated little or no impact on the proportion of the population who is uninsured.
- A study by the National Bureau of Economic Research finds 50 % of increase in Medicaid coverage is associated with a 50 % reduction in private insurance coverage –50 % crowd-out rate.