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Federal Medicaid Commission
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I can clearly see that the genesis for Medicaid reform should start with the states. I see the impacts that rising Medicaid costs are having on state budgets.

Medicaid is now our nation's largest publicly funded health insurance program providing health and long-term care coverage to over 51 million people in 2004. Over the past decade, Medicaid spending has more than doubled, increasing from $137 billion in 1994 to $304 billion in 2004.

The spiraling costs of Medicaid threaten our ability to provide critical services to our citizens, including public safety and education. In fact, in 2003 – based on a national average – total Medicaid spending surpassed elementary and secondary education spending for the first time and is now the largest single appropriation in overall state budgets.

The National Association of State Budget Officers noted in 2004 that, "even after a full economic recovery is underway for state budgets, increases in Medicaid costs will far outstrip the growth in state revenues into the future."

Spiraling Medicaid costs are placing grandparents and grandchildren on a collision course to compete for the same finite resources and it will lead to the difficult proposition of choosing between the care of our elderly and the education of our children.

As the states' Chief Executives, Governors collectively serve as the Board of Directors for a national Medicaid program – which means we have the fiduciary responsibility for a $300 billion health care organization.

Yet Governors must manage this program without the basic tools available to the executives of any commercial health insurance plan.

So why should we expect that our outcomes will be the same? It's time to change the rules so that states can utilize the best practices of the private sector. And it's time to do it now.

We are all aware of the problems many states have experienced by cutting eligibility and services for their Medicaid recipients. It's resulted in more emergency room visits, more expensive treatment and more lawsuits.

Compare that to what we've done in Idaho. When our budget problems forced holdbacks, we looked for ways to reduce spending with a minimal impact on our citizens. We focused on improving the management of Medicaid.

And what have been the results?

- No cuts in eligibility.
- No cuts in services.
- More than $150 million in savings and better care for patients.

Yet this successful management represents only temporary slowing in Idaho's Medicaid budget – largely because, in recent years, we were still dealing with the impacts of a rapidly growing Medicaid caseload.

If we are truly going to solve the problems of the current Medicaid program, we must turn our focus away from an antiquated, regulation-based system and toward one that focuses on results.

That is why I recently proposed a series of common-sense reforms that will modernize Medicaid in the State of Idaho and significantly change the way we administer this program.

We will focus on results instead of rules, outcomes instead of cumbersome regulations.

It is a vision of what Medicaid should be…not just of what it's allowed to be under the current bureaucratic framework.

As you all know, Medicaid enrollment is based on a multitude of eligibility categories – well over 50 different categories.

Recommendation #1

In Idaho, I am proposing that we reduce that unmanageable number to three separate programs:

- Low-income children
- The elderly
- And individuals with disabilities or special health needs

We will direct services toward quality of care instead of using the "one-size-fits-all" approach of offering the same services to everyone, regardless of need. These programs will have different policy goals and objectives based on the needs of those in each respective program.

Idaho Medicaid will design benefit packages based on the needs of beneficiaries and the program policy goals.

Recommendation #2

My proposal calls for using a Health Risk Assessment – or comprehensive physical exam – to ensure every participant has access to the benefits they need.

I have already included funding in my budget recommendation to increase provider payments for these services to ensure that every child will have a comprehensive check-up at the time that they enroll in the program.

We will also complete health assessments for any adult who enrolls in the program, and we will partner with Medicare, which already conducts a similar examination for our elderly and dual-eligible populations.

This will help us establish a baseline for the participant's health…it will help us direct the individual to the services they need…and it will help us determine if we're having success, or if we need to change our strategy.

Recommendation #3

For our low-income children who are relatively healthy, we will have a program focused on primary care, prevention and wellness.

It is important to realize, from a long-term perspective, that individuals do not develop chronic illness only when they turn 60. The habits that lead to those conditions are often developed at a much younger age.

And we're seeing this in America, today.

In fact, for the first time ever, since we've been able to track this data in the United States, Type 2 Diabetes…commonly referred to as "adult onset diabetes"…is being diagnosed in children.

This is the beginning of an epidemic – some studies even suggest that if this trend of chronic illness among America's youth continues, today's generation of children will have a shorter life expectancy than their parents.

As a nation, we cannot allow this trend to continue.

We must be proactive in our efforts to reverse it, so that kids can be healthy and future generations of Americans will be as healthy as possible.

Recommendations #4 & #5

We must also be proactive in eliminating barriers that prevent people with disabilities from seeking employment. And we will significantly enhance an individual's ability to choose and direct the services that are most appropriate for him or her under a model of consumer directed care.

Recommendation #6

The program for the elderly will focus on strengthening support services through family and informal caregivers and helping individuals stay in their homes and communities longer rather than being forced to rely on more expensive nursing home care.

In order to affect these common-sense reforms, Idaho must challenge some basic tenets of federal Medicaid law.

For example, current federal law requires that a State plan for medical assistance be in effect in all subdivisions of the state. This is known as the "Statewideness" requirement.

Recommendation #7

In my Medicaid reform plan I propose to implement a pay-for-performance model focused on best practices. But I am not proposing that we begin immediately in every corner of the state.

Instead, we will begin with a pilot project with the State's Physician Residency Programs and Community Health Centers.

As we build these new financing models, we'll start small in order to ensure that they are working to achieve real results.

This is a prudent approach, but requires waiver authority from the federal level. It's ironic that if we implemented these approaches statewide to begin with, it would be easier to gain federal approval, without any requirement that these expenditures are producing the outcomes we expect.

Recommendation #8

I'm also proposing a pilot program to provide preventive health services in public schools. Currently, Medicaid does reimburse participating school districts for services provided to children with special needs.

That means Medicaid will pay for services when a condition – let's say a conduct disorder – requires special services in the school.

Medicaid does not pay for the up-front services to prevent such a condition from getting to the point where a student will need special services.

This shouldn't make sense to anyone, and I am proposing that we change it.

Another current federal law that restricts states' ability to effect meaningful Medicaid reform is the "Freedom of Choice" provision. Under this law, any individual eligible for Medicaid may obtain Medicaid services from any provider that is qualified to furnish the services and is willing to furnish them.

This federal law restricts Idaho Medicaid from contracting with a limited number of vendors and providers.

Recommendation #9

My plan seeks to implement selective contracting strategies to help control the growth of Medicaid costs.

For example, in 2004, Idaho Medicaid spent $1.2 million on incontinence supplies, with over 150 suppliers.

In 2005, those costs shot up by 85% to $2.2 million…that's a problem in any budget.

Through selective contracting, we can identify vendors to deliver these supplies and reap the cost benefits of volume purchasing. To the extent that we can extend this purchasing approach to other services, we should leverage further reductions in costs.

We will also achieve significant savings through selective contracting with transportation brokers, dental plans and Targeted Case Management vendors.

States should have broad authority to employ the common network management tools – like private insurance plans do – in order to increase Medicaid's purchasing power and generate savings.

Recommendation #10

Cost sharing is another common tool used in commercial insurance to manage cost by benefits designs. I'm proposing common-sense, enforceable cost sharing provisions such as co-payments for certain services.

Specifically, these co-payments are planned to address inappropriate emergency room utilization, inappropriate emergency transportation, non-preferred prescription drugs, and missed appointments with primary care providers.

These co-payments are not designed to be significant revenue generators; and they are certainly not designed to create barriers to needed care.

These co-pays are being introduced solely to influence patient behavior, and create disincentives for inappropriate use of the health care system.

To the extent that we can divert inappropriate utilization –such as expensive ER encounters for non-emergent care – we should expect to see significant cost avoidance.

There are provisions in the Budget Reconciliation Act to include tiered co-pays for prescription drugs and authority for co-payments on non-emergency services delivered in a hospital emergency room.

Unfortunately, the federal Budget Reconciliation Act may actually make it harder for us to implement these common-sense reforms.

Another challenge states face is the complexity of eligibility rules. In addition to being costly to administer, these rules result in different benefit packages – not based on health needs – but arbitrary categories under federal law.

It just doesn't make sense to provide different benefits based on such arbitrary distinctions, as if a child's basic health needs somehow change when their family earns that one extra dollar that puts them over some established income thresholds.

Recommendation #11

That's why I'm requesting federal authority to equalize rules between all children's programs, both Title 19 and Title 21, which will result in one consolidated set of rules for children.

This will simplify the program and make it easier for children to receive health insurance coverage – based on their actual needs – instead of an arbitrary eligibility category.

Relatively healthy children – regardless of whether they were Title 19 or Title 21 – will have access to benefits that are comparable to benefits in commercial insurance plans.

Conversely, children who have special needs will have access to more intensive services, regardless of whether they were Title 19 or Title 21.

Recommendation #12

My proposal to redesign Medicaid will also help us address concerns of inappropriate utilization of services, before we pay the bills, instead of trying to figure out if the service was inappropriate – after the check's already in the mail.

One area of inappropriate use we've been concerned about in Idaho is mental health services. Community mental health services have grown from just over $40 million in 2003 to nearly $75 million in 2005…an 85% increase in just two years.

These expenditures were projected to exceed $100 million in two more years if we did nothing. As we began to look at this problem, we discovered that many families were using these services – not because their child had a serious mental health problem – but because they needed day care.

Under the "one-size fits" all approach, relatively healthy children had access to the same benefits as children with serious mental health disorders – as long as a provider was willing to put a diagnosis on the bill they sent to us for payment.
That's not good mental health treatment, and it's not good for children.

If a child needs more extensive coverage than can be provided under the Low-Income Children plan, than expanded coverage would be made available under the Plan for Individuals with Disabilities or Special Health Needs.

This is the right approach to designing benefits…based on the needs of the individual…not on what a provider is willing to bill us for.

Over the past several years, I have been working on long-term care issues. In 2003, as Chairman of the National Governors Association, I made long-term care my Chairman's Initiative for the year.

During that time, I traveled around the country meeting with academic and business experts on long-term care, as well as state and federal government officials who run these vital programs.

As a result of that effort, two nationally televised programs were aired on PBS and the NGA published a series of policy papers highlighting the best practices for long-term care at the state, federal and local levels.

Through that initiative, we began a national movement to help states prepare for the coming generation of Baby Boomers.

At the same time, we began addressing the challenges of long-term care in Idaho.

Idaho has done well in rebalancing its Medicaid long-term care system. We have fewer residents in nursing homes who's care is paid for by Medicaid today than we did in 2003.

Because we've been able to keep elders in their own homes, our Medicaid nursing home expenditures – with pricing inflation – have only grown 8.5% since 2003.

Recommendation #13

We've done this be expanding our use of home and community-based services as an alternative to more costly institutional care.

We expect the average number of individuals served in our home and community-based waiver to increase from just over 4,000 in 2003 to nearly 7,000 in 2007.

At a cost of $838 per month when caring for someone in their own home and community- compared to a cost of $3800 when in a nursing home – that's significant cost savings to the State.

Home and community-based services waivers are examples of tools that allow states to waive comparability provisions and target services based on health needs.

Since most states have been operating these waivers for years, it's good to see that the Budget Reconciliation Act would allow states to manage these programs without going through the burdensome process of seeking federal waivers. It's about time.

Yet, this doesn't go far enough to give states the level of flexibility they need to be proactive as we prepare for the coming generation of Baby Boomers.

Today, we have a system that requires that, before we can help someone in their home, they must become so frail that they qualify for nursing home level care. Does this make sense to anyone? It is wrong and it should be changed.

We know that a spouse, a child or even a neighbor, is caring for many of those individuals who have not yet deteriorated to the point that they qualify for long-term care services under the Medicaid program.

In many cases, the care they provide is keeping their loved one from needing the more intensive and expensive services offered by Medicaid.

But we also know the health of the caregiver is often fragile, and that the stresses and physical exertion of providing care can sometimes lead to a health care crisis for that individual, as well.

So what's the result? Unfortunately, what is becoming an all too familiar story, is that the person on the brink of qualifying for Medicaid is often pushed over that line, and is now relying entirely on Medicaid for his or her care…and sometimes that means actually deteriorating to a point where they need to go into a nursing home.

Again, this doesn't make sense.

Recommendation #14

So, I am proposing to significantly increase respite care and training for those informal caregivers who are taking care of a loved one.

By proactively addressing the needs of the individual who requires care, as well as the caregiver – collectively – we will extend the period of time that individuals do not rely on Medicaid and thereby reduce the overall cost of the program…it makes sense.

Seniors want to remain in their own homes…sometimes they just need a little help to do it…we should provide that help.

Recommendation #15

We should also promote the use of non-Medicaid financing options for long-term care, like reverse mortgages and the Long-Term Care Insurance Partnership program – a program that allows individuals who purchase a qualifying long-term care insurance policy to rely on Medicaid only after their policy has been exhausted, and without having to spend down all of their assets to qualify.

Simply put, if an individual buys a long-term care insurance policy, and if they hit the benefit cap of the policy, they will not have to become impoverished to qualify for Medicaid.

Because they took the steps to be personally responsible, we'll take the steps to reward that behavior.

Doesn't it make sense to encourage individuals to purchase long-term care insurance, instead of waiting for a serious need to arise before trying to figure out how to pay for the appropriate care?

Through a combination of the Partnership program and tax incentives, I believe long-term care insurance could be an effective tool to divert people from state and federally financed Medicaid programs, and even improve the quality of care those individuals receive.

Recommendation #16

In Idaho, we've taken the rights steps. Two years ago, I proposed and the legislature passed a 100 percent tax deduction for long-term care insurance premiums.

When you consider that many families are already taking advantage of comparable tax incentives, like Education Savings Accounts, it becomes clear that the means are there to help pay for long-term care insurance.

Recommendation #17

I would suggest that the last payment parents make to their children's Education Savings Account should be followed by the first payment to their own long-term care insurance policy.

Parents invest so much in their child's education because they want them to succeed in life. They should now take the next step to make sure, in the event of an accident or illness, that they do not inadvertently saddle their children with the expenses and the responsibility of being their primary long-term care provider.

While I believe in families taking care of families, I also believe that planning for the inevitable is the right thing to do, so that our children won't be required to take on that responsibility any sooner than may be necessary.

In order to be aggressive in promoting these non-Medicaid financing options, the federal government must take the same steps as states and provide incentives for our citizens to purchase private long-term care insurance policies.

Recommendation #18

The federal tax code should include a deduction or credit for long-term care insurance, and all states should be allowed to participate in the Long-Term Care Partnership program.

Currently, federal law prohibits all but four states from participating in this program. That should be changed.

With these recommendations, you can begin to see the steps that we need to take to implement a Medicaid program that will balance access, cost and quality.

States must have the flexibility to implement common sense reforms to simplify Medicaid eligibility, to design benefits and delivery systems based on health needs, to promote prevention, wellness and personal responsibility and to eliminate arcane rules that require individuals to become frail before we provide comprehensive, supportive services and respite.

Mr. Chairman, I think there is a great opportunity to reform the nation's faltering Medicaid system. Since I announced my plan last November, I have received endorsements from a number of Idaho provider associations, and the largest business association in Idaho, as well as several of Idaho's advocacy organizations.

While each of these groups has a different perspective on why reform is critical, it is the first time they have all agreed on a path forward.

I am proud of our efforts in Idaho and I look forward to your questions.

Summary of Recommendations

Recommendation #1
Redesign the current Medicaid into three separate programs based on the health needs of different populations:

1. Low Income Children
2. Elderly
3. Individuals with Disabilities or Special Health Needs

Recommendation #2
Utilize a Health Risk Assessment to determine needs of individuals at the time of program enrollment. Establish a health baseline for each participant. Track health improvements on an individual and aggregate basis.

Recommendation #3
For Low Income Children – Focus on primary care, prevention and wellness services.

Recommendation #4
For Individuals with Disabilities or Special Health Needs – Eliminate current Medicaid eligibility rules that function as barriers for employment.

Recommendation #5
For Individuals with Disabilities or Special Health Needs - Implement consumer directed models of care which provide participants more choice and control over their services.

Recommendation #6
For Elderly – Strengthen support services for informal care providers that promote home and community based services and delay institutional based care.

Recommendation #7
Implement pay-for-performance models to encourage Medicaid providers to achieve positive outcomes in accordance with evidence-based best practices.

Recommendation #8
Implement preventative health services in public schools.

Recommendation #9
Implement selective contracting strategies to control costs. Contract with a limited number of Medicaid providers, when feasible.

Recommendation #10
Implement cost-sharing arrangements to address inappropriate utilization of services. Establish co-payments targeted toward influencing patient behavior.

Recommendation #11
Equalize eligibility rules between Title 19 and Title 21 children's programs in order to base different benefit packages on health needs, as opposed to arbitrary distinctions based on income levels.

Recommendation #12
Address inappropriate utilization of services through benefits plan design. Establish different benefit packages based on health needs to reduce reliance on more cumbersome, and costly, utilization management techniques.

Recommendation #13
Expand Home and Community Based Services in order to prevent or delay more costly institutional based care.

Recommendation #14
Implement respite care programs and training for informal care providers in order to prevent or delay more costly institutional based care.

Recommendation #15
Promote the use of non-Medicaid financing programs, like reverse mortgages and long-term care insurance.

Recommendation #16
Enact 100% tax deduction for long-term care insurance at state and federal level.

Recommendation #17
Encourage individuals to transition from last payment to Education Savings Account to first payment toward purchase of long-term care insurance.

Recommendation #18
Allow all states to participate in the Long-Term Care Partnership program.