Build a Better Medicaid Program

A Policy Solution Guide For States

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STATE POLICY NETWORK
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Introduction

When the federal government established Medicaid in 1954, the program was intended to provide health insurance to Americans struggling with poverty—especially those with long-term healthcare needs, including the elderly and individuals with disabilities. It began as a federal-state partnership that promised not only funding, but also flexibility. States could adjust the program based on the unique needs of their populations.

In the years since, Medicaid and related federal oversight of the program have swelled. But expansion has not equaled improved quality care or cost efficiency. Instead, it has led to systematic issues that prevent Medicaid from serving the people who truly need it. Because Medicaid lacks simple but critical parameters, such as time limits, work requirements, and program integrity measures, its resources are often drained by individuals and situations that don't qualify for the type of support that Medicaid has been designed to provide. As a result, states are left with unwieldy Medicaid programs that struggle to prioritize resources for the most vulnerable and crowd out other needs within communities, such as funding for education or public safety initiatives.

The good news for states—and the future of Medicaid—is that states have the power to innovate their Medicaid programs and improve both costs and quality of care. This guide offers a slate of policy solutions that states can pursue to build a better Medicaid program—one tailored to the needs of their citizens, not calibrated to the mandates of federal lawmakers. Many of these policy solutions are reforms states can adopt immediately through legislative action; others will require a waiver from the federal government.

Lastly, a note on Medicaid expansion: As of 2022, 38 states have expanded Medicaid through the Affordable Care Act (ACA), which opened up the program to millions of able-bodied adults under the guise of comprehensive healthcare reform. For the other 12 states that have not taken this step, one of the most straightforward Medicaid solutions is to avoid expansion. States that have expanded Medicaid through the ACA can tackle cost overruns by sunsetting the expansion or pausing new enrollment, especially in states where expansion was passed into statutory code rather than put into the state's constitution.

About the Author

Joshua Archambault is a senior fellow on healthcare policy at both the Pioneer Institute and Cicero Institute. His past research has centered on the treatment of small businesses in the implementation of health reform in Massachusetts, alternative paths for other states to pursue, and delivery system reforms in Massachusetts as a cost containment measure from increasing healthcare spending. Josh served as Legislative Director for State Senator Scott Brown and as a Senior Legislative Aide in the Governor's Office of Legislative Affairs. During his tenure in the State House, Josh worked closely with municipal and business leaders on quality of life issues such as: public safety, improving the business climate and the education system. As a member of SPN's Healthcare Policy Working Group, he contributes his expertise to help other states develop policy solutions to increase healthcare quality and lower costs for their residents.

Legislative Reforms States Can Make Now

- **Adopt enhanced eligibility cross-checks.**
  With an improper payment rate above 20 percent in 2020, states can and must increase program integrity in Medicaid. A great first step is using modern data cross-checks. The concept is simple: States already have prison records, death records, wage and employment records, tax records, lottery and gaming winnings, and out-of-state food stamp card spending. State agencies should cross-check these state datasets for Medicaid enrollees to verify eligibility on a regular basis.

- **Stop accepting self-attestation and post-enrollment verification.**
  Many state Medicaid agencies use "self-attestation," or the honor system, when it comes to critical factors of eligibility, such as residency, age, caretaker status, and household composition. Many also only verify eligibility after an applicant enrolls in the program, using "post-enrollment verification." States can close these loopholes by requiring their Medicaid agencies to verify conditions of eligibility before enrollment, especially for able-bodied adults who enroll through the Affordable Care Act's Medicaid expansion.

- **Limit the use of pre-populated forms.**
  Current regulations require states to provide pre-populated forms on behalf of enrollees when they are due to renew in Medicaid. This makes waste and fraud more likely. But states can do more to limit waste and fraud. Agencies should only prepopulate forms with truly reliable information that is independently verified and "needed to renew eligibility" in accordance with the regulations. Such reliable and needed information may include an enrollee's name, physical address, and other personally identifying information. Enrollees should provide the rest of the information to requalify.

- **Require a report on the number of enrollees found to have moved out of state.**
  When an individual moves out of a state, he or she is no longer eligible to be enrolled in that state's Medicaid program. Yet states often only learn of an enrollee's ineligibility months later. For the majority of states that rely on managed care organizations and automatic, monthly premium payments, this is a major problem—and a major source of wasteful spending.

  In conjunction with more frequent eligibility cross-checks, more accountability and transparency can help mitigate the problem. Medicaid agencies should be required to work with managed care organizations to provide a report to the legislature detailing how many Medicaid enrollees have been found to no longer live in the state and how much time passed between the move, the agency's knowledge of the move, and the individual's disenrollment.

- **Require an annual report on the number of enrollees without claims.**
  Like health insurance in the private market, many Medicaid enrollees do not actually receive any services covered by Medicaid in a given year. Managed care organizations are more than happy to collect these enrollees' monthly premiums from state Medicaid agencies without incurring any costs.

  But without reliable information on how many enrollees make no claims, Medicaid agencies—and taxpayers—may pay the price in higher premiums. Knowing how many enrollees make no claims each year will empower agencies to negotiate fairer rates and make more accurate projections.

- **Limit the damage of hospital presumptive eligibility (HPE) with a three-strikes-you're-out system.**
  Right now, in most states, based on just a few questions about income, hospitals can deem individuals presumptively eligible for Medicaid. Eligibility begins right away, before any verification. With these incentives, it is unsurprising that hospitals have a bad track record in ensuring accurate eligibility enrollments through hospital presumptive eligibility.

  States should implement and enforce a three-strikes-you're-out approach to hospital qualification. The third time a hospital fails to meet standards, the Medicaid department should notify the hospital that it is no longer qualified to make HPE determinations.

State Reforms Possible Through Federal Waivers

- **Limit hospital presumptive eligibility to children and pregnant women.**
  During the Trump administration, several states applied for and received federal permission to return to pre-Obama administration rules surrounding hospital presumptive eligibility. States asked for permission to limit hospital presumptive eligibility to pregnant women and children to prevent hospitals' disorderly administration for all other populations, which currently results in hundreds of millions being spent on care for ineligible applicants.

- **Lock out able-bodied adults who commit fraud for six months.**
  Medicaid recipients who commit Medicaid fraud aren't necessarily removed from Medicaid, and they should be. In the past, states like Kentucky have requested, through an 1115 waiver, permission to disenroll able-bodied enrollees who "fail to report changes in circumstance in the required reporting period," and then implement a lockout period of six months.

Embrace federal options that give your state more flexibility.

Legislative Reforms States Can Make Now

- **Opt out of the federal Medicaid handcuffs so ineligible enrollees can be removed.**
  In March of 2020, under the Families First Coronavirus Response Act (FFCRA), the federal government offered states a 6.2 percent increase in federal matching funds for as long as the public health emergency remains in place. Like most federal funding, this offer came with a catch. Under so-called Maintenance of Effort (MOE) restrictions, states cannot remove any individuals from Medicaid—unless they die or move out of state—even if they become ineligible.

  The good news is that these handcuffs are optional. It's not too late for states to change course and turn down the funds. And, like the federal unemployment bonus, the initial rationale for the funding boost has ended. States should opt out of this deal and proceed with scheduled, annual redeterminations to identify enrollees who are ineligible.

- **Restore the minimum home equity exemption to protect long-term care services for the truly needy.**
  Under federal law, state Medicaid agencies cannot provide long-term care assistance for individuals with significant equity in their homes (about $900,000). States have the option to lower their exemption to the federal minimum (about $600,000). Many states already take this approach and preserve their program for the truly needy. States that don't should use the minimum home equity exemption to better prioritize their Medicaid program for those who rely on Medicaid the most.

State Reforms Possible Through Federal Waivers

- **Opt into the Financial Alignment Initiative to increase access and reduce costs for individuals who are dually eligible for Medicare and Medicaid.**
  About 12 million Americans are eligible for both Medicare and Medicaid. These "dual eligibles" suffer from uncoordinated care and what might be Medicaid's most misaligned financial system. These patients—and state Medicaid programs—pay the price.

  The federal government created the Financial Alignment Initiative to offer states a path to fixing some of these problems. States can opt in using either a managed care model or a fee-for-service model. Both models provide a more cost-effective way to integrate services, including commonly expensive services, such as behavioral health, and longterm services and supports like nursing homes. To save money and improve the quality and coordination of care, states should join the effort and begin to integrate care and payment systems.

Empower beneficiaries with healthcare options for their changing needs.

Legislative Reforms States Can Make Now

- **Incentivize Medicaid enrollees to shop for care at lower cost options.**
  The future of free-market health care reform is price transparency and price consciousness. Plans, including Medicaid, that allow and create incentives for patients to become informed consumers and shop for health care services on the basis of quality *and* price are the plans of the future.

  Medicaid programs often already use incentives like gift cards for patients to manage their health through wellness programs, annual checkups, and specific tasks like quitting smoking. It's time for states to create similar incentives for patients to shop among health care settings on the basis of value.

- **Increase plan options for Medicaid enrollees with chronic conditions.**
  On the private market, insurance plans specifically tailored for patients with certain chronic conditions like diabetes are becoming more and more prevalent. In Medicaid, these are called Chronic Condition Special Needs Plans (C-SNPs) that offer more comprehensive coverage for treatments relevant for the patients enrolled and less coverage for services these patients need less. As a result, patients on these plans can pay less for more that matters to them. States can also look at plans tailored to meet the complex care needs of specific populations, such as adults that as a youth experienced foster care.

  States should do more to open their Medicaid programs to such tailored, patient-centric plans. They work for patients. And they work for state budgets.

State Reforms Possible Through Federal Waivers

- **Offer direct primary care plans in Medicaid.**
  Direct primary care offers patients and physicians an innovative model of care and payment. Like a subscription service, patients pay monthly membership fees rather than fees for specific services. In exchange, they receive direct access to individualized health care without additional costs. These arrangements have been shown to increase the quality of care provided and save significant money with better care management for those with chronic conditions.

  State Medicaid agencies should develop plans for enrollees that offer this model. Such plans can provide higher-quality care for patients and lower costs for state agencies.

- **Index Medicaid coverage and benefits for able-bodied adults to economic conditions.**
  During times of low unemployment, states need able-bodied Americans in the workforce. That's why some states have indexed the duration of their unemployment

benefits to their unemployment rate to promote work in times of economic growth but strengthen the safety net for less prosperous times.

States can request permission to do the same for able-bodied adults in Medicaid by adjusting enrollment and coverage on a sliding scale that becomes more generous during times of higher unemployment.

- **Set work requirements for able-bodied adults in the expansion and parent/caretaker categories.**
  During the Trump administration, 18 states requested some form of work requirement for able-bodied adults on Medicaid, either in the Affordable Care Act expansion category or the parent/caretaker category, through an 1115 waiver request. The Biden administration and courts have since shut down the effort, but it could be reversed under future leadership.

  However, work requirements were working and continue to be the future of successful Medicaid reform, as they help enrollees leave poverty and avoid social isolation. For example, when Arkansas took its opportunity to implement work requirements in Medicaid, nearly 138,000 left the program. Eighty-seven percent of those people left with increased incomes or for reasons other than failure to comply with the requirement. States should move forward with the waiver planning process now so that they can benefit from any potential federal administration change that would embrace work requirements.

- **Institute an earned income disregard for Medicaid enrollees with disabilities.**
  As a program without a work requirement, Medicaid disincentives work. This is a well-known phenomenon among able-bodied adults, particularly those who enrolled through the ObamaCare expansion. Less well known, however, is Medicaid's effect on work for individuals with disabilities. Americans with disabilities on Medicaid often receive care exceeding $100,000 in value every year but can only receive Medicaid coverage if they earn money below certain thresholds.

  This means that individuals with disabilities often want to work or work more but don't in order to maintain their Medicaid coverage. States should disregard more earned income and charge such patients premiums to subsidize their own care and coverage. Individuals with disabilities will gain greater financial and personal independence and will pay more taxes, and government will spend less keeping them in dependency on other programs like food stamps and housing assistance.

Give providers better incentives to improve costs and healthcare quality.

Legislative Reforms States Can Make Now

- **Pay providers based on outcomes for behavioral health treatment.**
  Medicaid agencies should provide a bonus to behavioral health providers—such as those who provide inpatient mental health and substance abuse services—that succeed in keeping patients from returning to an inpatient facility for 90 days. This creates incentives for more thorough discharge planning and continued support after release to reduce expensive ER visits and readmissions. Medicaid agencies can pay for these bonus payments by reducing rates to low-performance inpatient behavioral health providers. Value-based payments that pay for performance are worth exploring especially for long-term services and supports.

- **Pay Medicaid primary care providers to discuss and fill out advance directives for patients.**
  End-of-life care for Medicaid enrollees constitutes some of the highest per-capita spending in state Medicaid programs. Yet, there are many patients without documented advance care planning, or advance directives, many who would either modify or express a desire to forgo high-intensity or high-resource care in a facility, if they could articulate their preference. State Medicaid programs should empower patients and lower future costs by incentivizing primary care providers to give patients more options by helping patients complete advance directives. For states with health information exchanges, such directives could be made available through that channel.

State Reforms Possible Through Federal Waivers

- **Institute different provider payment rates for different Medicaid enrollees.**
  Medicaid was designed to help needy populations like children, seniors, and individuals with disabilities. States should consider submitting a waiver to gain additional flexibility to meet this mission. By setting provider payment rates lower for able-bodied adults, as an example, more resources can go to the truly needy. Those individuals will have greater options as more providers open their doors to Medicaid beneficiaries in those categories because of higher payment rates.

- **Rebalance payment rates and methods to encourage more home-based care and less long-term nursing home care.**
  Long-term services and supports like nursing home care consume huge portions of state Medicaid budgets. Home-based care is significantly cheaper and often provides patients better and more comfortable care. But Medicaid's incentives and payment structure don't match this reality. States should rebalance long-term services and supports by lowering payment rates for institutional settings and raising payment rates for home-based care. States should also allow family members to be reimbursed for providing in-home care.


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