July 8, 2011

The Honorable Fred Upton
2183 Rayburn House Office Building
Washington, DC 20515

The Honorable Orrin Hatch
104 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Upton and Ranking Member Hatch,

We're writing to respond to your May 23rd letter to the nation's Governors asking for ideas to make Medicaid work better.

As national, state- and local organizations representing health care consumers, health care providers, and people of faith in 33 states and Washington D.C., we welcome your interest in preserving and strengthening this essential safety-net program.

We also share your concerns about the challenges states face in financing Medicaid, particularly in the midst of a recession, and appreciate that you are looking for ideas to ease these costs. To arrive at the right policy solution, we must start with an accurate assessment of the program's strengths and its challenges. Sound policy solutions will build on key strengths of the program:

- **Medicaid provides high-quality care that is uniquely suited to meet the needs of the vulnerable Americans it serves.** Your letter inaccurately depicts the quality of care in Medicaid as worse than in private insurance. While it is true Medicaid beneficiaries often have worse health *outcomes* than those enrolled in private coverage, this reflects the fact that Medicaid serves a fundamentally sicker, higher-risk, and more difficult-to-treat population than the private market. We must be careful not to confuse correlation with causation.

  Studies controlling for the underlying risk differences consistently show that Medicaid beneficiaries get care that is equal to – and sometimes better than – the care they would get in private coverage. For example, one study found that 74 percent of children enrolled in Medicaid or CHIP had a preventive or well-child visit in the past year, compared with only 59 percent of privately insured children and 41 percent of uninsured children.[1] Another study found that adult Medicaid enrollees with chronic illnesses were more likely to be taking appropriate medications than privately insured adults with these conditions.[2]

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[1] Lisa Dubay and Genevieve M. Kenney, Health Care Access And Use Among Low-Income Children: Who Fares Best? Health Affairs, January 2001, vol. 20(1).

[2] Thomas Rice, Shana Alex Lavarreda, Ninez A. Ponce, E. Richard Brown. The Impact of Private and Public Health Insurance on Medication Use for Adults with Chronic Diseases. Medical Care Research and Review, April 2005, vol. 62(2).

- **Medicaid plays an essential role in reducing the number of uninsured.** Your letter laments recent growth in Medicaid enrollment, and implies that the solution to states' budget troubles must entail scaling back on Medicaid coverage. But Medicaid spending is extremely concentrated in the sickest and frailest population: 5 percent of Medicaid enrollees – mostly the elderly and disabled – account for 57 percent of spending. So to generate significant cost-savings, states would either have to cut extremely frail seniors and people with disabilities off coverage for the long-term care they need to survive, or dramatically reduce eligibility for the other populations on Medicaid – low-income children and families.

  Of the 46 million low-income children and parents that rely on Medicaid, the majority are in working families without access to private coverage.[3] Any policy that scales back on Medicaid eligibility for this population would increase the ranks of the uninsured, leaving vulnerable Americans without access to the health care they need. This outcome is unacceptable from a human-cost perspective, and would increase the burden of uncompensated care costs on health care providers and throughout the health care system.

- **Medicaid is markedly more cost-effective than private coverage.** Your letter focused on the costs associated with Medicaid, but it ignored the fact that Medicaid is more cost-effective than any other coverage option. Indeed, if the 46 million low-income children and parents were insured on the private market, national health care expenditures would be significantly higher. After adjusting for differences in the populations, the per person cost of serving an adult on Medicaid is 20 percent less than under private coverage, and for children it is 27 percent less.[4] And Medicaid has done a better job at constraining health care cost growth over time: per enrollee Medicaid costs have grown at 4.6 percent annually over the past decade, compared to 7.7 percent annual growth in private market premiums.[5]

Despite Medicaid's cost-effectiveness, there is no doubt that the program is often difficult for states to manage financially. Finding ways to assist states means addressing the key challenges states face in managing their Medicaid costs, without resorting to shifting costs or denying coverage to seniors, people with disabilities or low-income children and families. States face several barriers in managing their Medicaid costs, including:

- **Medicaid is a counter-cyclical program.** Enrollment in Medicaid increases during a recession. This only underscores Medicaid's importance as a safety net: as families lose their jobs – and with it their insurance – Medicaid keeps them from becoming uninsured. But this enrollment increase comes at the exact time when state revenues are declining from a recession, putting severe pressure on state budgets.

- **Certain Medicare policies push costs onto states**. Medicare and Medicaid combine to provide coverage to low-income seniors and people with disabilities. But many federal

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[3] Kaiser Family Foundation. Medicaid: A Primer. June 2010. http://www.kff.org/medicaid/7334.cfm

[4] Leighton Ku and Christine Ferguson. Medicaid Works: A Review of How Public Insurance Protects the Health and Finances of Children and Other Vulnerable Populations. June 2011. http://www.firstfocus.net/library/reports/medicaid-works-a-review-of-how-public-insurance-protects-the-health-and-finances-of-

[5] Ibid

policies – in particular, the monthly Part D clawback payments that states make to Medicare and the two-year waiting period for people with disabilities to qualify for Medicare – simply push costs from Medicare onto state Medicaid programs.

- **Other Medicare policies act as a deterrent to better and more cost-effective care for seniors and people with disabilities.** Those eligible for both Medicaid and Medicare (the "dual eligibles") account for only 15 percent of Medicaid enrollment but 39 percent of Medicaid costs.[6] Their complex care suffers from a lack of coordination between Medicare and Medicaid that adds tremendously to health care costs and harms the quality of care. But because of the complicated interactions between Medicaid and Medicare, state efforts to provide more cost-effective care to the dually eligible may add to state costs while reducing federal costs. The absence of a shared savings mechanism between Medicaid and Medicare may act as a deterrent to states providing the most cost-effective care to this population.

- **The payment and delivery system reforms that are required to put Medicaid on a more sustainable path require administrative resources and upfront investments**. Like our health care system as a whole, Medicaid suffers from a fragmented health care delivery system that adds needlessly to health care costs while driving down the quality of care. States can reduce costs while improving care by investing in payment and delivery system reforms. For example, they can change payment structures to provide incentives for better coordinated care and to reward a higher quality of care rather than a high quantity of care. But these fixes are not simple. They often require significant administrative resources to get right, and they sometimes require upfront investments only to reap the savings a few years down the road. It can be difficult for cash-strapped states to devote the resources to these long-term solutions.

With these challenges in mind, it seems clear that turning Medicaid into a block grant along the lines of welfare reform, as suggested in your letter, would not be a responsive solution. Block grants fail to address any of the challenges laid out above. In fact, a block grant funding mechanism would actually worsen the financial implications of the counter-cyclical nature of the Medicaid program. Whereas the current matching system provides states with increased federal dollars as enrollment goes up, under a block grant program states would bear the entire cost of the recession-driven enrollment increase on their own.

Block grants also do nothing to slow the underlying growth of health care costs. They merely cap total federal spending, leaving states to pick up the rest on their own. The recent House Republican Budget – which converted Medicaid into a block grant program – would decrease federal spending on Medicaid for the 10-year period 2012 to 2021 by 34 percent ($1.4 trillion.) And by 2021, states would receive 44 percent less ($243 billion) than they would under current law. This doesn't alleviate state fiscal challenges; it adds to them.

First and foremost we should seek solutions that do *not* shift new costs onto states or beneficiaries. These policies would alleviate state costs, without pushing costs onto beneficiaries, by directly addressing the challenges laid out above:

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[6] Kaiser Family Foundation. Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries. May 2011. http://www.kff.org/medicaid/upload/4091-08.pdf

- **Automatically adjust the federal-matching rate (FMAP) during recessions.** The federal government could provide states with an automatic boost in their FMAPs during economic downturns. It could be triggered, for example, when unemployment rises above a set level. This would mitigate the impact on state budgets of the countercyclical nature of the Medicaid program, while helping them to maintain eligibility levels when the program is needed most: as families are losing their jobs and with it their coverage.

- **Eliminate or scale back the Medicare Part D clawback.** States make a monthly payment, known as "the clawback", to the federal Medicare program to account for a portion of the cost of outpatient prescription drugs provided to dual-eligibles through Medicare Part D. These payments have totaled to about $7 billion annually in recent years. Eliminating this requirement would provide significant fiscal relief to cash-strapped states.

- **Eliminate the two-year waiting period for Medicare.** Federal law requires people with disabilities to wait two years after they receive Social Security Disability Insurance (SSDI) before they can enroll in Medicare; during that waiting period, these people with very complex medical needs are often forced to rely on Medicaid as their sole source of coverage. State Medicaid costs would decrease by $1.5 to 2.1 billion annually if the federal government allowed everyone on SSDI to qualify immediately for Medicare.[7]

- **Implement a shared-savings program to allow states to reap some of the rewards of better caring for the dually-eligible.**

- **Provide technical assistance to help states adopt best practices in payment and delivery system reform.** CMS could help lower the costs of putting Medicaid on a more sustainable path by helping to disseminate lessons learned and best practices from state efforts to reform payment and delivery systems. They could also provide technical assistance, helping states to adapt successful policies to their unique environments. The Center for Medicare and Medicaid Innovation and the Medicare-Medicaid Coordination Office are already helping states with the upfront investment costs in system changes, for example by investing millions of dollars in helping states plan for better integrating the care for the dually-eligible. States would benefit tremendously if the federal government devoted more resources to these types of projects.

We thank you again for your interest in preserving this vital safety net program. If we can provide you with any other information about the policies we suggest in this letter, please contact Katherine Howitt at Community Catalyst at khowitt@communitycatalyst.org or (617) 275-2849. We look forward to working with your offices to reduce state Medicaid costs while ensuring that the program continues to provide high quality care to America's most vulnerable residents.

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[7] Gina Livermore, David Stapleton, and Henry Claypool. Costs and Benefits of Eliminating the Medicare Waiting Period for SSDI Beneficiaries. Center for Studying Disability Policy. March 2009. http://www.mathematica-mpr.com/publications/pdfs/disability/medicarewaitperiodbr09-02.pdf

Sincerely,

Community Catalyst
Boston, MA

AIDS Council of Northeastern New York
Albany, NY

AIDS Foundation of Chicago
Chicago, IL

Alabama Appleseed Center for Law & Justice, Inc.
Montgomery, AL

Alabama Arise
Montgomery, AL

Asian & Pacific Islander American Health Forum
Washington, DC

Association of Perinatal Networks of New York State
Binghamton, NY

Black Women's Health Imperative
Washington, DC

Boston Medical Center
Boston, MA

Boston Public Health Commission
Boston, MA

The Bronx Health Link
Bronx, NY

Campaign for Better Health Care
Urbana, IL

The Center for Community Solutions
Cleveland, OH

Center for Immigrant Health Care Justice
St. Louis, MO

Center for Independence of the Disabled, New York
New York, NY

Center for Public Policy Priorities
Austin, TX

Center for Rural Affairs
Lyons, NE

Cerebral Palsy Associations of New York State
Albany, New York

The Children's Aid Society
New York, NY

Children's Alliance of New Hampshire
Concord, NH

Citizen Action of New York
Albany, NY

Coalition of Wisconsin Aging Groups
Madison, WI

Colorado Consumer Health Initiative
Denver, CO

Community Healthcare Network
New York, NY

Community Legal Services
Philadelphia, PA

Connecticut Association for Human Services
Hartford, CT

Connecticut Health Foundation
Hartford, CT

Connecticut Health Policy Project
New Haven, CT

Connecticut Parent Power
Hartford, CT

Connecticut Voices for Children
Hartford, CT

Consumer Health Coalition
Pittsburgh, PA

Consumers for Affordable Health Care
Augusta, ME

The Continuum
Reno, NV

Corporation for Ohio Appalachian Development
Athens, OH

Disabled in Action of Metropolitan New York
New York, NY

Disabilities Network of New York City
New York, NY

Empire Justice Center
Rochester, NY

Family Support in Central New York, Inc.
Holland Patent, NY

Family Voices,
Washington, DC

Family Voices at the Rhode Island Parent Information Network
Cranston, RI

Fiscal Policy Institute
Latham, NY

Florida CHAIN
Jupiter, FL

Georgia Budget and Policy Institute
Atlanta, GA

Georgians for a Healthy Future
Atlanta, GA

Granite State Organizing Project
Manchester, NH

The Greater Hudson Valley Family Health Center, Inc.
Cornwall, NY

Harris County Healthcare Alliance
Houston, TX

HAWC Community Health Centers
Reno, NV

Health Action New Mexico
Bernalillo, NM

Health Care for All
Boston, MA

Health Care For All New York
New York, NY

The Health Foundation of Central Massachusetts
Worcester, MA

Health Law Advocates
Boston, MA

Health Law Advocates of Louisiana
New Orleans, LA

Heartland Alliance for Human Needs & Human Rights
Chicago, IL

Hudson Health Plan
Tarrytown, NY

Illinois Maternal and Child Health Coalition
Chicago, IL

Kansas Health Consumer Coalition
Topeka, KS

Kentucky Equal Justice Center
Lexington, KY

Legal Aid Society of Southwest Ohio LLC
Cincinnati, OH

Livingston County Department of Health
Lakeville, NY

Louisiana Consumer Healthcare Coalition
Breaux Bridge, LA

Maine Children's Alliance
August, ME

Make the Road New York
Jackson Heights, NY

Maryland Citizens' Health Initiative
Baltimore, MD

Massachusetts Chapter of the American Academy of Pediatrics
Cambridge, MA

Massachusetts Citizens for Children
Boston, MA

Massachusetts Law Reform Institute
Boston, MA

Massachusetts Medical Society
Waltham, MA

Maternity Care Coalition
Philadelphia, PA

Medicaid Matters New York
Albany, NY

Metropolitan Council on Jewish Poverty
New York, NY

Michigan Consumers for Healthcare Advancement
Lansing, MI

Mississippi Center for Justice
Jackson, MS

Mississippi Health Advocacy Program
Jackson, MS

National Health Law Program
Washington, DC

National Initiative for Children's Healthcare Quality
Boston, MA

Neighborhood Health Plan of Rhode Island
Providence, RI

New England Consortium Poverty Reduction Initiative
South Portland, ME

New England SERVE
Cambridge, MA

New Hampshire Voices for Health
Concord, NH

New Jersey Citizen Action
Highland Park, NJ

Nevada Lawyers for Progressive Policy
Reno, NV

Niagara Cerebral Palsy
Niagara Falls, NY

North Carolina Justice Center
Raleigh, NC

North Central Area Agency on Aging
Hartford, CT

North Shore Child and Family Guidance Center
Roslyn Heights, NY

Ohio Citizen Advocates
New Albany, OH

Ohio Poverty Law Center
Columbus, OH

Ohio Psychological Association
Columbus, OH

Oregon Health Action Campaign
Gresham, OR

Peace & Social Concerns, Chapel Hill Community Church
Chapel Hill, NC

Peninsula Counseling Center
Valley Stream, NY

Pennsylvania Health Access Network
Philadelphia, PA

Pennsylvania Health Law Project
Philadelphia, PA

The People's Empowerment Coalition of Ohio
Cincinnati, OH

Philadelphia Unemployment Project
Philadelphia, PA

PICO National Network
Washington, DC

Planned Parenthood Mar Monte
Reno, NV

Public Health Institute
Bronx, NY

Raising Women's Voices
New York, NY

Rhode Island Health Center Association
Providence, RI

Rhode Island KIDS COUNT
Providence, RI

Schuyler Center for Analysis and Advocacy
Albany, NY

Senior Legislative Action Committee of Sullivan County
South Fallsburg, NY

South Carolina Appleseed Legal Justice Center
Columbia, SC

Take Action Minnesota
St. Paul, MN

Tennessee Health Care Campaign
Nashville, TN

UHCAN Ohio
Columbus, OH

Utah Health Policy Project
Salt Lake City, UT

Upper Hudson Primary Care Consortium
Queensbury, NY

Vermont Campaign for Health Care Security Education Fund
Montpelier, VT

Vermont Family Network
Williston, VT

Virginia Organizing
Abingdon, VA

Voices for Illinois Children
Chicago, IL

Voices for Vermont's Children
Montpelier, VT

Washington CAN!
Seattle, WA

Westchester Disabled on the Move
Yonkers, NY

Women's Way
Philadelphia, PA

504 Democratic Club
New York, NY