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On Healthcare

HEALTHCARE

THE EVOLUTION OF MEDICAID

Announcer: Welcome to Navigant On Healthcare, offering insights for healthcare leaders striving for success in an evolving industry.

Host: Today, we're speaking with David Mosley, managing director and leader of the state practice within the government healthcare solutions unit at Navigant. Dave's focus is on government healthcare, providing clients with valuable insight, policy guidance, financial modeling, revenue strategy, and technical assistance. He has a background that includes addressing complex budget and financing issues for states across the country. He has served two governors in his work history, and as a city manager, Dave directed the financial operations, claim processing system, rate setting, and audit functions of a state's $14 billion Medicaid program. I'm your host, Bob Kim.

Hi, Dave. Thanks for joining us today on Navigant On Healthcare.

David Mosley: Good morning, sir. It's a pleasure to be with you.

Host: Great. Thanks for joining us. Let's get started. We're in the midst of another significant transformation in healthcare, been in the midst of it for a while. Medicaid is a hot topic, as always. Can you provide three or four facts for our listeners that they probably don't know about Medicaid?

Dave: I'd be happy to. I think one of the most interesting facts is that Medicaid covers more individuals than Medicare or the VA. It's actually the largest health insurer in the United States. When we hear folks speaking on TV or in the newspaper, various Congressional hearings, we hear a lot about Medicare, we hear a lot about VA. You typically don't hear as much about Medicaid. It's a partnership that exists between the federal government and the states. The states pay a percentage based on the level of prosperity within a state. You would have a state, such as Massachusetts, that pays 50% of the Medicaid bill, and you would have a state, such as Mississippi, that pays only about 23% to 24% of the tab. While the funding varies, the propensity or the penetration of Medicaid is much more vast than people would realize. I think, secondly, is that folks don't realize that Medicaid pays for almost 80% of all nursing home days. When you hear about healthcare issues attributable to the elderly population, or disabled population, most folks think about Medicare.

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About Navigant

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However, again, nearly 80% of all nursing home days are paid for by Medicaid and it's 70% of the revenue attributable to the nursing home industry. Within states, it's about 24% of their Medicaid budget, so about one quarter of all Medicaid funds goes to long-term care for the elderly and disabled. That brings up what I would argue is the third most meritorious point for today, which is that Medicaid is not health insurance. Many folks equate Medicaid, or compare Medicaid, to Medicare to Veterans Care to commercial care, and it's simply an erroneous comparison. Medicaid is, in fact, long-term care, vision insurance, dental insurance, and a plethora of social services which are deemed to address quality of life issues. Medicaid was created in 1965 as a program that was supposed to parody Medicare, it has grown to something far more substantial to where we're addressing quality of life issues and services that are neither curative nor restorative.

Host: Well, there's a lot of talk about Medicaid reform these days. How may that impact those benefits and all the different programs? What's your perspective on that?

Dave: It's interesting. Medicaid continues to see unlimited demands and what I believe is going to be increasingly scarce funds. Many of our states are experiencing Medicaid cannibalizing other programs, and what I mean by that is while governors and legislators are cutting back transportation, they're cutting back education, environment, wildlife, higher education, whatever it might be, they're doing so while simultaneously trying to fund more money for Medicaid. Medicaid, again, is cannibalizing states' budgets. What you see is governors and legislators are generally unwilling to take people off of Medicaid by offering more restrictive enrollment criteria. They're also unwilling to take services off the menu. Of course, there are only a few variables. One is the number of people. Number two is the services that they consume, and three is the rates that you pay for those services. What you've seen is states shifting to managed care.

Managed care, of course, presumes to remove all variables except for n, the number of people, because it capitates the dollars going to the plans. It also speaks to the menu of services the plans must offer, and it allows the plans to negotiate the rates that they're paying to Medicaid providers. Unfortunately, my prognosis is that we're going to continue to see pressure on the rates paid to Medicaid providers and, most predominantly, hospitals. The reason being is that for, as long as I've been in this business, which is now 30 years, you see folks at the state level believe that hospitals can magically do one of two things, one of which is to reduce cost. The other is to shift the Medicaid burden to other payer types, in that, if Medicaid pays less than the full cost of treating Medicaid beneficiaries, that creates a deficit. That deficit then gets passed on to private payers, to commercial payers. In fact, it's a hidden tax.

If you're in a state where the Medicaid agency doesn't reimburse, for instance, hospitals at the full cost of serving Medicaid beneficiaries, the penalty is paid by the corporations doing business in that state that provide healthcare for their employees or the people seeking to obtain private healthcare coverage because that money's got to come from somewhere. It's a tough argument sometimes, but it really does behoove states to use those blended dollars that we talked about that are anywhere from 50% federal to 74%, 75% federal to fully reimburse under the Medicaid program, such that there's not this hidden or invisible tax that's passed on to a commercial or the populace of the state in general. Again, the hospitals which are really the hub in the hub-and-spoke model, particularly in rural areas, I think they're going to see the most pressure, which is indeed unfortunate.

Host: Right. I want to talk about the Medicaid block grant program, if I may. Back in February of this year 2017, you were interviewed by Becker's Hospital Review. You addressed five key questions about the impact of the Medicaid block grant program to hospitals. How would providing states with fixed federal grants for Medicaid spending change the current program?

Dave: Well remember that the current program for every dollar the state spends, some portion thereof is matched by the federal government. Again, anywhere from 50% up to about 75%. What would happen is, most likely, and this is something I've started working with Congressman Cassidy's office 10 years ago, now Senator Cassidy, is a PMPM cap. They would look at what the historic spending was for different groups of Medicaid people: one being the expansion population, one being the elderly, one being the disabled, one being the TANF population, which is Temporary Assistance for Needy Families (basically women and healthy children -- the least expensive group to provide care for). When the federal government caps that, they pass off the risk to the states. The federal government doesn't have a balanced government requirement. States do have a balanced budget requirement. When you push risk down to a state that must balance its budget, the state has to push that risk off to another entity. They simply can't absorb the risk.

The answer seems to be that they'll push it off to managed care entities. We are starting to see groups of hospitals with physicians creating what we call a provider's sponsored plan to bid against, or compete with, traditional managed care companies. Those are small and they're growing very slowly. There are few predominant players in the Medicaid managed care business, and they're making quite a bit of money. What would we would see as, again, the federal government looks to limit their exposure, they'll pass off risk to the states. The states will look to pass off risk to managed care companies. That creates an environment where, of course, the managed care companies then have the prerogative to negotiate with providers on rates. We get back to the previous point, which is: with a capitated amount of funds, they're going to have to push down rates. The cause, the number people that are covered, or the eligibility criteria, is sticks and stone (?) by the state. The service menu and the services that are covered is set by the state, so the only variable left is what the managed care companies are paying to providers.

It creates a tough environment. The whole concept behind this was that states would have more flexibility. As Congress and the current administration started going to states and saying: "We're interested in this capitated model. We're going to give you more flexibility. What flexibility are you looking for?" Unfortunately the look in the eyes of many at the state level was perhaps that of the dog that chased the bus and finally caught it, not knowing then, what to do with the bus. States want flexibility, but states are reluctant to take people off the program. States are reluctant to reduce the menu of services that are available, so it's a tough road. I'm not very hopeful that it's a near-term fix. It's going to take some real doing and something inclusive of, perhaps, what the Republicans are trying to do, but much more global, which I think is a perspective that the Democrats are looking for.

Host: Unfortunately, this is all the time that we have. I'm sure we could go for hours on this topic, as well as other things -- all the great things that you do for Navigant and our clients. I hope our listeners have found this conversation useful. I know I've certainly learned a lot more about Medicaid as a result of this conversation. Again, thank you, Dave for sharing your expertise with us today.

Announcer: That concludes today's episode. Be sure to check in with us for future installments of the Navigant On Healthcare podcast series on navigant.com/healthcarepodcast. Navigant On Healthcare is a podcast series produced by Navigant's healthcare practice. If you enjoyed this episode, please share it with friends and colleagues on social media. Learn more at navigant.com.

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