Medicaid Reform Should Be a Priority for Nebraska

Since the June 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius* found that Medicaid expansion under the Affordable Care Act must be voluntary for states, advocates for expanding the Medicaid program have been hard at work. After efforts to expand Medicaid in Nebraska failed in 2013, Senator Kathy Campbell introduced LB 887 in the 2014 legislative session. Although the bill was promoted as a more market-friendly approach to expansion, the ineffective cost-control mechanisms, the misplaced priorities, and the long-term burden for Nebraska taxpayers[1] proved too much for the Unicameral, and the bill failed to become law.

After two years of debate on proposals for Medicaid expansion, it is time to consider alternatives that can improve health care options and outcomes for Nebraska's most vulnerable citizens: those who the Medicaid system was designed to protect and who will remain underserved without needed reforms.

Annual Nebraska state Medicaid spending has nearly doubled over the last decade, growing at a rate much faster than state revenues, with an increase from $1.1 billion in 2000 to $1.9 billion in 2012.[2] Even without Medicaid Expansion, Nebraska is projected to spend $34.4 billion on Medicaid during the next decade, compared with $10.9 billion over the last ten years.[3]

Costs for Nebraska's Medicaid program are substantially higher than neighboring states and the national average.[4] If costs were aligned with the region, taxpayers could save up to $177 million per year.[5] If Nebraska's Medicaid costs matched the national average, taxpayers could save up to $208 million per year.[6]

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[1] "The WIN Act is a Loser for Nebraska." Platte Institute for Economic Research. March 19, 2014. [URL: http://www.platteinstitute.org/research/detail/the-win-act-is-a-loser-for-nebraska]

[2] "Financial Management report for fiscal years 1997 through 2001." Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. 2011.; "Financial Management report for fiscal years 2002 through 2011." Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. 2011.; "Financial Management report for fiscal year 2012." Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services. 2013.

[3] Holahan, John, et al. "Cost and coverage implications of the ACA Medicaid expansion: National and state-by-state analysis." Kaiser Family Foundation. 2012.

[4] "Medicare and Medicaid statistical supplement." 2012 edition. U.S. Department of Health and Human Services. 2013.

[5] Calculations based upon per capita and total Medicaid spending in Nebraska compared to the HHS Region VII average.

[6] Calculations based upon per capita and total Medicaid spending in Nebraska compared to the national average.

While total program costs are rising rapidly, the state's share of these costs has risen even faster. Nebraska taxpayers now shoulder nearly 47 percent of the cost of the Medicaid program, up from just 40 percent a decade ago, adding nearly $125 million each year to the state's share of program costs.[7]

Despite these increases in spending, access and quality care issues persist for vulnerable populations. Two-thirds of Nebraska counties face shortages of primary care providers and all but one county have shortages of mental health providers.[8] 1,500 Nebraskans with intellectual or developmental disabilities remain on waiting lists to receive Medicaid services.[9] Reform means bankable savings to address these critical needs.

Increased scrutiny of Medicaid eligibility that goes beyond federal requirements is an important tool for securing vital program funding for truly vulnerable Nebraskans in their time of need. Reforms to restore integrity to the Medicaid programs in Pennsylvania and Illinois provide a remarkable model that has saved millions of dollars in those states, providing benefits to recipients and taxpayers. Pennsylvania's technology upgrades enabled state officials to discover hundreds of thousands of ineligible benefits recipients and led to a $300 million savings in the first ten months alone.[10] A sweeping integrity initiative was implemented in Illinois after an Inspector General report revealed that 34 percent of randomly selected Medicaid files were found to contain eligibility errors, mostly relating to basic eligibility requirements like income, residency, and household composition. Illinois officials estimated that the enhanced eligibility verification program would save approximately $350 million through its fee-for-service Medicaid program.[11]

Nebraska should also consider building on the managed care reforms already achieved here to upgrade Medicaid in the state and realize significant savings like reformers have done in Florida, Kansas, and Louisiana. This means expanding competition between health plans, something that would facilitate the creation of enhanced benefit packages at no additional cost to taxpayers. Instead of only two plans in the state — the minimum required by the federal government — Nebraska's population could likely justify three or four plans. More choices for those receiving Medicaid benefits can mean savings for taxpayers while also providing better benefits for patients.

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[7] "Federal financial participation in state assistance expenditures: Federal matching shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2005 through September 30, 2006." U.S. Department of Health and Human Services. 2004.; "Federal financial participation in state assistance expenditures; Federal matching shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2014 through September 30, 2015." U.S. Department of Health and Human Services. 2014.

[8] "Health professional shortage areas: Primary care." Health Resources and Services Division. U.S. Department of Health and Human Services. 2014.; "Health professional shortage areas: Mental health." Health Resources and Services Division. U.S. Department of Health and Human Services. 2014.

[9] "Waiting lists for Medicaid section 1915(c) home and community-based services waivers." Kaiser Commision on Medicaid and the Uninsured. Kaiser Family Foundation. 2010.

[10] Eisenhower, Clint. "CSG innovations awards application 12-E-12- PA." Council of State Governments. 2012.

[11] Long, Ray. "Illinois legislature passes deep health care cuts." *Chicago Tribune*. May 25, 2012.

In Florida, the state was able to secure dozens of value-added benefits[12] through the competitive bidding process, increasing service quality and patient satisfaction while actually reducing costs for taxpayers. Similar expansion of plan competition in Kansas resulted in broader benefits options valued at $6 million per year at no additional taxpayer expense.[13] The Florida reforms netted taxpayers baseline savings of 10 to 15 percent,[14] and Kansas taxpayers have seen an absolute reduction in Medicaid spending of 5 to 7 percent.[15] If Nebraska were to achieve similar results, it could mean $100 million to $300 million dollars in initial savings.

Policymakers in Nebraska should work to ensure that taxpayers here are getting the best value for their dollars, and that those dollars are making a difference in the lives of those who need help the most.

For more information on Medicaid reform in Nebraska, see the Platte Institute's September 2014 policy study, "Medicaid Reform: Strengthening Nebraska's Health Care Safety Net"

[12] "A snapshot of the Florida Medicaid Managed Medical Assistance program." Division of Medicaid. Florida Agency for Health Care Administration. 2013.

[13] "Annual report to CMS regarding operation of 1115 waiver demonstration program: Year ending December 31, 2013." Division of Health Care Finance. Kansas Department of Health and Environment. 2014.

[14] Harman, Jeffrey S. "Do Provider Service Networks result in lower expenditures compared with HMOs or Primary Care Case Management in Florida's Medicaid program?" Health Services Research 49(3): 858-877. 2014.; Bragdon, Tarren. "Florida's Medicaid reform shows the way to improve health, increase satisfaction and control costs." Heritage Foundation. 2011.

[15] Calculations based upon 2013 KanCare expenditures as compared to 2011 historical Medicaid expenditures. See, e.g., "Annual report to CMS regarding operation of 1115 waiver demonstration program:
Year ending December 31, 2013." Division of Health Care Finance. Kansas Department of Health and Environment. 2014.