GOVERNORS PERSPECTIVE ON MEDICAID pdf

1: A Governorâ€™s Perspective on Medicaid Policy Priorities in the States - AHIP

At AHIP's National Conference on Medicaid (October), the Honorable Ralph Northam, Governor of the Commonwealth of Virginia, will share timely insights onmaking Medicaid work. Virginia is the latest state to expand Medicaid under the Affordable Care Act.

February 20, Updated: February 21, at Rick Scott said Wednesday he supports expanding Medicaid and funneling billions of federal dollars to Florida, a significant policy reversal that could bring health care coverage to 1 million additional Floridians. Scott, a former hospital executive, spoke with unusual directness about helping the "poorest and weakest" Floridians â€” a stunning about-face for a small-government Republican who was one of the loudest voices in an aggressive, and ultimately unsuccessful, legal strategy to kill a law he derided as "Obamacare. On Wednesday, he called the proposed Medicaid expansion, at least for an initial period, "common sense. That is far from certain, particularly in the more partisan House. I am personally skeptical that this inflexible law will improve the quality of health care in our state and ensure our long-term financial stability. Joe Negron, R-Stuart, who chairs a Senate committee studying the health care law. He said senators would reach their own conclusions likely in early March. Part of his self-described "new perspective" came from the death of his mother, Esther, last year, he said. The privatization expands on a five-county pilot program that has been rife with problems. Critics worry for-profit providers are scrimping on patient care and denying medical services to increase profits. Some doctors have dropped out of the pilot program, complaining of red tape and that the insurers deny the tests and medicine they prescribe. Patients complained they were bounced from plan to plan with lapses in care. Nearly half of the , patients enrolled in the pilot have been dropped from at least one plan, federal health officials noted at one point during negotiations. Medicaid, a joint state-federal, government-run health care program, is voluntary for states. But every state participates, in part because of the good financial terms. The federal government covers about 55 percent of all Medicaid costs in Florida and covered about 68 percent in recent years with additional stimulus funding. The health care law tried to entice states to expand eligibility to Medicaid by raising income eligibility limits. To do so, the federal government agreed to fund percent of the cost for states to expand Medicaid for three budget years. The federal government would then cover 95 percent of the costs in , 94 percent of the costs in , 93 percent of the costs in and 90 percent of the costs in and beyond. Scott said Wednesday that he had to look past his long-standing opposition to the health care law to reach his decision. We had an election in the fall, and the public made their decision. Federal government conditionally approves Florida plan to privatize Medicaid system. Hours later, Scott endorses plan to expand Medicaid eligibility. Top GOP lawmakers, who must sign off, remain noncommittal. Case for the economy A report for two consumer groups cites economic benefits. Top GOP lawmakers, who must sign off on expansion, remain non-committal tease hed goes right 1 inch 1 inch of body type 1 inch 1 inch of body type 1 inch 1.

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2: Governor C.L. â€œButchâ€• Otter - The State of Idaho

s. 11kg. goverors' perspective on medicaid hearing before the committee on finance united states senate one hundred fifth congress.

Copyright notice Introduction Viewed from one vantage point, Medicaid has been one of the most successful social programs this country has launched. It represents a dramatic achievement in providing access to care for low-income people and stands in sharp contrast not only to the situation that existed prior to the passage of the Medicaid program, but also to the plight of the uninsured today. It provides coverage to more than 25 million people, many of whom would otherwise be added to the ranks of the uninsured. Yet, despite its important contributions to access to health care for the poor, Medicaid has never been a popular program. Indeed, it is the health care program everyone loves to hate. Providers believe Medicaid pays them too little and too slowly. Federal executives see a constant stream of State Medicaid waiver requests, with tortuous arguments for budget neutrality, that seek to raid the Federal treasury. And clients view Medicaid as a mixed blessing: It offers a vital health benefits life line, but they view it as stigmatizing, and obtaining care is often frustrating. Both sides of the ideological aisle also have their reasons to dislike the Medicaid program. Their view is that welfare programs, including Medicaid, have caused more harm than good by promoting dependency and using taxpayer dollars unwisely. Not surprisingly, given these perceptions, Medicaid has not built a strong constituency and has received only a fraction of the analytical attention devoted to Medicare. Another reason for this lack of affection and focus is the complexity and diversity of the program. As is well known by the readership of this journal, Medicaid is really three programs in one: Remembering that each of these 3 programs looks a little different in every State, one realizes that Medicaid is really different programs spread across the 50 States. It is difficult to comprehend, analyze, or mobilize support for a program this diverse. The result is that Medicaid plays its role as payer of last resort and provides care to the most vulnerable populations without much fanfare or support. As Human Services Commissioner and Associate Commissioner in New Jersey, and long-time advocates for Medicaid, we sometimes even found ourselves losing our affection for the Medicaid program, as annual Medicaid increases consumed funds needed for other priority areas. In any given year, the increase in Medicaid necessary just to maintain current services consumed about one-half of all the new funds available for our department. This left the homeless, the mentally ill, the elderly, the developmentally disabled, veterans, welfare recipients, and other needy groups to fight for the leftovers after Medicaid had taken its share. The last 10 years In recent years, Medicaid has gone through some important changes. With State and national economies faltering, the early eighties saw a period of cost containment in the Medicaid program. During this time, the States and the Federal Government faced a common challenge: The specific challenge Medicaid faced was how to limit expenditures without resorting to the traditional, quick-fix Medicaid cutsâ€”reducing eligibility, eliminating benefits, or reducing payments to providers. Although Federal policy changes in the early eighties reduced Medicaid eligibility for some groups Omnibus Budget Reconciliation Act of , Public Law , by and large, States worked hard to avoid draconian measures, and out of this period came an interest in new financing and service alternatives. Spurred by the need for cost containment and by the search for alternatives to harmful cuts, many Medicaid agencies began slowly to change in character. Once large agencies that simply paid bills, Medicaid administrators began to take more initiative, using their control over reimbursement as a mechanism to try to improve the health care system for their clients. In effect, many Medicaid programs became laboratories for change. They also became more active purchasers, seeking to use their buying power to achieve savings. During this time, important experiments were launched in prepaid managed health care, utilization review, case management, diagnosis-related groups DRGs , negotiated rates, home and community-based services for the elderly, disabled, and persons with acquired immunodeficiency syndrome AIDS , and other forms of payment reform. As State economies improved in the mid-eighties, Congress moved to expand Medicaid coverage. Thus, Medicaid moved from an era of cost containment to one of careful and selective expansion. It was during this time that the historical step was taken of breaking the link between Medicaid and welfare eligibility. This

resulted in a series of significant expansions of Medicaid, particularly for low-income women and children, and laid the basis for a potentially much broader and very different program in the future. With the passage of welfare reform in , another subtle but important change was made in the Medicaid program. Medicaid came to be viewed as part of a broader strategy to address the problem of poverty in America. Welfare recipients almost always cite the fear of losing health insurance as a major disincentive to leaving welfare and going to work. But through the Family Support Act as part of a package of services including job training, education, child care, and case management, the 1-year guarantee of Medicaid eligibility for people who leave welfare because of employment has become a cornerstone of the welfare reform effort. The use of a Medicaid extension in welfare reform relieves a woman on public assistance of the need to make a Hobbesian choice between taking an entry-level job that would leave her children without health insurance and remaining on public assistance. Medicaid has evolved substantially in the last decade, moving from cost control, through innovation, to expansion. The important question is which strands of this recent history will dominate in the decade ahead. The challenge ahead As we move into the nineties, the Medicaid program will have to confront several realities if we are to sustain the accomplishments of the past and do better in the future. First, we are once again entering a period, like the early eighties, of fiscal constraints at the State level. Governors are once again eyeing their Medicaid budgets with suspicion. Nothing shapes the development of Medicaid policy at the State level more than the health of the State budget. And once again, we are entering a period when State budgets are shaky at best. Healthy State economies have permitted the States to pick up the slack as Federal spending, constrained by the deficit, slowed. With State deficits re-emerging, the ability of States to maintain the safety netâ€”and a growing Medicaid programâ€”will weaken. Without new resources, it may be that the laboratories of the eighties, the States, are running out of gas. The standard menu of Medicaid reforms may be played out. In the eighties, Medicaid agencies made existing resources go further. But Medicaid is not a magic act; it cannot maintain services in the absence of both State and Federal resources. It is our sense that it is better to work to reduce inappropriate services and develop financing alternatives than to eliminate coverage of particular services, as Oregon is attempting to do. In any event, explicit service limitations present a new and unexplored face of the Medicaid debate. Second, like building a house on a beach that is washing away, we have been expanding the Medicaid program while the foundation of the program deteriorates before our eyes. As the participation of physicians and other health professionals in Medicaid wanes, the access we are providing to those covered by Medicaid is increasingly access only to a hospital emergency room or Medicaid mill. When it comes to providing primary care, emergency rooms make poor family doctors. It makes little sense, for example, to expand Medicaid coverage for pregnant women, if there is no obstetrician within 50 miles willing to provide prenatal care or to deliver her baby. This is being done now, for example, where Medicaid financing is part of comprehensive school-based service programs. We can expect increased tension between two views of Medicaid: Women and children represent almost 70 percent of Medicaid recipients, but less than 25 percent of Medicaid expenditures Congressional Research Service, As the population continues to age, we can expect even more pressure for Medicaid resources to be expended on behalf of those needing long-term care services. This is a persistent problem in Medicaid and one that remains very real. All these stresses and cross-pressures play out in an environment where the problems that Medicaid must address are getting worse rather than better. The problems of the uninsured, the elderly, the urban poor, and, in some States, the devastation of crack and AIDS, are growing, while resources are static. We sometimes forget that two of our biggest problems, AIDS and crack, did not exist 10 years ago. This tension between capacity and need is the major challenge faced not only by Medicaid, but by the entire health care system in the nineties. These institutions are on the front lines, and they are disproportionately dependent on the Medicaid program. Future directions It is unlikely that the problems faced by Medicaid will be dealt with comprehensively. We seldom solve social problems in our country through bold single strokes. Just as it is likely that we will address the overall health insurance problem by building in increments on what we have, it is also likely we will strengthen the Medicaid program through a series of incremental steps. If we are to see positive incremental change, it will be important to strengthen the foundation of Medicaid, to build the infrastructure as well as to maintain the positive new directions of recent years. First, we need to take steps to bring primary

care physicians and other health professionals into the Medicaid program and to hold on to the ones we have. To do this, fees must be increased, a measure that will certainly cost more. There is, however, one way to begin to address this problem without substantial new expenditures: Managed-care plans reallocate resources from emergency rooms and other services to primary and preventive care. In a good Medicaid managed-care plan, it is possible to increase reimbursement to primary care physicians at no additional overall cost to the Medicaid program. But Medicaid managed care has been stalled for years, mired in red tape and waiver processes, provider ambivalence, analytic uncertainty, and questionable State commitment. These obstacles can be overcome, but it will require a renewed effort by government, and openness by providers, to take the plans for managed-care programs off the drawing board and beyond the demonstration stage. Second, we should continue to look for opportunities to expand Medicaid coverage to the uninsured. For example, buy-in plansâ€"an idea discussed in the Bush-Dukakis presidential debate and alluded to in the Omnibus Reconciliation Act of â€"can be developed. Through a buy-in to Medicaid, it is possible to offer a significant percentage of the working uninsured an option for health coverage at rates substantially below those otherwise available in the marketplace. Yet Medicaid buy-in plans have not been developed to any substantial extent. Where they exist, Medicaid managed-care plans represent an opportunity for buy-in strategies; buying in to managed care is obviously preferable to buying in to care in emergency rooms or Medicaid mills. Broader use of buy-in also offers the potential to reduce the stigma of Medicaid by making it a more inclusive program with a more diverse clientele. It will also be important to maintain recent efforts to make Medicaid a more active force for better health care, rather than just a passive payer of bills. For example, many States have taken the lead in building comprehensive prenatal care programs into their Medicaid plans. Such programs offer a comprehensive package of services and typically also reform payment to make it possible to provide comprehensive care on a single-point-of-entry basis. The usual approach is to provide a global fee for a comprehensive package of services including outreach, the identification of high-risk cases, home visiting, case management, nutrition and substance abuse counseling, and other critical services necessary to make a difference through prenatal care. This is important because providers are unlikely to offer comprehensive, single-point-of-entry services if they have to submit separate bills to Medicaid agencies for each individual service. Also, clients will not get comprehensive quality services if they have to go shopping for services at 5 or 10 different locations. Comprehensive prenatal care programs could be mandated by the Federal Government as a necessary part of every State Medicaid program, or alternatively, States could be given incentives to offer such plans through enhanced Federal matching rates. There is ample precedent for enhanced matching rates where the Federal Government wants to encourage State action. Similarly, if the recent eligibility expansions are to achieve their full potential, it will also be important for Medicaid agencies to continue to expand efforts to reach newly eligible populations. As State administrators well know, offering a service does not guarantee its use. As the link was broken between Medicaid and welfare eligibility, Medicaid agencies lost their natural connection to women and children in the welfare office. As a result, Medicaid agencies will need to become more active in outreach activities, a role they have not historically played. The Federal Government could encourage such activities at very limited cost by mandating outreach or enhancing matching rates for outreach activities. Although there are cost implications to encouraging comprehensive care and outreach in Medicaid, it would be a modest investment compared with the benefits.

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3: Perspectives On Medicaid Expansion | Kaiser Health News

Medicaid is failing patients and is a target for waste, fraud, and abuse, not because the States are doing a bad job, but because Washington's bureaucracy has tied States' hands, preventing them.

Two southern states, Louisiana and Kentucky, have reversed positions on Medicaid expansionâ€”after electing new governors. This shift is a reminder, as the presidential contest draws so much focus, that down-ballot races also matter. When it comes to health policy, governors can make a huge difference. In Louisiana, former Gov. His successor, John Bel Edwards, made expanding the program a central plank of his election campaign. Other governors, too, have changed direction. Tom Wolf in Pennsylvania replaced the more conservative plan of his Republican predecessor with a conventional expansion under the ACA. In very red Alaska, the independent governor, Bill Walker, forced a Medicaid expansion on a resistant legislature. Matt Bevin was elected after loudly promising to scrap the Medicaid expansion launched by his predecessor, Steve Beshear. Bevin backed off his plan to scrap the Medicaid expansion but has since told the Obama administration that he would scrap the expansion unless the U. As the chart above illustrates, the contrast between Louisiana and Kentucky, two Southern states, is sharp. Louisiana rapidly enrolled , uninsured people by July 15, using a streamlined eligibility and enrollment system that, among other measures, deemed people who are eligible for the Supplemental Nutrition Assistance Program SNAP automatically eligible for Medicaid. In Kentucky, by contrast, if Gov. Bevin is channeling his opposition to the ACA into a more conservative approach to Medicaid. Depending on how HHS responds to his demands for a waiver, time will tell if this position, like his earlier campaign rhetoric, is a negotiating tactic on which he does or does not follow through. There are 12 gubernatorial elections this year, three in states that have not expanded Medicaid: Missouri, North Carolina, and Utah. The remaining 36 states have gubernatorial elections in ; so far, 14 of those are non-expansion states. Among those poised to hold elections in are Texas, Florida, and Georgia, the three non-expansion states with the largest populations of uninsured residents. Republicans are likely to retain most of the governorships in non-expansion states, but several Republican governorsâ€”including, notably, John Kasichâ€”have expanded Medicaid. Governors take on a variety of health-care issues, and manyâ€”including opioids, the Zika threat, and health-care costsâ€”are pressing. But as events in Louisiana and Kentucky are showing, there is a lot at stake in health care in down-ballot races in this and coming election cycles.

4: Gov. Rick Scott's 'new perspective': expand Medicaid after all

Perspective from The New England Journal of Medicine â€" U.S. Governors and the Medicaid Expansion â€" No Quick Resolution in Sight Perspective. U.S. Governors and the Medicaid Expansion.

5: Perspectives on the Medicaid program

Reforming Medicaid Waivers: The Governors' Council Perspective on Federalism Today | 6 Medicaid is a significant burden on state budgets, representing an average of 16 percent of state general fund spending, second only to K and higher education spending. vi As.

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