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Idaho lawmakers examine local control reform package for Medicaid

After Rep. Janice McGeachin, R-Idaho Falls, was appointed to head the House Health and Welfare Committee in December of 2010, she promised to bring a more active approach to the post and work to delve deep into policy issues important to Idahoans.

It looks like McGeachin is keeping her promise by looking into a way to drastically alter the Medicaid system in Idaho. The Idaho Falls Republican, joined by five of her fellow committee members, took part in a nationwide conference call centered on Medicaid reform and how the Gem State might be able to save millions each year through giving more control over the program to state officials.

The crux of the call? If states have freedom to basically go their own way with Medicaid, good things will follow, or so said David Alexander, former Rhode Island secretary of Health and Human Services on the call sponsored by the Galen Institute, a free-market think tank based in Alexandria, Va.

“We wanted to turn the program on its head,” said Alexander of Medicaid. “We knew we had enough money in the system.” Alexander helped reform the Rhode Island system during his time there, though he did get help from the administration of President George W. Bush, which approved the special program on Jan. 19, 2009, a day before Bush left office.

By many observations, the Alexander plan is working. In the last 18 months, the program saved the state about \$100 million. Idaho might not be able to expect such great cost-savings because Rhode Island’s Medicaid budget is much larger than the Gem State’s. Last year, Idaho and the federal government spent about \$1.5 billion on Medicaid, while Rhode Island and the feds team up to spend more than \$12 billion on the program annually.

For those who might fear that the giving control to the Idaho Legislature would mean less help for the poor because of cuts to programs and changing eligibility requirements, the Alexander model isn’t about that. “We’ve done this without reducing eligibility,” he said. McGeachin told *IdahoReporter.com* that reducing eligibility won’t be on the table if Idaho follows the Alexander plan. “Our eligibility levels are already pretty low in relation to other states, so I don’t think that’s really an issue for us,” she said.

The plan essentially lets states have freedom to do as they like with Medicaid, as long as they stay under a certain financial amount. Alexander said that in negotiations with the federal government about the plan, the cap was critical in gaining approval. “We said ‘we won’t ask for more money if you give me flexibility,’” Alexander explained. “I think we all know there’s enough money in the state if we had flexibility from onerous federal laws.”

Besides being a bargaining chip for Rhode Island, Alexander said the cap also served a dual-role for state officials: incentive to find fraud and waste within the system. “By having that cap, it forced us to dig deep in our system and identify fraud and waste,” he explained.

In a research paper about the cap, Alexander says that Rhode Islander lawmakers also gain from having the cap because they have financial certainty for the program for five years at a time, a provision laid out in his package.

Once Rhode Island was given control of the system, Alexander said, state officials looked into several options to reduce costs and meet the financial cap. Things that had never been considered before under federal guidelines – options like telemedicine, competitive contracting, and health savings accounts – were deployed to cut costs.

Another key element was working to find different options for those elderly citizens in nursing homes who are able to live at home with some government assistant. Alexander said that more than 1,000 people have been given in-home nursing, meals, and other aid to keep them out of more expensive nursing homes, a move which saved Rhode Island big bucks.

Instead of asking the federal government for waivers – permission to administer a program differently than federal guidelines require – Rhode Island can make rapid changes to programs and tweak benefits to best fit state residents. Alexander said that waiting for waivers often means waiting times of 12-18 months. “We [states] have to balance our budgets, so we can’t afford to wait multiple years for innovations,” he explained.

Additionally, the state was given quicker answers for policy questions from the U.S. Department of Health and Human Services. Instead of waiting three to four months for answers, Alexander said, state officials received replies within 45 days. “We got freedom administratively, which helped our staff,” Alexander boasted.

Not everything is under state control with the plan, however. Minor changes to Medicaid programs can go unreported by the state, but large policy shifts need the 45-day review process and permission from the feds.

And it’s that freedom that might entice Idaho lawmakers to push the plan. “It’s going to have a different flavor in each state,” said Alexander. “But to do this, the state legislatures must be on board.”

From initial observations, the Idaho Legislature may be on board with the Alexander plan. “I’ve been telling Sen. Crapo that if they gave us 20 percent less money and this freedom, we could get this thing solved,” said Rep. Tom Loertscher, R-Iona, as he left the conference room.

The largest obstacle to moving toward a Rhode Island model might be the administration of President Barack Obama, Alexander said. McGeachin feels that if the plan is the right one, the federal government will work with the states to make the correct choices. “The federal government actually needs our help,” said McGeachin. “The new health care plan is so big and they are struggling to figure out how it’s all going to work. The federal government needs the states to step up to the plate and offer solutions. “

It’s not set in stone that lawmakers will pursue the Alexander plan. “It’s our job to be prudent and study these things carefully,” said McGeachin. “From what I’ve read so far, it sounds like a really good plan to me.”

If the Legislature chooses to enact the proposal, McGeachin said lawmakers could order the Idaho Department of Health and Welfare to develop an Idaho-specific proposal for the Obama administration. Legislators might also take an easier route and simply voice support for the plan through non-binding resolutions.