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A National Challenge: How States Are Trying to Control Medicaid Costs (And Why It's So Hard)

Vernon K. Smith, Health Management Associates

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Introduction

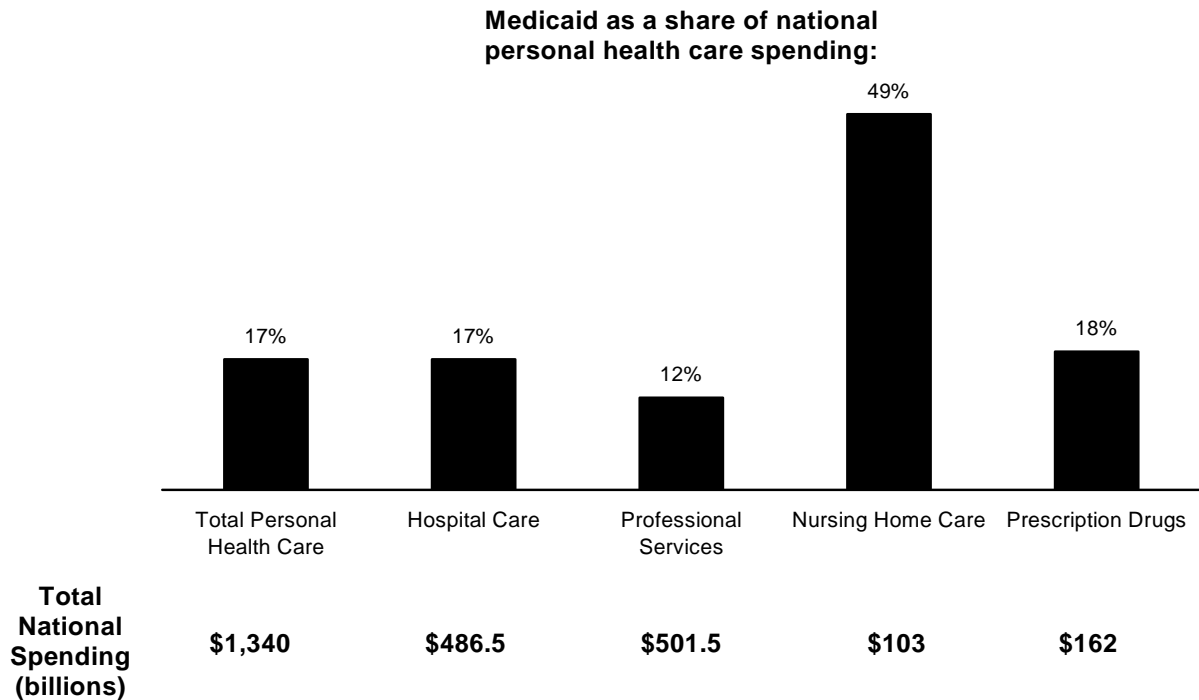
As states entered Fiscal Year 2005, they were faced with a mix of good news and bad news. After three years of intense fiscal stress, most states were anticipating an improved revenue picture. At the same time, several factors continued to place pressure on states to contain Medicaid costs. This report is based on a 50-state survey of Medicaid administrators that was conducted in the summer of 2004 concerning their states' Medicaid spending growth and cost containment strategies.

What is Medicaid and what role does it play in our health care system?

Medicaid is a publicly funded health insurance program that provides coverage to low-income children, families, seniors, and people with disabilities. Medicaid also fills gaps in Medicare coverage for many low-income seniors, particularly for prescription drugs and long-term care. It is the largest publicly funded health insurance program, providing health and long-term care coverage to 52 million low-income children and adults in FY 2004, compared to 42 million covered by Medicare. Medicaid also supplements Medicare coverage for 7 million low-income seniors and people with disabilities who are enrolled in both programs. [In **Michigan**, Medicaid provides coverage to approximately 1.4 million persons.¹]

As Figure 1 shows, Medicaid plays a major role in our nation's health care system, paying for nearly half of nursing home care, and 18% of prescription drugs.

Figure 1: Medicaid's Role in the Health Care System, 2002



SOURCE: Levil, et al, 2004. Based on National Health Care Expenditure Data, Centers for Medicare and Medicaid Services, Office of the Actuary.

How does Medicaid work?

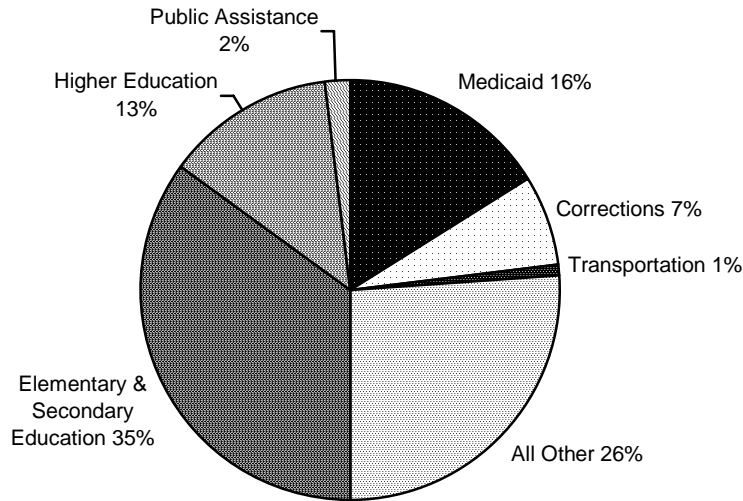
States must design and administer the program according to the federal rules. Within the federal structure, states enroll beneficiaries using their own eligibility criteria, decide on some covered services, and set payment rates for providers. States decide key policies, such as use of managed care systems; they also may provide coverage for "optional" services beyond the required core services (e.g., non-emergency dental and vision coverage for adults). The federal government sets minimum requirements, authorizes deviations ("waivers") from these requirements, and audits expenditures and performance.

Medicaid is jointly funded by states and the federal government, with the federal government matching state spending on an open-ended basis. The federal match rate, known as the federal medical assistance percentage (FMAP), varies by state from 50 to 77 percent. [In **Michigan**, the federal Medicaid matching rate is about 56.7¹ percent.]

Because of the matching formula, state spending brings increased federal dollars into the state, providing an incentive for states to increase funding for health and long-term care services. On average, states spend about 16% of their state budgets on Medicaid, making it the second largest program in most state budgets, after education (see Figure 2). [In **Michigan**, almost one quarter of state General Fund/General Purpose revenues go to Medicaid.²]

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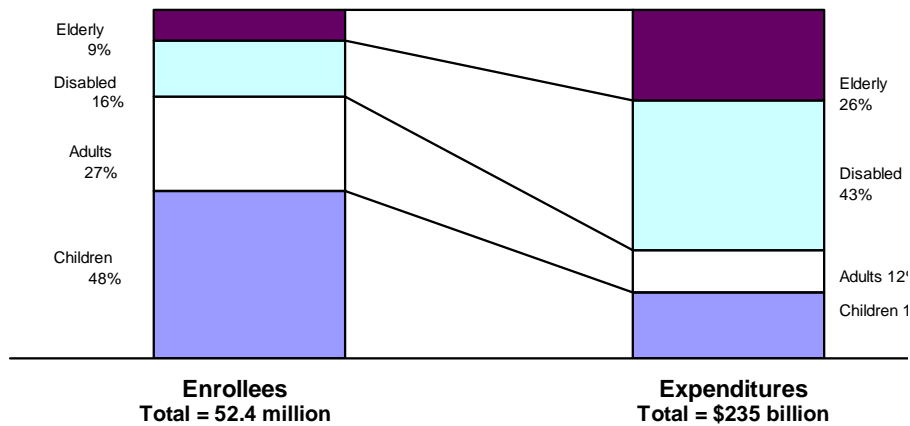
Figure 2: State Medicaid Spending as a Percent of General Fund Expenditures, 2002



Total State General Fund Spending=\$496 Billion

SOURCE: National Association of State Budget Officers, 2002 State Expenditure Report, November 2003.

Figure 3: Medicaid Enrollees and Expenditures by Enrollment Group, 2001



Expenditure distribution based on Congressional Budget Office data that includes only federal spending on services and excludes DSH, supplemental provider payments, vaccines for children, administration, and the temporary FMAP increase. Total expenditures assume a state share of 43% of total program spending.
 SOURCE: Kaiser Commission estimates based on CBO and Office of Management and Budget data, 2004.

Where does most Medicaid spending go?

Medicaid expenditures vary for the different populations served. Although low-income children and families represent about three-fourths of Medicaid beneficiaries, they account for only one third of the expenditures (see Figure 3). On the other hand, elderly and disabled individuals, who represent just one quarter of the beneficiaries account for 70 percent of the expenditures, reflecting their intensive use of acute and long-term care services.

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What are the trends in Medicaid expenditures?

In FY 2004, total Medicaid spending increased an average of 9.5%.¹¹ As Figure 4 shows, this increase is slightly more than 2003, but lower than the average annual growth rate of 11.9% that occurred over the 2000-2002 period.

State administrators cite several key factors as top drivers of Medicaid spending growth in FY 2004. The most frequently mentioned factors include:

- Medicaid enrollment growth
- Increasing costs of prescription drugs
- Rising costs of medical care
- Rising costs of long-term care

Figure 4: Average Annual Growth Rates of Total Medicaid Spending



SOURCE: For 1992-2002: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64); For 2003 and 2004: Health Management Associates estimates based on information provided by state officials.

11. Total Medicaid spending reflects actual payments to medical providers for services rendered to beneficiaries. It includes special payments to providers, such as Disproportionate Share Hospital (DSH) payments but does not include Medicaid administrative costs. [see glossary for definition of DSH payments]

What are the trends in enrollment?

Medicaid enrollment increased during the economic downturn, as more families lost jobs and fell into poverty. Medicaid enrollment is projected to grow 4.7% in FY 2005, which is a slower pace than was seen between 2001 and 2004. State Medicaid officials attributed continued growth in enrollment to several factors:

- The economic downturn, resulting in increasing numbers of low-income uninsured people – particularly children and families (most significant for 23 states)
- The effect of eligibility expansions or restorations (10 states)
- Increased numbers of eligible elderly and disabled because of demographic changes (3 states)
- Outreach for programs such as the State Children's Health Insurance Program or food stamps, which identify additional persons eligible for Medicaid (3 states)

What is the current revenue picture?

Many individual states, including Michigan, are expecting large budget shortfalls for FY 2005 while Medicaid costs continue to increase.

Since 2001, as the national economy worsened and state revenues slowed, states have been forced to cut back on all state programs. As a result, they have had to make difficult choices that have affected health coverage for millions of low-income people across the country.

As states enter FY 2005, revenue has been growing and is expected to continue to grow; however, many individual states, including Michigan, are expecting large budget shortfalls for FY 2005 while Medicaid costs continue to increase. Additionally, the temporary fiscal relief to states provided by the federal government through the Jobs Growth and Tax Reconciliation Act of 2003 will end in 2005, thus significantly increasing the state share of Medicaid expenses. Anticipated gaps between revenue and expenditure growth will exert enormous pressures on states to reduce or control costs.

[Michigan officials cited overall caseload size and the phase out of special financing as key factors contributing to overall spending growth in FY 2004. For FY 2005, they cited increasing caseload, loss of one-time federal fiscal relief and loss of special financing as most significant factors.]

What strategies are states using to contain costs?

FY 2005 will be the fourth consecutive year that states have implemented significant cost containment initiatives, although a few states also are adopting modest benefit or eligibility expansions. Most states are implementing not just single cost containment measures but a more comprehensive set of strategies, including:

- Reducing or freezing provider payments
- Controlling pharmacy costs
- Reducing benefits
- Reducing or restricting eligibility
- Increasing co-payments
- Implementing disease management programs
- Implementing cost controls for long-term care
- Targeting fraud and abuse

Next, we will discuss how states are using each of these strategies.

Strategy 1: Reduce or freeze provider payments

Medicaid rates for payments to providers are generally the lowest of any payer, sometimes below the cost for delivering care. Payment reductions or freezes (which amount to reductions because of cost inflation) can have an impact on the availability of providers who will accept Medicaid and thus on access to care. Still, when faced with increasing fiscal pressures, many states used this strategy:

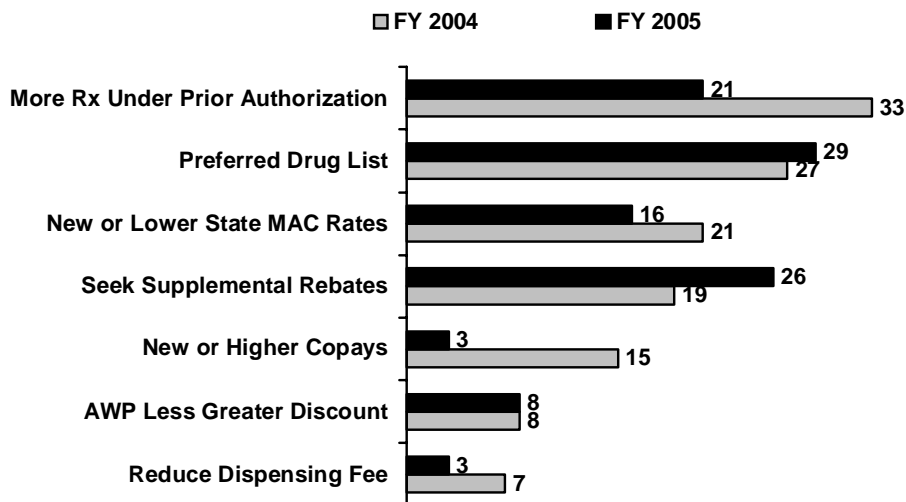
- In FY 2004, all 50 states and the District of Columbia cut or froze payment rates to at least one provider group; 47 states said they would so in FY 2005.
- States were most likely to cut reimbursement rates for physicians (42 states for 2004 and 33 for 2005).
- Cutting reimbursement rates to hospitals and nursing homes or Managed Care Organizations is more difficult because state statutes regulate reimbursement rates. Nevertheless, a number of states froze rates for one or more of these groups for 2004 or 2005.

[Michigan reduced or froze provider payments for FY 2004 and FY 2005.]

Strategy 2: Control pharmacy costs

States continued to focus significant attention on controlling the cost of prescription drugs, which have been growing at double-digit rates for several years. Cost containment strategies were implemented by 47 states and the District of Columbia in FY 2004 and by 43 states in FY 2005 (see Figure 5 drug cost reduction strategies).

Figure 5: Medicaid Prescription Drug Policy Changes FY 2004 and FY 2005



SOURCE: Kaiser Commission on Medicaid and the Uninsured survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2004.

For 2005, the most frequently used strategies included:

- **Implementing preferred drug lists (29 states)**
- **Seeking supplemental rebates (26 states)**
- **Placing more drugs under prior authorization (21 states)**
- **Paying a larger discount off of the Average Wholesale Price (AWP) for drugs (8 states)**

In FY 2005, fewer states set lower Medicaid Maximum Allowable Costs (MACs)^{III} for drugs (16 states) or reduced dispensing fees paid to pharmacies (3 states). For FY 2005 only 3 states adopted new or higher patient co-payments; however, in FY 2004 15 states had done so, and Medicaid rules limit patient co-payments to a “nominal” amount – generally \$3 per service. Thus, some states may have already reached the upper limit of co-payments.

[In FY 2004 **Michigan** implemented new or lower MACs, prior authorization for more drugs, and use of a preferred drug list; in FY 2005 Michigan implemented paying a larger discount off the AWP for drugs, a reduction in dispensing fees, and use of a preferred drug list.]

Strategy 3: Reduce Covered Benefits

For FY 2005, fewer states were cutting benefits and more were restoring benefits cut in previous years:

- Only 9 states cut benefits in 2005, compared to 19 in 2004
- 14 states intended to restore or expand benefits cut in previous years

In general, benefit cuts involved “optional” services, particularly those extended to adults, including elderly and disabled persons. Services that were cut included:

- Dental, vision and hearing services for adults
- Chiropractic and podiatry services
- Psychological services
- Physical and occupational therapy
- Personal care services

States either eliminated these services entirely or limited the amount of services covered.

[**Michigan** suspended coverage in FY 2004 for adults for the following services: chiropractic, non-emergency dental, hearing aids, and podiatry. In FY 2005, it restored coverage for podiatry and hearing aids.]

Strategy 4: Reduce or Restrict Eligibility

Reducing eligibility for Medicaid is often difficult for states to implement because these reductions affect vulnerable populations who usually have no other access to health insurance. However, during the recent economic downturn, 38 states reduced or restricted Medicaid eligibility over a 4-year period (2002-2005). On the other hand, in 2004 and 2005 several states expanded coverage to previously excluded groups, such as the working disabled, people under family planning waivers, or uninsured women with breast or cervical cancers.

Eligibility changes fell into three categories: 1) eligibility rule changes; 2) application and renewal process changes; and 3) premium changes. We will discuss each separately.

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^{III}. State MAC programs assign upper limits to the amount Medicaid will pay for certain generic drugs for which the federal government has not set an upper limit.

Changes to Eligibility Standards

In order to receive the enhanced federal match authorized by the Jobs Growth and Reconciliation Act of 2003, states were required to maintain eligibility through June 2004 at the levels in effect on September 2, 2003. No states made reductions that affected the Medicaid matching rate in 2004. Although fewer states are implementing reductions in 2005, the changes will affect a larger number of people. States planned a variety of eligibility changes such as:

- Eliminating coverage for specific populations [e.g., medically needy adults with incomes above the TANF level] (2 states in FY 2004, 3 states in FY 2005)
- Eliminating continuous eligibility (2 states in 2004)
- Increasing the spend-down threshold level for the aged, blind, and disabled [amount of their own money they must spend before becoming eligible for Medicaid] (1 state in 2004)
- Reducing the income eligibility limit for certain groups [e.g., pregnant women with incomes between 200% and 235% of the federal poverty level; aged and disabled persons with incomes between 100% and 133% of the federal poverty level] (6 states in 2004; 3 states in 2005)

At the same time, some states expanded eligibility to previously uncovered groups by:

- Increasing the income eligibility level for aged and disabled individuals (1 state in 2004; 2 states in 2005)
- Eliminating TANF work requirements in determining eligibility for Medicaid (1 state in 2004)
- Enabling disabled workers to buy in to Medicaid coverage (2 states in 2004)

Changes to Application and Renewal Processes

Through the late 1990s and into 2001, states adopted measures designed to simplify and streamline Medicaid application and re-determination procedures. In the face of budget difficulties, some states reversed this process (10 states in 2004 and 4 in 2005). Major changes included:

- Instituting more frequent periods for re-verification of eligibility
- Eliminating continuous eligibility for certain groups (i.e., requiring periodic re-verification of eligibility)
- Eliminating policies that allow for self-declaration of income, in effect increasing the amount of required documentation

[Michigan made no reductions in eligibility in FYs 2004 or 2005. In 2004, it expanded coverage to disabled adults who are working through the Ticket to Work Program.]

Premium Changes

In a limited number of situations, states can require premiums as a condition of coverage. In 2004 and 2005 a few states implemented premium changes, including:

- Increased premiums for parents and children covered under expansion waivers (Massachusetts and Vermont)
- New or higher premiums for disabled workers (Iowa, Louisiana, Minnesota, and Nevada)
- New premiums on certain disabled children covered under the "Katie Beckett"^{IV} rules (Maine)

IV. Rules that allow states to cover certain disabled children under 19 if the child meets SSI standards for disability, would be eligible for Medicaid if in an institution, and is receiving home medical care that would be provided in an institution.

[Michigan made no premium changes in FYs 2004 and 2005].

Strategy 5: Increase or Implement Co-payments

Payments must be “nominal” — generally defined as \$3 or less per service.

When imposing patient co-payments, states must comply with the federal Medicaid law. Payments must be “nominal” — generally defined as \$3 or less per service — and cannot apply to certain services, or certain eligibility groups, such as children or pregnant women. Over the past several years, states have relied more on co-payments as part of their cost containment strategies, although a substantial body of research indicates that even nominal co-payments can deter low-income individuals from receiving needed care.³

In FY 2004, 20 states imposed new or higher co-payments; for FY 2005, 9 states did so. The most frequent co-payment imposed was for prescription drugs (discussed under containing drug costs). A few states increased co-payments for:

- Hospital inpatient and outpatient visits
- Non-emergency use of emergency rooms
- Hearing, vision, dental and therapy services
- Physician office visits
- Ambulatory services
- Home health

[Michigan implemented no new or increased co-payments during 2004 or 2005.]

Strategy 6: Implement Disease and Case Management Programs

States have initiated programs to manage asthma, diabetes, hypertension, depression, congestive heart failure, mental and behavioral health, and obesity.

An increasing number of states are turning to disease and case management initiatives to help contain costs. Between 2002 and 2004, 42 states began programs. These initiatives are seen as a relatively low-cost way to improve health care for people with chronic and disabling conditions, including many adult Medicaid beneficiaries. Quality results from these programs are promising but not conclusive because there are several barriers: 1) participation is voluntary; 2) turnover is high among enrollees; and 3) payment rates to providers are low.⁴ In a recent health benefits survey of employers,⁵ 15 percent of firms responded that disease management strategies were very effective in containing costs.

The trend among states is clearly toward more comprehensive care management programs; states have initiated programs to manage asthma, diabetes, hypertension, depression, congestive heart failure, mental and behavioral health, and obesity. In the future, states may have a more difficult time implementing care management programs because persons eligible for both Medicaid and Medicare will be moving their drug coverage to Medicare.

[Michigan did not provide data on this strategy.]

Strategy 7: Implement Cost Controls on Long-Term Care and Home and Community Based Services

Although long-term care (LTC) represents over one-third of Medicaid spending, states did not initially adopt cost containment in this area. However, as other methods of controlling costs have been exhausted, states are beginning to focus on LTC. Cost containment strategies include:

- Reducing the number of nursing home beds
- Reducing the number of days for which Medicaid will pay a nursing home when the resident is in the hospital

- Reducing payments to nursing homes when a bed is held for a resident who is temporarily away from the facility for a number of days, e.g., visiting a child for a holiday
- Tightening eligibility criteria
- Downsizing the capacity of intermediate care facilities for the mentally retarded
- Changing formulas for nursing home reimbursement

In the past two years, some states have implemented cost controls on home and community-based services (HCBS), which are services provided to frail elderly and disabled persons in their own homes to prevent or delay their need for institutional care. Some states have limited the number of available Medicaid waiver slots for HCBS, thus reversing a trend of the past five years when states expanded access to community-based support services in response to the U.S. Supreme Court decision in *Olmstead v L.C.* (June, 1999). This decision found that the unjustified institutionalization of people with disabilities is a violation of the Americans with Disabilities Act.

Other cost cutting measures in HCBS included:

- Limiting hours authorized for specific instrumental activities of daily living
- Restricting private duty nursing hours
- Reducing the allowable budget for high-cost cases
- Implementing utilization review procedures

[In FY 2004 **Michigan** implemented reductions to the Medicaid Personal Care Program (Home Help) by limiting the number of hours authorized for specific instrumental activities of daily living, freezing provider rates, limiting the definition of providers, and requiring annual recertification of medical need. For 2005 changes were made to definitions and screening procedures but these changes were expected to be revenue neutral.]

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Strategy 8: Target Fraud and Abuse

Many states enhanced ongoing activities or started new activities designed to control fraud and abuse. In some cases these actions were tied to new management information systems, additional staff or an increased number of provider audits. Activities included locking high-use recipients in to a single doctor, establishment of a new fraud unit within the state Office of Inspector General, and a greater focus on third party liability recoveries. Between 2002 and 2005, 32 states have put in place new fraud and abuse mechanisms.

[**Michigan** implemented no new initiatives in fraud and abuse during this period.]

What are the issues for the near future?

As states moved into FY 2005 with a somewhat improved economic picture, several factors will present new challenges. We anticipate that three factors coming up in 2005 and 2006 will have an impact on states' ability to contain Medicaid spending growth.

The Expiration of Federal Fiscal Relief

Temporary federal relief that assisted states in 2003 and 2004 has come to an end, thus vastly increasing the state burden of Medicaid costs. The Jobs Growth Tax Relief Reconciliation Act of 2003 provided states with an enhanced federal match rate (FMAP) for Medicaid expenditures. The enhanced FMAP enabled 36 states to resolve Medicaid shortfalls and helped 31 states avoid,

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minimize, or postpone Medicaid cuts or freezes. With the expiration of the enhanced FMAP, state spending on Medicaid will grow enormously in FY 2005; legislatures have authorized spending growth in state general funds of 11.7% for FY 2005, compared to 4.8% growth in FY 2004. A number of state administrators commented on the fiscal hardship this will impose. However, officials in 20 states indicated that the expiration of the enhanced FMAP had been anticipated and the impact minimized.

States that have relied heavily on these special financing arrangements report that the increased scrutiny will have a big impact on their state Medicaid financing.

Increased Scrutiny of Special Financing Arrangements

As states have struggled in recent years to deal with Medicaid shortfalls without undermining essential services to vulnerable populations, some have turned to special financing arrangements to maximize the amount of federal money flowing to states. These arrangements include the use of funds from other governmental units (Intergovernmental Transfers, or IGTs) and/or provider taxes to make up the non-federal share of Disproportionate Share Hospital (DSH) payments^v or Upper Payment Limit (UPL) reimbursements. At the same time, the federal Centers for Medicare and Medicaid Services (CMS) has increased its scrutiny of these arrangements, often through the Medicaid State Plan amendment approval process. States that have relied heavily on these special financing arrangements report that the increased scrutiny will have a big impact on their state Medicaid financing.

[Michigan officials cited increased scrutiny of special financing arrangements as a key factor driving Medicaid spending growth in the state.]

Implementation of the Medicare Prescription Drug Benefit

Implementation of the new Medicare Part D drug benefit that is scheduled to take effect January 1, 2006 has provoked some concern among states regarding people who are eligible for both Medicare and Medicaid (dual eligibles).

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- The greatest concern is about the "**clawback**" provision of the Medicare law that will require states to make payments to the federal government to help finance the drug benefit for those with dual eligibility.
- Proposed regulations raised the possibility that states may be responsible for enrolling in the Medicare Part D drug plan over 6 million individuals with dual eligibility. In addition, states were concerned that the Medicare drug plans will not cover all the medications now covered under Medicaid.
- States were also concerned that costs would increase because of a "**woodwork effect**," as more Medicare beneficiaries discover they are eligible for Medicaid when they apply for the subsidies available to persons with low-incomes.

Only 3 states (California, New York, and Rhode Island) reported receiving additional administrative resources for FY 2005 to prepare for the implementation of the Part D Medicare benefit. However, all states will be expected to begin determining eligibility for Part D low-income subsidies beginning in July 2005 and must marshal the needed resources to accomplish this task.

v. DSH funds are provided to hospitals that serve a disproportionate share of uninsured patients.

What is the outlook for 2005 and beyond?

Medicaid did play a critical safety net role for many vulnerable individuals during the recent economic downturn. The current financing structure of the program, with federal matching dollars and guaranteed eligibility for those who qualify, allowed Medicaid to play this critical role. However, the challenges discussed above, combined with trends of increasing poverty and eroding private insurance, will continue to put pressure on Medicaid enrollment and spending growth. States are responding in different ways to these trends:

- Some states are seeking to control costs through Section 1115 waivers, which give them the flexibility to implement enrollment caps and benefit reductions.
- Several states have begun to view Medicaid as an effective means to address the issue of the uninsured and to expand coverage.

The recent period of fiscal stress has regenerated interest on the state and federal levels in restructuring the federal Medicaid law. Major issues include the way the program is financed and the relative role of states and the federal government. The direction this discussion takes will have significant implications for state budgets, for program beneficiaries, and for the ability of the program to serve as part of the safety net for vulnerable populations.

For more detailed information on this survey, read the complete report: Smith, V., Ramesh, R., Gifford, K., Ellis, E., Rudowitz, R., & O'Malley, M. (2004, October). *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*. Washington, DC: The Kaiser commission on Medicaid and the Uninsured. Available on line at www.kff.org/medicaid/7190.cfm.

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