North Carolina Family Impact SEMINAR

Medicaid Cost Containment Strategies in North Carolina and Other States

Convened by

Center for Child and Family Policy, Duke University

School of Government, University of North Carolina at Chapel Hill

North Carolina Family Impact Seminar

Medicaid Cost Containment Strategies in North Carolina and Other States

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Purpose and Presenters

Medicaid Cost Containment Strategies in North Carolina and Other States is the first North Carolina Family Impact Seminar in a series designed to connect research and state policymaking.

Family Impact Seminars analyze the impact an issue, policy, or program may have on families. Family Impact Seminars started on a national level over 20 years ago. They have since transitioned into a network of state-level seminar series supported in part by the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison. The seminars and supporting materials are designed to bring together research, practice, and policy experts from a range of disciplines to share information and help bring research to policymaking. The seminars deliberately take an educational, nonadvocacy approach. They are a forum for providing objective, nonpartisan, solution oriented research to state policymakers, including legislators, legislative and gubernatorial staff, and state agency officials.

This seminar featured the following speakers:

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For further information on the North Carolina Family Impact Seminar series, see the North Carolina Family Impact Seminar website: http://www.childandfamilypolicy.duke.edu; or contact:

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Selected Family Impact Seminar Briefing Reports

Each seminar is accompanied by a briefing report that summarizes research on a topic and identifies policy options from across the political spectrum. Copies of this and future briefing reports are available at: www.childandfamilypolicy.duke.edu/fisindex.html

Other Family Impact Seminar Briefing Reports on Health Issues

State	Seminar Title
CA	**Health Care Reform and California's Vulnerable Families** http://www.library.ca.gov/CAFIS/reports/94-02/94-02.pdf
DC	**Sign'em Up: Strategies to Enroll Eligible Children in DC Healthy Families** http://www.ncemch.org/dcfps/pdf/05_2000.pdf
DC	**Do School-based Mental Health Services Make Sense?** http://www.ncemch.org/dcfps/pdf/11_1999.pdf
DC	**HIV/AIDS: Helping Families Cope** http://www.ncemch.org/dcfps/pdf/04_1995.pdf
DC	**Substance Abuse Prevention and Treatment Programs: A Family Approach** http://www.ncemch.org/dcfps/pdf/02_1995.pdf
IN	**Healthy Environments for Young Children** http://www.cfs.purdue.edu/CFF/pages/publications/familyimpactseminar1999.pdf
MI	**Innovative State and Local Approaches to Health Care Coverage for Children** http://icyf-ftpwebsvr.icyf.msu.edu/icyf/pdf/familyimpact20105.pdf
NE	**Rising Health Care Costs**
NE	**Public Children's Health Insurance: Implications of Shifting Regulations**
NY	**Healthy Communities: Concepts and Collaboration Tools** http://www.human.cornell.edu/faculty/summrpt_s98.html
NY	**Community-based Health Planning**

Table of Contents

Executive Summary

In FY 2004, North Carolina's Medicaid Program spent nearly $8.5 billion on health coverage for 1.5 million citizens. The state's Medicaid spending grew at a rate of 11.9%. In North Carolina, as in other states, the continued growth in Medicaid spending is an increasingly pressing concern.

This report discusses Medicaid cost containment strategies in North Carolina and other states. A "family impact perspective" on policymaking informs this report. Specifically, policymakers routinely consider environmental or economic impacts of programs. Family Impact Seminars aim to help policymakers examine the impacts of policies on families. Family Impact Seminars provide objective, nonpartisan, solution-oriented research to state policymakers.

In North Carolina, as in other states, the continued growth in Medicaid spending is an increasingly pressing concern.

This report consists of four briefs:

The first brief describes **the Medicaid Program in North Carolina**. The brief illustrates eligibility criteria, expenditures for different population groups of recipients, available benefits, and their costs. The brief also discusses changes to North Carolina's Medicaid program in the past 15 years, including expansions in eligibility criteria and programmatic changes in managed care, prescription drugs, provider rates, recipients, and recipient services.

The second brief addresses **how states are trying to control Medicaid costs.** This brief first provides a view of the national Medicaid program, highlighting how Medicaid enrollment and expenditures continue to rise in all 50 states. The brief then reviews an array of measures states have enacted in the past two years, highlighting North Carolina's recent activities within each of these strategies. The brief concludes with a forecast of what states might expect regarding spending trends and other challenges in the years to come.

The third brief addresses **state experiences with Medicaid managed long-term care**. This brief examines the current status of the Medicaid managed long-term care market on a national level, discusses the potential benefits and challenges of implementing new managed long-term care programs, and describes North Carolina Medicaid's preliminary ventures into the managed long-term care arena. It concludes with a short discussion of the potential impact of managed long-term care on families.

The fourth brief describes **selected cost containment strategies for Medicaid prescription drug spending**. This brief reviews Medicaid prescription drug spending and cost containment strategies that have been implemented across the country, highlighting approaches in Florida and North Carolina. It focuses some attention on several emerging strategies not yet implemented in North Carolina: preferred drug lists, supplemental rebates, and multi-state purchasing pools.

Four Questions to Guide Policymakers' Consideration of North Carolina's Medicaid Cost Containment Strategies

- How do North Carolina families contribute to the challenges of growing Medicaid costs and the state's ability to contain these costs?
- How are North Carolina families affected by rising Medicaid costs?
- How are North Carolina families affected by current cost containment policies?
- To what extent can North Carolina families help to generate solutions to the state's cost containment difficulties, and how might Medicaid services be more cost effective if they do?

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• Staff of the Speaker of the North Carolina House of Representatives

We appreciate the invaluable input of the North Carolina Family Impact Seminars Legislative Advisory Committee and Planning Committee:

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Rep. Jeff Barnhart	**Rep. Carolyn Justice**
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An Overview of Medicaid in North Carolina*

Lisa J. Berlin
Center for Child and Family Policy
Duke University

Abstract:

In North Carolina, as in other states, Medicaid cost containment is an increasingly pressing concern. This brief offers details on North Carolina's Medicaid program in order to provide recent state level information, and to help set the stage for the consideration of specific cost containment strategies discussed in the subsequent briefs. This brief illustrates who is eligible for coverage and the expenditures for the different population groups of recipients. A description of benefits available under North Carolina Medicaid and the costs of each type of benefit is also described. This brief describes changes to North Carolina's Medicaid program in the past 15 years, including expansions in eligibility criteria, and program changes in managed care, prescription drugs, provider rates, recipients, and recipient services. Finally, next steps in Medicaid cost containment in North Carolina are considered from a family impact perspective.

* This brief is based on information presented in *Medicaid Program Overview* by Carol Shaw, Fiscal Research Division, North Carolina General Assembly, March 2005, and supplemented with additional, forthcoming information provided by the North Carolina Department of Health and Human Services, Division of Medical Assistance, and, for national data, by information from the Michigan Family Impact Seminar. Portions of this brief are derived from the work of Vernon K. Smith, Jr. (See "A National Challenge: How States Try to Control Medicaid Costs and Why It Is So Hard.")

Medicaid: A Snapshot

In 1965, as part of the "War on Poverty," President Johnson created the Medicaid program to extend health insurance coverage to low income Americans. Medicaid is an entitlement program, which means that the government must pay for the covered health services of eligible Medicaid beneficiaries. Medicaid provides health insurance to pregnant women, low income children, parents of dependent children, seniors (age 65 or older), people with disabilities, and certain other specified groups (such as women diagnosed with breast or cervical cancer). In addition to belonging to one of these target groups, Medicaid recipients must satisfy certain financial requirements in order to qualify. Medicaid also supplements Medicare coverage for many low income seniors or people with disabilities.[1] Medicaid is the largest publicly funded insurance program, serving over 52 million low income children and adults. Medicaid plays a major role in the U.S. health care system. In the area of maternal and child health, Medicaid pays for prenatal care and delivery of more than a third of all U.S. births and comprehensive health care for about one quarter of all children. In relation to care for seniors and people with disabilities, Medicaid covers about half of the care for all nursing home patients and pays for both home- and community-based long-term care services.

In FY 2004, 1.5 million North Carolina residents, about 18%, received Medicaid. Over 870,000 children participated, and Medicaid covered approximately 45% of all births. Two thirds of the state's 41,000 nursing home beds were also financed by Medicaid.

Medicaid Cost Containment in North Carolina: A Growing Concern

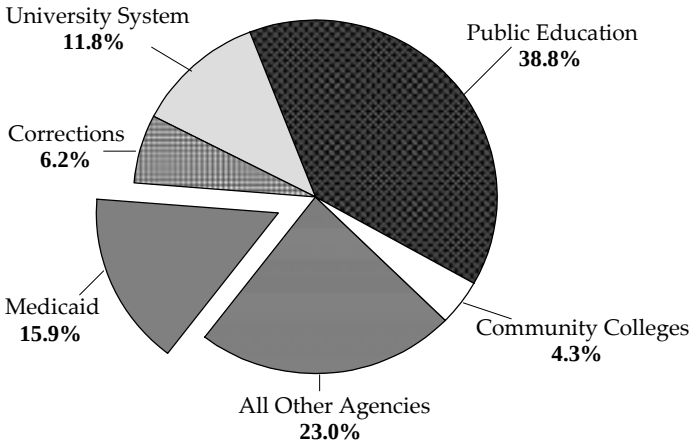
Medicaid is administered by states and counties. Costs are shared between federal and state governments, depending on need, with a formula based on state per capita income (the Federal Medical Assistance Percentage or FMAP). States may finance the nonfederal share completely or may require local governments to share up to 60% of the program costs. In North Carolina, the state pays for 85% of the nonfederal share of Medicaid services and requires counties to pay 15% of the nonfederal share.

In North Carolina, as is typical in other states, Medicaid is the second largest program in the state budget after education. In FY 2004, Medicaid expenditures were $8.5 billion, 16.1% of all North Carolina (governmental and nongovernmental) health care expenditures. Medicaid accounts for 15.9% of the 2005 General Fund operating budget (see Figure 1) and 63.5% ($2.45 billion) of the state's Health and Human Services General Fund (see Figure 2).

Figure 1: The NC Medicaid Program

General Fund Appropriations by Major Program Area

FY 2005

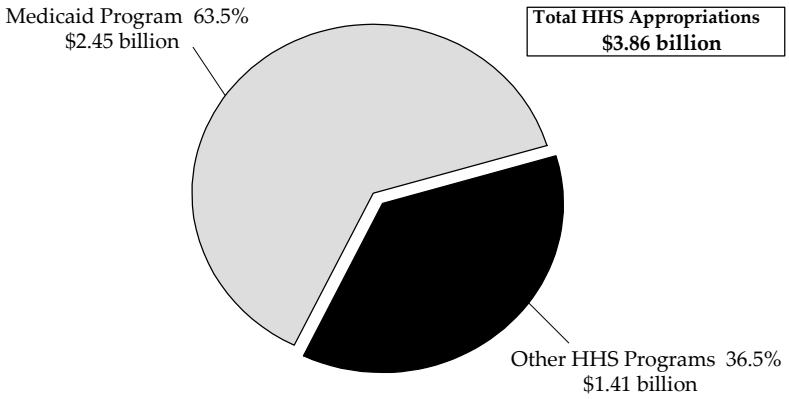


Source: NC General Fund Operating Appropriations SFY 2005 Fiscal Research Division 2/05

Figure 2: The NC Medicaid Program

Medicaid's Share of HHS General Fund

Appropriations for FY 2005



Source: NC General Fund Operating Appropriations SFY 2005 Fiscal Research Division 2/05

Figure 3: The NC Medicaid Program

History of Medicaid Expenditures

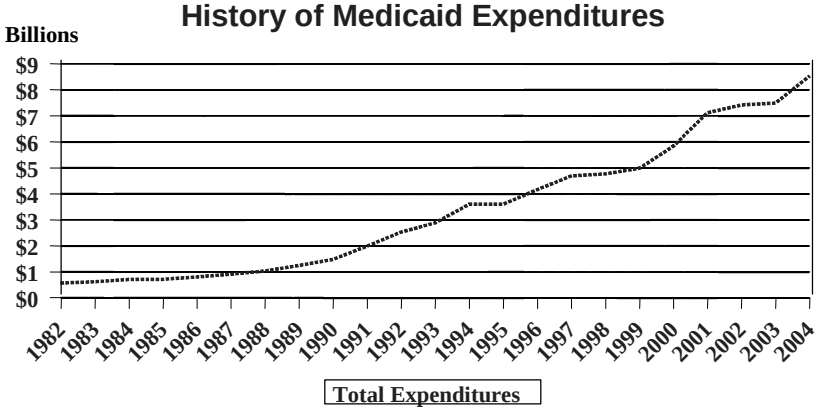


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Figure 3 depicts the history of North Carolina Medicaid expenditures between 1982 and 2004. In FY 2004, U.S. Medicaid spending grew at an annual rate of 9.5%, while in North Carolina it grew 11.9%. Medicaid cost containment is an increasingly pressing concern in North Carolina and other states.

North Carolina Medicaid in Detail

The remainder of this brief offers details on North Carolina's Medicaid program in order to provide recent state level data and to help set the stage for consideration of specific cost containment strategies discussed in the subsequent briefs. Three subsections follow: North Carolina Medicaid beneficiaries, North Carolina Medicaid benefits, and changes to North Carolina's Medicaid program in the past 15 years (since 1990). Expenditures and cost containment issues are highlighted throughout.

North Carolina Medicaid Beneficiaries

Under federal law, all states operating a Medicaid program must serve specific groups of people called mandatory population groups. Current federal law also provides federal reimbursements for coverage to certain optional population groups that are selected at states' discretion but allowed under federal law. Each state is allowed to choose which optional population groups it serves.

The mandatory population groups are as follows:

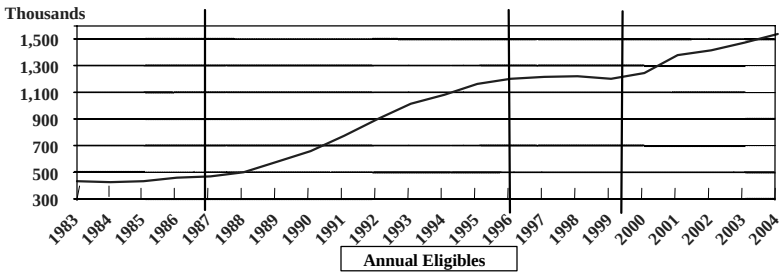
- Adults in Families with Children (based on the AFDC State Plan as of July 16, 1996)
- Persons Eligible for Transitional Benefits (individuals transitioning off of welfare)
- Aged, Blind, and Disabled Supplemental Security Income (SSI) Recipients
- Infants born to Medicaid eligible women with family incomes equal to or less than 133% of Federal Poverty Guidelines (FPG)
- Children ages one through five with family incomes equal to or less than 133% of FPG
- Pregnant Women with family incomes equal to or less than 133% of FPG
- Children 100% of FPG ages six through age 18 with family incomes equal to or less than 100% of FPG
- Recipients of Adoption Assistance and Foster Care
- Refugees/Aliens
- Certain Medicare Recipients (Dual Eligibles, Qualified Medicare Beneficiaries, Specified Low income Medicare Beneficiaries, Qualified Disabled and Working Individuals)

The optional population groups served in North Carolina are as follows:

- Children ages 19 and 20 meeting AFDC income standards
- Special Needs Adoptive children
- Recipients of State/County Special Assistance
- Recipients of State Assistance to the Blind
- Persons receiving care under home- and community-based waivers
- Aged, Blind, and Disabled persons presumed eligible for but not receiving SSI
- Aged, Blind, and Disabled persons with incomes equal to or less than 100% FPG (these are individuals with incomes that are too high to qualify for SSI)
- Medically Needy Persons (must meet the spend down requirement)
- Women with Breast and Cervical Cancer (income must be 185% of FPG or less)

Figure 4: The NC Medicaid Program

History of Annual Eligibles



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A series of expansions in 1987, along with the economic downturns of the early 1990s and early 2000s led to significant increases in both Medicaid participation and Medicaid expenditures.

Figures 4 and 5 illustrate the history of North Carolina Medicaid participation since 1987. During the early 1980s, the number of eligible people did not grow significantly (see Figure 4). Beginning in 1987, a series of mandated and optional eligibility expansions took place. These expansions, along with the economic downturns of the early 1990s and early 2000s led to significant increases in both Medicaid participation and Medicaid expenditures. Between FYs 2003 and 2004, the state population grew by 1.1% and the number of people eligible for Medicaid increased by 4.5%.

When Medicaid began, the program focused on providing medical care for the disabled, aged, and families – generally those receiving cash assistance. Since 1987, Medicaid has been expanded to cover many individuals, including children and pregnant women who are not receiving welfare or SSI (see Figure 5).

Figure 6 illustrates the proportions of participants served by North Carolina's Medicaid program in FY 2004. The two largest categories of Medicaid participants are children (34.5%) and low income adults in families with children (32.1%). Thus, almost 70% of all Medicaid recipients in 2004 were low income children and their families.

Figures 7 and 8 illustrate North Carolina's Medicaid costs in FY 2004 per population group. Although children and families make up the largest of the three principal groups of Medicaid recipients, they account for only about $2.3 billion or 31% of Medicaid costs. Elderly recipients and those with disabilities comprise approximately 13% and 16% of total recipients respectively. However, these two groups account for approximately $5 billion or 60% of total expenditures.

Figure 5: The NC Medicaid Program
New Groups since 1987

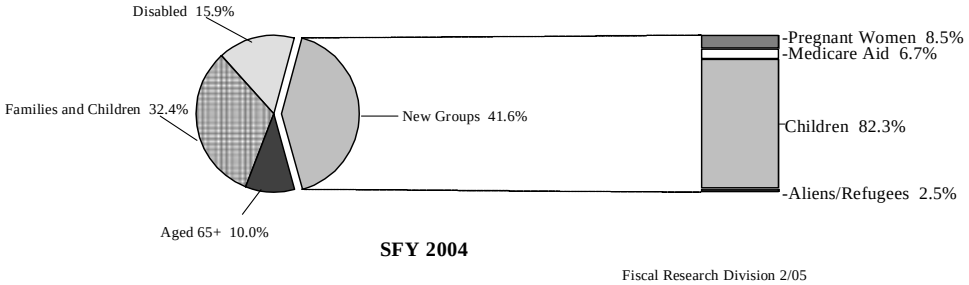
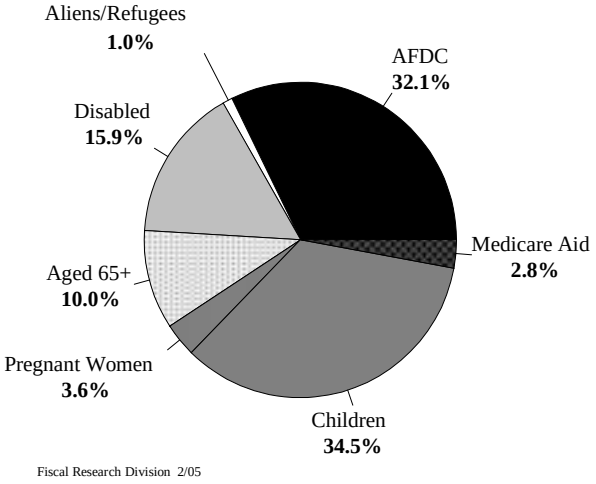


Figure 6: The NC Medicaid Program
Medicaid Eligibles- FY 2004



North Carolina's Medicaid Benefits
Under federal law all state Medicaid programs must cover specific mandatory benefits. State programs may also elect to provide certain optional benefits.

The mandatory benefits are as follows:

- Health Check (Early Periodic Screening, Diagnosis, and Treatment, EPSDT) Services for children under 21
- Family Planning Services
- Federally Qualified Health Center Services (Community, migrant health centers)
- Home Health Services (includes supplies and durable medical equipment used in the home)

Almost 70% of all Medicaid recipients in 2004 were low income children and their families.

Figure 7: The NC Medicaid Program
Expenditures and Recipients- FY 2004

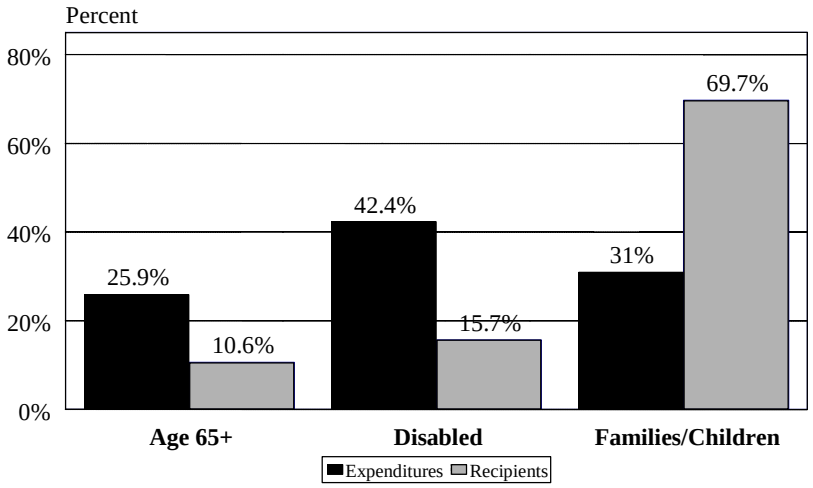


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Figure 8: The NC Medicaid Program
Expenditures and Recipients- FY 2004

Eligibility Category	Number of Recipients	Expenditures	Annual Cost Per Recipient
Elderly	204,135	$1,941,800,149	$8,932
•Aged	162,675	$1,912,877,837	$10,992
•Medicare-Aid	41,460	$28,922,311	$665
Disabled	243,774	$3,127,627,817	$11,971
Families & Children	1,074,554	$2,285,088,549	$1,967
Aliens & Refugees	18,987	$51,681,385	$2,735

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- Rural Health Clinic Services
- Inpatient Hospital Services
- Outpatient Hospital Services
- Physician Services
- Laboratory and X-Ray Services
- Nurse Midwife Services
- Nurse Practitioner Services
- Nursing Facility Services for individuals ages 21 or older
- Specialty Hospital Services
- Transportation
- Vaccines for Children

With respect to optional benefits, North Carolina's Medicaid program covers all of the allowable optional benefits except for nonmedical services offered in a religious hospital or setting:

- Ambulance Transportation
- Targeted Case Management Services
- Chiropractic Services
- Community Alternatives Program (CAP) Services (Home- and Community-based Care)
- Dental Care Services (including dentures)
- Diagnostic, Screening, Preventive Services
- Eyeglasses
- Hospice
- Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
- Inpatient Hospital for Individuals 65 or older in Institutions for the Mental Diseases
- Nurse Anesthetist Services
- Medical Social Work Services
- Inpatient Psychiatric Care for individuals under 21
- Occupational, Physical, and Speech Therapies
- Optometry Service
- Personal Care Services

- Podiatry Services
- Prescription Drugs
- Prosthetics and Orthotics
- Private Duty Nursing Services
- Psychology (Mental Health) Services
- Rehabilitation Services (Mental Health)
- Respiratory Care Services for ventilator-dependent individuals
- Speech, Hearing, and Language Services

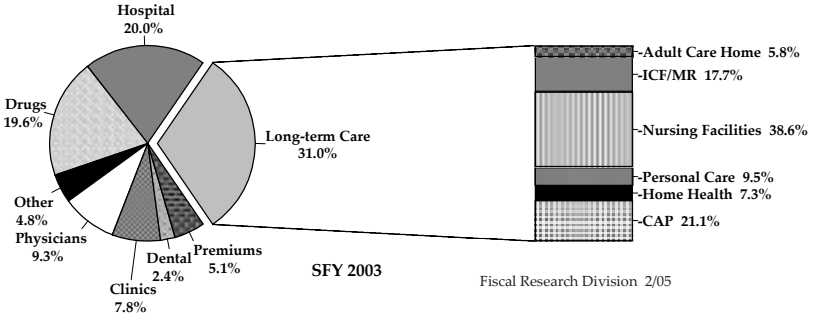
Individuals eligible for Medicaid can receive these services from a variety of different sources, including public agencies (e.g., local health departments, county owned home health agencies), state hospitals, and other public and private health care providers.

Figure 9 illustrates the proportions of services covered by North Carolina's Medicaid program in FY 2003. The two largest service categories are inpatient and outpatient hospital services (20% of all expenditures) and long-term care (31% of all expenditures).

The two largest service categories are inpatient and outpatient hospital services and long-term care.

Figure 9: Medicaid Program

Expenditures for Services



Changes to North Carolina's Medicaid Program Since 1990: Expansion of Eligibility Criteria and Initiation of Managed Care and Other Cost Containment Strategies

Since 1990, the North Carolina Medicaid program has expanded eligibility criteria for both mandatory and optional eligibility groups.

In addition, managed care initiatives have been introduced, beginning in 1991 with Carolina ACCESS, Carolina Alternatives, and ACCESS II. These initiatives aim to increase access to care, promote community-based systems of care, enhance care management, and improve the quality of care and cost effectiveness of the Medicaid program. The Medicaid managed care program in North Carolina is now known as Community Care of North Carolina (CCNC).

CCNC is a collaborative effort among the state, counties, community institutions, and physicians. CCNC is composed of 13 local networks consisting of more than 3,000 physicians. The networks include more than 900 physician practices and serve 555,000 Medicaid recipients across 82 counties. The program is expected to operate statewide by December 2005.

The Medicaid managed care program in North Carolina is now known as Community Care of North Carolina (CCNC).

For FY 2003-04 the cost of CCNC was $28.5 million. Medicaid pays $5 per member per month (split evenly between the network as an enhanced care management fee and the primary care provider for case management). In return, the networks are responsible for identifying high cost patients and developing plans to manage service use and costs, providing evidence-based disease management services, controlling prescription drug use, and controlling unnecessary emergency room use.

Other cost containment strategies that have been implemented fall under four major domains and are listed below. Where possible, relevant legislative sessions are also noted:

Prescription Drugs[2]:

- Established Prior Authorization Program for certain high cost drugs
- Created Maximum Allowable Cost (MAC) drug list
- Limited most drugs to a 34-day supply
- Increased use of generic drugs
- Established a voluntary preferred drug list, known as the Prescription Advantage List (PAL)

- Increased copayments for brand name drugs
- Created new requirements for coordination of pharmacy benefits
- Eliminated coverage for weight loss and weight gain drugs
- Reduced dispensing fees

Provider Rates:

- Reduced physician rates from 100% of Medicare rates to 95% (2002 Regular Session)
- Eliminated inflationary increases for FY 2003 and 2004 (2003 Regular Session)
- Reduced reimbursement rates by 5% for the following providers or services: Private duty nursing, home infusion therapy, home health supplies, durable medical equipment, optical services, ambulatory surgery centers, and high risk procedures (2002 Regular Session)
- Reduced hospital payments by .5% (2002 Regular Session)
- Limited reimbursement of Medicare crossover claims to Medicaid rates (2002 Regular Session)
- Applied Medicaid medical policy to Medicare crossover claims (2002 Regular Session)

Recipients:

- Applied federal transfer of asset policies to real property excluded as tenancy-in-common, or as nonhome site property made income producing under Title XIX of the Social Security Act (2002 Regular Session)
- Applied estate recovery policies to Medicaid costs for in-home personal care services (2002 Regular Session)
- Adopted the SSI method for considering equity value in income-producing property for seniors, blind, and otherwise disabled persons[3] (2002 Regular Session)
- Required parental income to be counted when determining eligibility for pregnant minors[4] (2002 Regular Session)
- Eliminated 12-month State Transitional Medicaid coverage for families and children who are working and are no longer receiving welfare payments (2003 Regular Session)

Services:

- Reduced the monthly and daily limits for personal care services (2001 General Session)
- Eliminated coverage of optional circumcision
- Reduced case management services for adults and children (2001 General Session)

In addition to these measures, North Carolina received a one-time, temporary fiscal relief package from the federal government with enhanced reimbursements that have allowed North Carolina to reduce state appropriations to the Medicaid program. This measure expired June 30, 2004. To maximize federal revenues, North Carolina has used state expenditures in the five state hospitals as match to draw federal funds for Medicaid recipients served in those facilities.

Medicaid Cost Containment in North Carolina: Next Steps According to a Family Impact Perspective

An understanding of North Carolina's Medicaid program and its recent cost containment efforts can help policymakers consider specific next steps. In doing so, a family impact perspective may be valuable for considering particular cost containment strategies. Undoubtedly, different strategies will have various effects on different types of families: rural families compared with urban families; large, multigenerational families compared with single parent families, etc. Cost containment strategies that limit recipients to particular providers may force families in some rural areas already experiencing provider shortages to travel farther for care. Strategies that focus on long-term care will likely have the greatest impact on multigenerational families including elder members. Cost containment strategies that focus on prescription drugs will likely have the greatest impact on families who make heavy use of prescription drugs, such as families with a special needs child. As such differential impacts are documented, more nuanced information and more informed strategies will evolve.

Endnotes

[1] Medicaid pays the Medicare premiums and deductibles for certain low income Medicare recipients who cannot qualify for comprehensive Medicaid benefits.

[2] Legislative dates are not noted for this section because these measures were enacted by a combination of legislative mandate and discretion of the Division of Medical Assistance.

[3] Under the SSI rules, individuals can only exclude property as income producing if the equity value of the property is no greater than $6,000 and the person makes at least 6% of the value in income each year. In the past, individuals were allowed to exclude real or personal property of any amount regardless of the value if it produced any net income.

[4] This provision was subsequently repealed because it was found to conflict with federal law.

A National Challenge: How States Try to Control Medicaid Costs and Why It Is So Hard*

Vernon K. Smith, Jr.
Principal, Health Management Associates

Abstract:

The challenge of controlling Medicaid costs is at the forefront of every state's budget and policy discussions. For years states have implemented a range of Medicaid cost containment strategies. However, the combination of ongoing budget shortfalls and Medicaid enrollment growth leaves states looking for further cost containing measures. This brief discusses of the Medicaid program generally – what it is, whom it is for, and how Medicaid enrollment and expenditures continue to rise. It also provides an overview of cost containment measures adopted and implemented by states over the last two years, with particular attention to North Carolina. The conclusion presents a brief discussion of what states might expect in the years to come.

Many states entered FY 2005 faced with a mix of good and bad news. After three years of intense fiscal stress, most anticipated 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 conducted in the summer of 2004 concerning their states' Medicaid spending growth and cost containment plans.

* Most of the material in this brief is taken directly or adapted from *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005* by Smith, V., et al. (October 2004). Additional material comes from the *Medicaid Program Overview* by the Fiscal Research Division, North Carolina General Assembly, March 2005. The brief was adapted to North Carolina from the Michigan Family Impact Seminar brief on the same topic by Jenni Owen, Center for Child and Family Policy, Duke University.

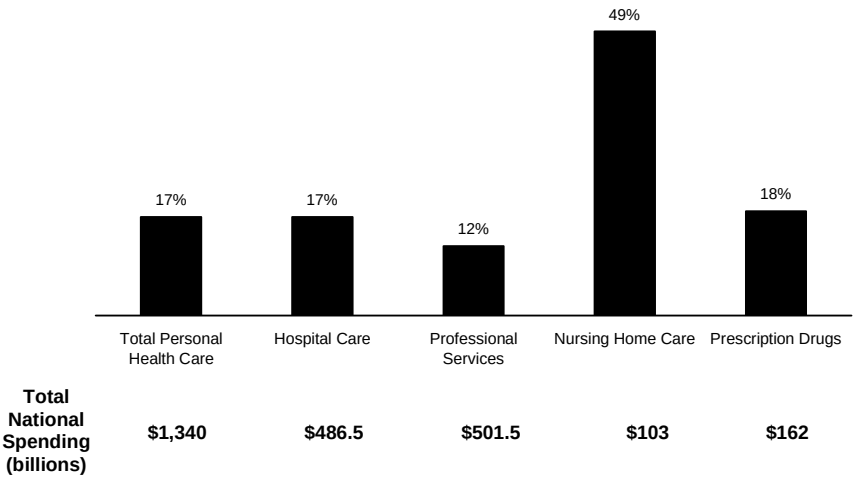
What Is Medicaid and What Role Does It Play in Our Health Care System?

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 seven million low income seniors and people with disabilities enrolled in both programs. Medicaid covered 1.5 million North Carolina residents sometime during FY 2004. This is equivalent to 17.7% of the state's population.

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.

For FY 2005, Medicaid is 15.9% of the North Carolina General Fund operating budget. Ten years ago that number was 8.2%.

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



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

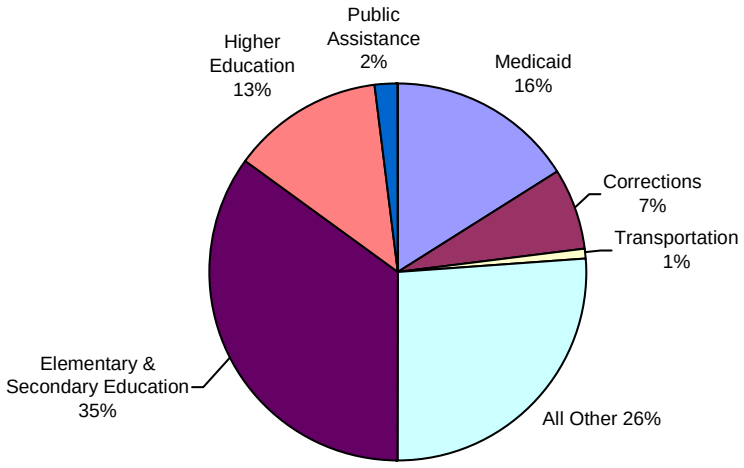
How Does Medicaid Work?

States must design and administer the program according to 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. States also may provide coverage for optional services beyond the required core services (e.g., prescription drugs, nonemergency 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%. North Carolina's FY 2005 FMAP is 63.63%. In 2006 it will be 63.49%. This is lower than the 65.8 matching rate that the state received under Federal Fiscal Relief, which ended on June 30, 2004. (See more in "The Expiration of Federal Fiscal Relief section.")

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). For FY 2005 Medicaid is 15.9% of the North Carolina General Fund operating budget. Ten years ago that number was 8.2% (see Figure 3).

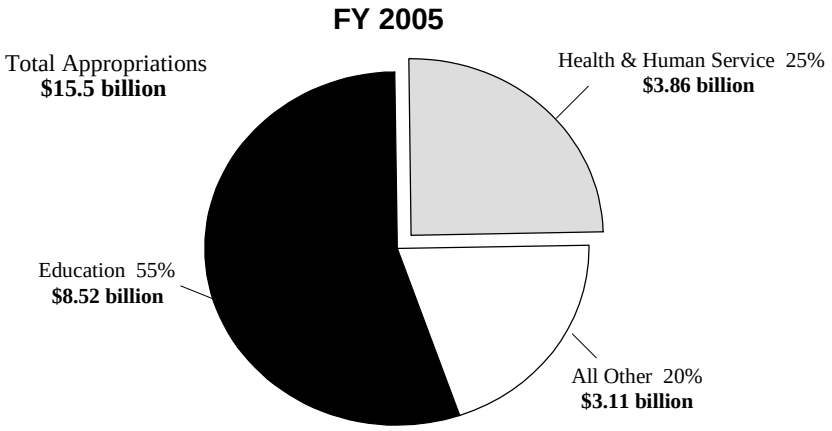
Figure 2: State Medicaid Spending as a Percent of General Fund Expenditures, 2002



Total State General Fund Spending = $496 billion

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

Figure 3: Medicaid Program
HHS Share of General Fund Appropriations



Fiscal Research Division 2/05 *Source: NC General Fund Operating Appropriations SFY 2005*

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 4). On the other hand, elderly and disabled individuals who represent just one quarter of the beneficiaries, account for 70% of the expenditures, reflecting their intensive use of acute and long-term care services.

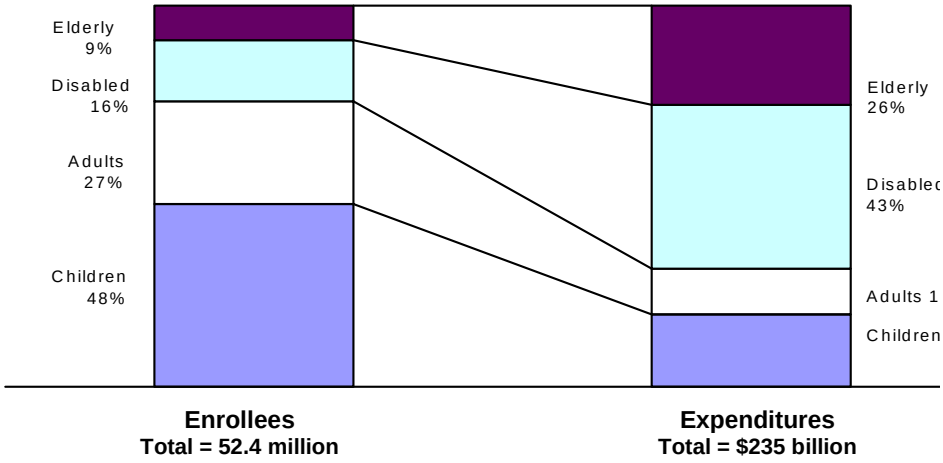
The same is true in North Carolina. In FY 2004, children and families represented 69.7% of the Medicaid recipients while accounting for only 31% of the expenditures. Elderly and disabled recipients combined accounted for 26.3% of the recipients and 68.3% of expenditures for Medicaid.

What Are the Trends in Medicaid Expenditures?

In FY 2004, total Medicaid spending for the U.S. increased an average of 9.5%.[1] Figure 6 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:

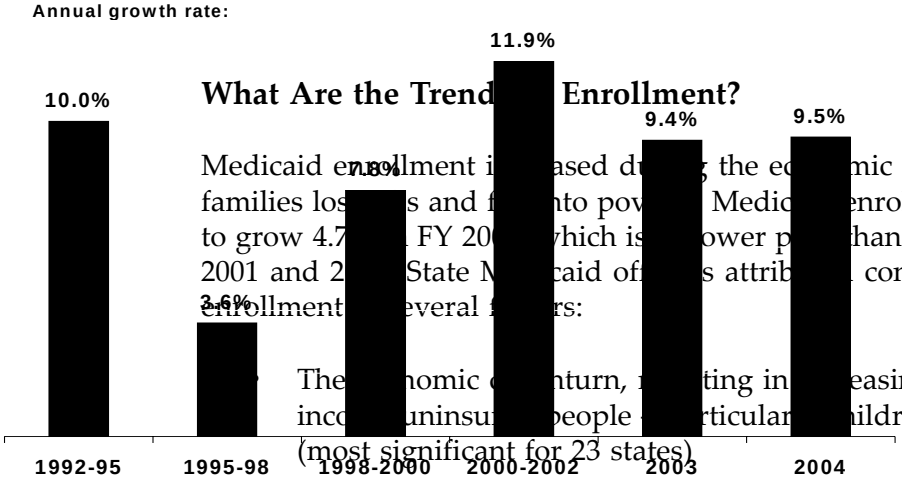
Figure 4: Medicaid Enrollees and Expenditures b Enrollment Group, 2003



Expenditure distribution based on Congressional Budget Office (CBO) data that includes only federal spending on services and excludes DSH (disproportionate share hospital), supplemental provider payments, vaccines for children, administration, and the temporary FMAP (federal medical assistance percentage) 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.

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

Figure 6: 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.

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 2004, which is a lower pace than was seen between 2001 and 2003. State Medicaid officials attribute 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 (ten states)
- Increased numbers of eligible elderly and disabled because of demographic changes (three states)
- Outreach for programs such as the State Children's Health Insurance Program or food stamps, which identify additional persons eligible for Medicaid (three states)

According to North Carolina officials, the key factors in enrollment growth in FY 2005 were the economy and overall population growth.

What Is the Current Revenue Picture?

Since 2001, as the national economy worsened and state revenues slowed, states have been forced to cut back on state programs. They have had to make difficult choices affecting health coverage for millions of low income people across the country.

In FY 2005, revenue has been growing and is expected to continue. However, many individual states, including North Carolina, are experiencing large budget shortfalls 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 has ended, 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.

North Carolina officials cited prescribed drugs, physician fees, and inpatient hospital and mental health clinics as key factors contributing to overall spending growth in FY 2004. For FY 2005, they cited increases in the consumption rate, eligibles, and cost per unit of services as the most significant factors.

What Strategies Are States Using to Contain Costs?

FY 2005 is 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 copayments
- Implementing disease management programs
- Implementing cost controls for long-term care
- Targeting fraud and abuse

North Carolina was the only state in 2004 to report plans for using each of the above eight strategies. In 2005, the state reported plans to use four of them: pharmacy controls, disease management/case management, targeting of fraud and abuse, and long-term care cost controls.

Note: Not reporting a strategy for a particular year does not mean the strategy is not in use in the state responding, but that the state has not implemented a new component of that strategy in the year in question. 2004 and 2005 are reported here.

The following sections discuss the range of approaches states are taking in using 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 may impact access to care. Some, but not all patients could identify alternative sources of care such as community-based care. Still, when faced with increasing fiscal pressures, many states used this strategy.

Medicaid rates for payments to providers are generally the lowest of any payer, sometimes below the cost for delivering care.

- 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 do 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.

North Carolina attempted to freeze some provider payments for FY 2004 by eliminating inflationary increases. The state did not implement reductions or freezes to provider payments in 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 7 drug cost reduction strategies).

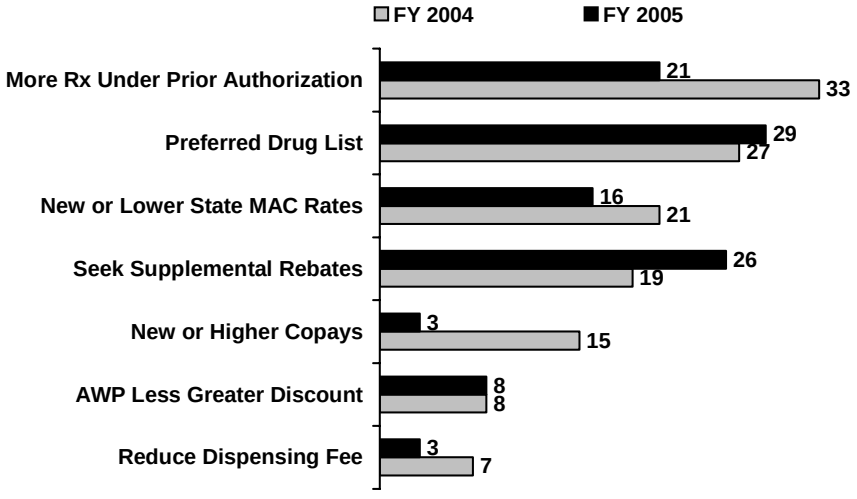
For 2005, the most frequently used strategies included:

- 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 (eight states)

For FY 2005 only three states adopted new or higher patient copayments; in FY 2004 15 states had done so. Given that Medicaid rules limit patient copayments to a nominal amount (generally $3 per service), this drop may be explained by the fact that many states already reached the upper limit of pharmacy copayments and therefore could not increase them any more.

In FY 2003-04 North Carolina implemented a cost avoidance model for pharmacy claims. Specifically, if a Medicaid recipient has a known third party insurer, the pharmacist must bill that third insurer first. (Having a third party insurer does not preclude Medicaid eligibility.) The North Carolina General Assembly took budget reductions during the 2003 session that were called Drug Utilization Management ($26 million in 2003-04 and $36 million in 2004-05).

Figure 7: 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.

Strategy 3: Reduce Covered Benefits

In FY 2005, fewer states are cutting benefits and more are restoring benefits cut in previous years:

- Only nine 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

North Carolina limited personal care services (PCS) to 3.5 hours per day up to a maximum of 60 hours per month for children, parents/adults, the disabled, and aged.

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

In FY 2004, North Carolina limited personal care services (PCS) to 3.5 hours per day up to a maximum of 60 hours per month for children, parents/adults, the disabled, and aged. For the same groups, the state implemented:

- Coverage for certain over-the-counter drugs
- Medical necessity criteria for some recipients to receive 20 hours over the 60-hour limit on personal care services
- Expanded treatment options for age related macular degeneration
- Coverage to promote healing of nonunion fractures (osteogenic stimulators)

North Carolina has cut weight loss and weight gain drugs from 2005 coverage. The state has expanded coverage to include prosthetics and orthotics for adults over age 21. It has also expanded coverage to independent practitioners who serve the mental health population.

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. During the recent economic downturn, however, 38 states reduced or restricted Medicaid eligibility over a four-year period (2002-2005). On the other hand, for 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 discussed separately below: eligibility rule changes; application and renewal process changes; and premium changes.

Changes to Eligibility Rules

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 (Temporary Assistance for Needy Families) level] (two states in FY 2004; three states in FY 2005)
- Eliminating continuous eligibility (two states in 2004)
- Increasing the spenddown threshold level for the aged, blind, and disabled [amount of their own money] they must spend before becoming eligible for Medicaid (one 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] (six states in 2004; three 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 (one state in 2004; two states in 2005)
- Eliminating TANF work requirements in determining eligibility for Medicaid (one state in 2004)

- Enabling disabled workers to buy in to Medicaid coverage (two states in 2004)

If a Medicaid applicant or recipient disposes of assets for less than fair value, he or she may be penalized by becoming ineligible for Medicaid long-term care assistance for a period of time. North Carolina extended the application of its transfer of assets policies to recipients receiving in-home personal care services as well as those who reside in a nursing home or other medical institutions. The North Carolina General Assembly did not enact any changes to eligibility requirements for 2005.

Changes to Application and Renewal Processes
Through the late 1990s and into 2001, states had adopted measures designed to simplify and streamline Medicaid application and redetermination procedures. In the face of budget difficulties, some states have reversed this process (ten states in 2004 and four in 2005). Major changes included:

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

North Carolina did not make changes to the application and renewal processes for 2005.

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[2] rules (Maine)

North Carolina does not impose premiums on recipients.

Strategy 5: Increase or Implement Copayments

When imposing patient copayments, states must comply with the federal Medicaid law. It specifies that 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 copayments as part of their cost containment strategies, although a substantial body of research indicates that even nominal copayments can deter low income individuals from receiving needed care (Hudman & O'Malley, p 30).

In FY 2004, 20 states imposed new or higher copayments; nine states did so in FY 2003. The most frequent copayment imposed was for prescription drugs (discussed under containing drug costs). A few states increased copayments for:

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

North Carolina did not implement new or increased copayments for 2004 or for 2005.

Strategy 6: Implement Disease and Case Management Programs

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 (Williams, 2004). In a recent health benefits survey of employers (Kaiser Family Foundation, 2004), 15% 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.

North Carolina expanded its disease management initiatives to more counties in FY 2004 and 2005 and added conditions such as asthma, diabetes, and congestive heart failure to the included diseases. In addition, in FY 2004 North Carolina expanded the Community Care of North Carolina (CCNC) program in which local networks of primary care providers and public and private community institutions coordinate prevention, treatment, referral, and other services for Medicaid recipients. The program slows the rate at which Medicaid costs would increase through implementation of care management, adoption of best practices, and local providers' accountability to reduce service duplication and fragmentation.[3]

Strategy 7: Implement Cost Controls on Long-term Care and Home- and Community-based Services

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

For North Carolina's related activity in this area, see mention above of personal care services and subsequent brief by Brian Burwell entitled "State Experiences with Managed Long-term Care in Medicaid."

Strategy 8: Target Fraud and Abuse

Program Integrity (PI) has reduced by 51% the number of days needed by the PI nurses to investigate and close a case.

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 in high use recipients 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.

North Carolina has implemented new activities designed to control fraud and abuse. Recently, new fraud and abuse detection software (FADS) was added, which has improved performance. Program Integrity (PI) has reduced by 51% the number of days needed by the PI nurses to investigate and close a case, and the average recovered per case of fraud and abuse has increased.

As states moved into FY 2005 with a somewhat improved economic picture, several factors presented new challenges. Following are three of the factors for 2005 and 2006 that will impact states' ability to further 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, 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, minimize, or postpone Medicaid cuts or freezes. With the expiration of the enhanced FMAP, state spending on Medicaid has grown enormously in FY 2005. Legislatures have authorized an average annual Medicaid growth rate 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. As noted above, North Carolina's FMAP declined from 2004-2005 and will decline slightly further in 2006.

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 nonfederal share of Disproportionate Share Hospital (DSH) payments[4] 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.

North Carolina officials, like officials in many other states, cited increased scrutiny of special financing arrangements as a key factor driving Medicaid spending growth in the state. States and the Center for Medicaid Services are engaged in discussions about this issue.

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). These concerns apply to all states.

- 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 over six million individuals with dual eligibility in the Medicare Part D drug plan. 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 three 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.

What Is the Outlook for 2005 and Beyond?

All states will be expected to begin determining eligibility for Part D low income subsidies beginning in July 2005.

Medicaid played 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. The challenges discussed above, however, 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 federal Medicaid law. A major issue is 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, program beneficiaries, and the ability of the program to serve as part of the safety net for vulnerable populations.

The Impact of Cost Containment Strategies on Families

Changes to Medicaid naturally affect people other than the individual recipients for whom the changes address. Family members experience the impacts of changes whether related to eligibility expansion or reduction, the requirement of prior authorization for prescription drugs, allowable costs for nursing home care, and the many other dynamic aspects of Medicaid law and policy. As policymakers continue to grapple with containing Medicaid costs, it is important to remain vigilant to the many ways in which potential and actual cost containment measures will impact families.

For more detailed information on the survey on which this brief was based, see the complete report:

Smith, V., et al. (October 2004). *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 online at www.kff.org/medicaid/7190.cfm.[5]

Endnotes

[1] 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.)

[2] 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 receiving home medical care that would be provided in an institution.

[3] North Carolina General Assembly Fiscal Research staff presentation, March 2005.

[4] DSH funds are provided to hospitals that serve a disproportionate share of uninsured patients.

[5] Additional references include:

1. Hudman, J. & O'Malley, M. (2004, March). Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low income Populations. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

2. Kaiser Family Foundation and Health Research and Education Trust. (2004). *Employer Health Benefits 2004 Annual Survey.* Washington, DC: The Kaiser Family Foundation. www.kff.org/insurance/7148/index.cfm.

3. Williams, C. (September 2004). *Medicaid Disease Management: Issues and Promises.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

State Experiences with Managed Long-term Care in Medicaid*

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Abstract:

Across the country, state Medicaid programs are expressing renewed interest in developing managed care programs for beneficiaries who require long-term care. Several states have programs already in place. Others are in the planning or early implementation stages. This brief examines the current status of the Medicaid managed long-term care market, discusses the potential benefits and challenges of implementing new managed long-term care programs and briefly describes North Carolina Medicaid's preliminary ventures into the managed long-term care arena. It concludes with a short discussion of the potential impact of managed long-term care on families.

North Carolina's Medicaid program spent almost 2.5 billion dollars on long-term care services in FY 2004. (See Table 1.) Combined Medicare and Medicaid expenses for persons receiving publicly financed long-term care were approximately $132 billion during that same year. These figures include skilled nursing care, some intermediate care facilities, home health care, home- and community-based care and personal care services. With the aging of the baby boomers, these figures will likely increase dramatically in the coming years. Some states are trying to anticipate and plan for the growing long-term care population by implementing programs of managed care. Many state Medicaid programs already provide some case management

* Most of the material in this brief is taken directly or adapted from *The Past, Present and Future of Managed Long Term Care* by Saucier, Burwell and Gerst (April 2005).[1] Additional sources consulted include "Medicaid and Long-Term Care," Kaiser Commission on Medicaid and the Uninsured (March 2005)[2] and North Carolina Institute of Medicine, "A Long-Term Care Plan for North Carolina: Final Report" (January 2001).[3] The brief was prepared by Aimee N. Wall, UNC School of Government.

Table 1: North Carolina Medicaid Expenditures for Long-term Care Services: 1999-2003

SERVICE	FY 1999 EXPENDITURES	FY 2000 EXPENDITURES	PERCENT CHANGE 99-00	FY 2001 EXPENDITURES	PERCENT CHANGE 00-01	FY 2002 EXPENDITURES	PERCENT CHANGE 01-02	FY 2003 EXPENDITURES	PERCENT CHANGE 02-03	FY 2004 EXPENDITURES	PERCENT CHANGE 03-04	FY 2004 EXPENDITURES PER CAPITA
Nursing Home Services	$812,806,762	$832,715,476	2.4	$876,233,835	5.2	$893,316,570	1.9	$895,224,875	0.2	$1,096,619,059	22.5	$128.39
ICF-MR Total	$393,413,325	$396,863,370	0.9	$400,129,463	0.8	$416,422,558	4.1	$418,466,631	0.5	$431,968,043	3.2	$50.58
ICF-MR Public	$198,921,469	$199,779,469	0.4	$201,603,802	0.9	$217,246,697	7.8	$218,023,828	0.4	$226,581,561	3.9	$26.53
ICF-MR Private	$194,491,856	$197,083,901	1.3	$198,525,661	0.7	$199,175,861	0.3	$200,442,803	0.6	$205,386,482	2.5	$24.05
Personal Care	$153,648,159	$181,578,642	18.2	$221,200,189	21.8	$269,054,608	21.6	$299,929,413	11.5	$362,050,065	20.7	$42.39
HCBS Waivers-Total	$320,851,451	$379,056,944	18.1	$454,909,887	20.0	$481,491,981	5.8	$471,709,572	-2.0	$503,455,508	6.7	$58.95
HCBS Waivers-MR/DD	$149,910,940	$190,496,958	27.1	$235,232,775	23.5	$254,035,290	8.0	$263,186,889	3.6	$269,303,718	2.3	$31.53
HCBS Waivers-A/D	$158,674,755	$175,386,785	10.5	$201,447,795	14.9	$205,384,679	2.0	$183,297,444	-10.8	$208,165,729	13.6	$24.37
Home Health	$76,262,699	$83,412,799	9.4	$84,772,196	1.6	$97,169,928	14.6	$96,337,348	-0.9	$101,671,283	5.5	$11.90
Total Home Care	$550,762,309	$644,048,385	16.9	$760,882,272	18.1	$847,716,517	11.4	$867,976,333	2.4	$967,176,856	11.4	$113.24
Inpatient Hospital Care	$872,956,725	$1,020,053,634	16.9	$1,089,213,851	6.8	$1,114,697,390	2.3	$1,088,507,536	-2.3	$1,215,215,373	11.6	$142.28
Inpatient DSH	$227,672,613	$263,744,946	15.8	$259,509,072	-1.6	$276,816,659	6.7	$379,978,702	37.3	$416,749,256	9.7	$48.79
Inpatient Mental Health	$16,846,455	$24,327,737	44.4	$25,885,125	6.4	$32,442,979	25.3	$35,937,626	10.8	$37,024,688	3.0	$4.33
Mental Health DSH	$170,292,750	$176,842,977	3.8	$174,935,077	-1.1	$179,324,307	2.5	$2,917,716	-98.4	$3,178,664	8.9	$0.37
Medicaid Managed-Care Premiums	$46,209,841	$55,263,543	19.6	$66,807,897	20.9	$33,271,385	-50.2	$20,485,785	-38.4	$21,838,098	6.6	$2.56
Prescribed Drugs	$620,864,891	$803,648,718	29.4	$984,643,814	22.5	$1,089,180,219	10.6	$1,291,255,693	18.6	$1,575,005,285	22.0	$184.41
Total Long-term Care	$1,756,982,396	$1,873,627,231	6.6	$2,037,245,570	8.7	$2,157,455,645	5.9	$2,181,667,839	1.1	$2,495,763,958	14.4	$292.21
Targeted Case Management	$67,102,065	$72,276,927	7.7	$85,574,303	18.4	$99,014,845	15.7	$98,216,787	-0.8	$116,061,608	18.2	$13.59
P.A.C.E.	$0	$0	0.0	$0	0.0	$0	0.0	$0	0.0	$0	0.0	$0.00
Total Medicaid	$4,987,172,053	$5,571,242,345	11.7	$6,239,709,423	12.0	$6,812,021,955	9.2	$7,228,626,129	6.1	$8,290,567,550	14.7	$970.68

Source: CMS 64 data, Office of State Agency Financial Management.

services for users of home- and community-based care. Most, however, do not provide a comprehensive program for managing all of a patient's care – from the community to the hospital to the nursing home and possibly back again. While the size of the nation's managed long-term care population is still relatively small, several states are implementing innovative new programs designed to serve this expanding, resource intensive population. This brief is intended to provide readers with a general understanding of the issues involved in implementing a managed long-term care program.

What Is Managed Long-term Care?

The term managed care refers to the comprehensive care coordination traditionally provided by HMOs and similar organizations rather than basic case management services.

To most audiences, the phrase long-term care refers not only to the health care delivered in nursing and adult care homes but also to home health care services and a wide range of supportive services that assist individuals with the basic activities of life, such as preparing food, eating, dressing, and managing medication.

Referring to such care as managed can mean different things to different people. For example, it can mean that a fee is paid to a case manager each month to help enrollees elect health care options, choose providers, and coordinate care. Alternatively, it can mean that a per person monthly fee, called a capitation payment, is paid to a Health Maintenance Organization (HMO) or similar organization. The enrollees receive all of their care from providers participating in that HMO based on care guidelines issued by the HMO. There are multiple variations on these managed care models, but an overarching principle is that the managed care organizations generally bear some financial risk because they must provide all of the covered services and they receive only a capitation payment. This model builds in a strong incentive for these organizations to save money as compared to the traditional fee-for-service model.

For purposes of this brief, the term managed care refers to the comprehensive care coordination traditionally provided by HMOs and similar organizations rather than basic case management services.

How Many Medicaid Beneficiaries Are Enrolled in Managed Long-term Care?

Historically, state Medicaid programs have implemented managed care models predominantly in the primary and acute care settings. In the 1980s, a few states attempted to implement variations of managed care into the long-term care setting and several more initiated programs in the 1990s. For various reasons, enrollment did not grow at the rate many predicted. In 2004, approximately 2.3% of the Medicaid-funded long-term care population – or just under 70,000 people – received their

long-term care benefits through a managed care program. While this number is relatively small, the potential target population is quite large – with over three million public long-term care users and over $130 billion in public long-term care expenditures in 2003. (See Table 2.)

Table 2
Estimated Size of the Public Long Term Care Market 2003

Beneficiaries	In Nursing Homes	1,700,000
	In HCBS Waiver Programs	550,000
	Receiving Personal Care Services	830,000
	Total	**3,080,000**
Expenditures	**For Institutionalized Beneficiaries:**	
	Medicaid NF Expenditures	$44.8 billion
	Other Medicaid Expenditures	$19.2 billion
	Medicare Expenditures	$22.5 billion
	Total	**$86.5 billion**
	For Community – Based LTC Beneficiaries:	
	HCBS Waiver Expenditures	$4.1 billion
	Personal Care Expenditures	$5.0 billion
	Other Medicaid Expenditures	$10.6 billion
	Medicare Expenditures	$26.1 billion
	Total	**$45.8 billion**

Note: These are preliminary estimates. Estimates only include aged and disabled Medicaid beneficiaries receiving long term care benefits. Excludes persons with developmental disabilities and/or severe mental illness.

HCBS: Home- and Community-based Services
LTC: Long-term care
NF: Nursing facilities

In the last few years, several states have been showing renewed interest in implementing programs of managed long-term care.

In the last few years, several states have been showing renewed interest in implementing programs of managed long-term care. Some of the states (Texas, Florida, Minnesota) with existing managed long-term care programs are pursuing or considering expansions. One state is in the process of enrolling individuals in a new program (Massachusetts) and several states (California, Maryland, Hawaii, Washington) are in the early stages of developing and implementing new programs. Table 3 provides a general overview of the characteristics of some of these state programs.

Table 3. Characteristics of Selected Managed Long Term Care Programs

	PACE (includes "pre-PACE")	Florida Frail Elder Option	Arizona Long Term Care System (ALTCS)	Wisconsin Partnership Program	Minnesota Senior Health Options (MSHO)	New York MLTC Plans	State of Texas Access Reform (Star) + Plus	Florida Diversion	Wisconsin Family Care	MnDHO	Mass Health Senior Care Options (SCO)
Implementation Date	1983 (On Lok)	1987	1989	1995[1]	1997	1997	1998	1998	2000	2001	2004
Populations Eligible	55+ with NF-level LTC needs	Aged and Disabled; NF-level LTC needs	Aged and Disabled; NF-level LTC needs	Aged and Disabled; any LTC needs	All Aged	Aged and Disabled with NF-level LTC needs (aged/disabled varies by plan)	All Aged and Disabled	Aged with NF-level LTC needs	Aged and Disabled; NF-level LTC needs	All Physically Disabled	All Aged
Voluntary/ Mandatory for Medicaid	Voluntary	Voluntary	Mandatory	Voluntary	Voluntary	Voluntary	Mandatory	Voluntary	Mandatory	Voluntary	Voluntary
Geographical Coverage	40 urban programs in 17 states	2 urban counties in Southeast Florida	Statewide (urban and rural)	6 counties (rural and urban)	7 urban and 3 rural counties	Multiple counties (rural and urban, but mostly urban)	1 urban county; statewide urban expansion proposed	25 urban and contiguous counties	5 counties (rural and urban)	4 urban counties	Nearly statewide (rural and urban)
Medicaid Payments	Capitated primary, acute and LTC; rate structure varies.	Capitated primary, acute and LTC; three rate cells.	Capitated primary, acute and LTC;single blended rate	Capitated primary, acute and LTC; multiple rate categories	Capitated primary, acute and LTC (NF limited to 6 mos.); multiple rate cells	Capitated LTC only, (primary and acute FFS); multiple rate cells	Capitated primary, acute and LT (NF limited to 1 mo.; Rx not in cap); multiple rate cells	Capitated primary, acute and LTC; single rate	Capitated LTC only, (primary and acute FFS); two rate cells	Capitated primary, acute and LTC (NF limited to 6 mos.); multiple rate cells	Capitated primary, acute and LTC; multiple rate cells
Medicare Payments	Capitated	FFS	FFS[2]	Capitated	Capitated	FFS	FFS[2]	FFS	FFS	Capitated	Capitated

[1]Wisconsin Partnership began operating in 1995 as a partially capitated Medicaid model. In 1999, it received the federal waivers needed to become a fully capitated Medicaid/Medicare model.
[2]Some beneficiaries have opted to join companion capitated Medicare Advantage plans.

What Kinds of Organizations Provide Managed Long-term Care to Medicaid Populations?

Most of the organizations providing managed long-term care to aged and disabled Medicaid beneficiaries are small private nonprofit plans with total enrollments under 1,000. The majority of these plans are affiliated with a provider – a company that offers long-term care services (e.g., home- and community-based care, skilled nursing care) and has developed its own plan to manage care for a group of enrollees. One of the problems with this model is that health care providers generally do not have experience with the business side of managed care.

There are some traditional managed care companies that have ventured into the market, but the numbers are much smaller. One of the key problems with these models can be a lack of experience working with patients requiring long-term care (e.g., frail elderly, disabled). There are two national for-profit managed care companies that have established a significant presence in the market – Evercare, an affiliate of UnitedHealth Group, and Amerigroup. In addition, a few public plans have emerged in Arizona and Wisconsin, and in Massachusetts' new program a few start-up companies are rising to the challenge.

Consumer satisfaction survey results have been consistently high in most managed care programs.

With the exception of Arizona, these managed long-term care plans focus primarily on developing programs in urban areas. This ensures that they will have access to a critical mass of potential enrollees as well as an adequate supply of health care providers to establish networks.

What Are The Benefits of Implementing a Managed Long-term Care Program?

Cost Savings

Opinions vary regarding the specific benefits of or value added by managing long-term care. With respect to cost savings, the studies are inconclusive. Estimates of program savings range from 5 to 35%, but there are limitations and qualifications that apply to all of the research findings. It is simply not clear whether the programs actually save money for state Medicaid programs. States do report that they are refining their payment systems and hope that additional cost savings may be realized in the future. Even without significant savings, states may prefer managed long-term care to fee-for-service because the capitated payment structure allows for more predictability when planning Medicaid budgets.

Access to care

With respect to access to care, studies clearly show that management of long-term care can have positive outcomes. In general, managed long-term care:

- Reduces the use of higher cost services, including emergency rooms, hospitals and nursing homes
- Increases access to home- and community-based services
- Allows more flexibility in services than fee-for-service
- Allows consumer-directed care without a waiver (e.g., enrollees choose their services and pay for them through a fiscal intermediary)
- Streamlines access to care by helping the enrollee navigate the system more efficiently
- May save the consumer money relative to fee-for-service if the state does not require comparable cost sharing

Quality

Managed long-term care has the potential to alleviate some of the burden of time consuming service coordination that families now face.

It is unclear whether the quality of care delivered in these managed long-term care programs varies from traditional fee-for service. For example, one study of an intensive staff model managed care program (PACE[4]) reports excellent indicators for enrollees (improved quality of life, functional status, longer life span), but a study of a different program found the care of enrollees living in nursing homes to be of poorer quality than the care received by nursing home residents in a neighboring state. Despite the variety of study outcomes, consumer satisfaction survey results (another quality indicator) have been consistently high in most programs.

What Challenges Face a State Medicaid Agency Considering Development of a Managed Long-term Care Program?

One of the most daunting challenges facing states wishing to enter this market is program design. Existing managed long-term care programs are highly diverse. There is not necessarily a model that can easily be replicated. A state must decide which populations will be eligible, where the services will be offered, whether enrollment will be mandatory or voluntary, how to coordinate with Medicare with respect to dual eligibles, and perhaps most importantly, how to establish appropriate payment rates. Other challenges to consider include:

- Obtaining legal authority from the federal government (waivers), particularly if the program is intended to integrate Medicare and Medicaid
- Negotiating with other interested parties, such as aging networks, the long-term care industry and the hospitals
- Building an adequate infrastructure in the state Medicaid agency to support a new program
- Identifying organizations interested in establishing new plans

What Is Happening in North Carolina with Respect to Medicaid Managed Long-term Care?

In the 1990s, North Carolina began the process of developing a program of managed long-term care, but the effort was abandoned prior to implementation. In 2004, the General Assembly authorized the creation of two pilot PACE programs, one in the east and one in the west.[5] PACE is a federal program that combines Medicaid and Medicare funding streams into a single capitated managed care program that serves all of the health care needs of a relatively small frail elderly population. In other words, PACE programs assume the financial risk of providing health care services to elderly people who qualify for nursing home care services with the hope of keeping the enrollees out of the hospital or nursing home for as long as possible.

PACE is a federal program that combines Medicaid and Medicare funding streams into a single capitated managed care program that serves all of the health care needs of a relatively small frail elderly population.

The North Carolina Division of Medical Assistance (DMA) has hired a program manager for PACE and is working closely with one potential PACE provider in the Wilmington area who is considering setting up a pilot site in the eastern part of the state. To date, no providers have expressed interest in setting up the second pilot site in the west. DMA expects to begin actively seeking potential candidates in June 2005. Development of a new PACE site typically takes at least 18 - 24 months. DMA updated the General Assembly on their progress on March 1, 2005; the report is available at http://www.dhhs.state.nc.us/dma/PACELegislativeStatus.pdf.

If these PACE pilot sites begin actively enrolling patients, they would be the state's first Medicaid managed long-term care program. While they would provide important information for state policymakers, the budgetary impact of such programs would be slight because the populations served would be quite small.

How Would Managed Long-term Care Impact Families?

Families with adults or children who require complex, long-term medical care and personal care services spend tremendous amounts of time and energy coordinating the patient's care. Managed long-term care has the potential to alleviate some of this burden on families. On the other hand, depending on program design, managed care could also be perceived as disempowering family members who wish to have some level of control over or participation in the patient's care. Some families may prefer a fully integrated, comprehensive managed care system like PACE. Other families may prefer a program that allows them to play a more hands-on role in the patient's care, such as some of the consumer-directed models that are being tested in other states. While perhaps not immediately intuitive, it is certainly possible to design a program that provides both managed care and consumer direction. Such a system could allow the patient (and the patient's family) flexibility in choosing services and service providers, but impose a cap on the total amount of resources used.

Given that the research suggests managed long-term care programs generally have high consumer satisfaction ratings and that the programs may result in fewer out-of-pocket expenses for the patient and his or her family, chances are good that families would react positively to such a program. But program design, as discussed above, will present a significant challenge for any state entering this market. When designing a new program, the state will have to consider the different effects that their decisions could have not only on providers and patients, but also on the patients' families.

Endnotes

[1] *The Past, Present and Future of Managed Long-term Care* by Paul Saucier, Brian Burwell and Kerstin Gerst (April 2005). Soon to be available at http://aspe.hhs.gov/_/topic/topic.cfm?topic=Long-Term%20Care.

[2] "Medicaid and Long-Term Care," Kaiser Commission on Medicaid and the Uninsured (March 2005). Available at http://www.kff.org/kcmu.

[3] North Carolina Institute of Medicine, "A Long-Term Care Plan for North Carolina: Final Report" (January 2001). Available at http://www.nciom.org/pubs/long-term.html.

[4] Program of All-Inclusive Care for the Elderly.

[5] S.L. 2004-124, § 10.12.

Overview of Selected Cost Containment Strategies for Medicaid Prescription Drug Spending*

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Abstract:

In North Carolina, Medicaid spending on outpatient prescription drugs has increased an average of 21% each year for the past eight years. Like other states, North Carolina has implemented numerous strategies over the years to contain these costs. This brief reviews Medicaid prescription drug spending and cost containment strategies in general. It then offers an overview of a handful of relatively large scale strategies that other states have implemented in recent years. It highlights states' use of preferred drug lists, supplemental rebates and multistate purchasing pools.

Prescription drug spending in the United States has been rising steadily for years – increasing at double digit rates from 1996-2004. National spending quadrupled between 1990 and 2002.[1] These trends are expected to continue well into the foreseeable future. On a national level, outpatient prescription drug spending overall is expected to increase 11.4% in 2005 and 11.6% in 2006.[2] State Medicaid programs, like other health care payers, are struggling to develop mechanisms that effectively control their prescription drug spending. Every state – including North Carolina – has implemented numerous strategies to control spending. Following the background on prescription drug spending and cost containment measures, this brief highlights

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several emerging strategies that North Carolina has not yet implemented and, by way of example, will discuss Florida's experience with those strategies.

How Much Does North Carolina Medicaid Spend on Outpatient Prescription Drugs?

Taking into account projected spending for 2005, North Carolina Medicaid spending for prescription drugs has increased on average 21% each year for the past eight years. Prescription drugs accounted for about 11% of total Medicaid expenditures in 1998, but are expected to make up over 20% of total spending in 2005. (See Table 1.)

Table 1: NC Medicaid Expenditures for Prescription Drugs

SFY	Prescription Drugs Paid	% of Medicaid Total Expenditure	% Increase of Prescription Drug	Medicaid Total Expenditure
1998	455,381,447	10.85%		4,197,522,724
1999	557,772,671	12.94%	22.48%	4,311,798,597
2000	754,505,194	15.73%	35.27%	4,796,682,219
2001	927,240,693	16.96%	22.89%	5,468,556,418
2002	1,056,158,750	17.10%	13.90%	6,175,910,221
2003	1,203,630,913	18.27%	13.96%	6,586,787,583
2004	1,470,328,522	19.95%	22.16%	7,369,370,752
2005	1,729,324,900	20.57%	17.61%	8,406,324,580

Note: Compiled by the NC Department of Health and Human Services, Division of Medical Assistance.
SFY 2005 expenditures are based on 2005-07 ESTIMATES

How Will the New Medicare Prescription Drug Benefit Affect North Carolina's Spending?

Many low income elderly people and other Medicaid recipients are considered dual eligibles – that is, they are eligible for both Medicaid (because of income) and Medicare (typically because of age). This population usually includes people who are high users of prescription drugs. One industry group (PhRMA) estimates that while people 65 and older account for only 9% of the total Medicaid population, they comprise almost 30% of the population group with the highest drug spending.[3]

Medicare will begin covering many prescription drugs for the dual eligibles beginning in 2006. The U.S. Department of Health and Human Services projects that when these populations are shifted over to Medicare, Medicaid spending as a percentage of all prescription drug spending will decrease from 18.1% in 2005 to 9.4% in 2006. This decrease, however, does not account for what many refer to as the clawback provision of the new Medicare law.[4] Under that provision, states are required to assist the federal government with paying for the prescription drug benefit for these dual eligibles. Every state must make monthly payments to the federal government. The calculation of the payment is based on a percentage of what the state would have paid for prescription drugs for these dual eligibles under Medicaid. In 2006, states must pay 90% of the amount they would have paid. By 2015, the percentage will decrease to 75%.

In addition to the concerns related to the clawback provision, state agencies are also worried about the potential woodwork effect following implementation of the Medicare drug benefit. Some agencies are actually anticipating an increase in Medicaid spending because they expect the number of dual eligibles enrolled in Medicaid to increase. This could happen because seniors may first learn of their eligibility for Medicaid when they enroll in the new Medicare drug benefit.[5] Taking both the clawback and woodwork issues into consideration, overall cost savings to state Medicaid programs may not be significant.

Some agencies are anticipating an increase in Medicaid spending because they expect the number of dual eligibles enrolled in Medicaid to increase.

How Does North Carolina Medicaid Decide How Much to Pay for a Particular Prescription Drug?

The total amount a state pays for outpatient prescription drugs is a combination of the state's reimbursement formula and any rebates that the state receives from pharmaceutical manufacturers.[6] State Medicaid programs have some flexibility in establishing their reimbursement formulas. The federal government establishes an absolute ceiling (the Federal Upper Limit or FUL) for some generic drugs. Each state then has the flexibility to decide on a specific reimbursement formula. The state's formula is expected to represent the Estimated Acquisition Cost (EAC) for the drugs. States have developed a variety of different formulas over the years. In North Carolina, prescription drugs are reimbursed at the lower of:

- The average wholesale price (AWP) minus 10%[7]
- The state maximum allowable cost (MAC)[8]
- The FUL
- The provider's usual and customary charge[9]

In addition, a dispensing fee is added to the charge. Most other states' formulas rely on deducting a percentage of cost from the AWP and/or adding a percentage of the cost to the Wholesale Acquisition Cost (WAC).[10]

After the state has paid for a drug, it will receive a rebate from the manufacturer. All states are entitled to a rebate based on a federal formula. In order for an outpatient prescription drug to be covered under any states' Medicaid program, the drug manufacturer must enter into an agreement with the federal government to provide a rebate of a percentage of the cost of the drug. The rebate is calculated by the federal government and the cost savings is shared with the states. In short, the federal rebate amount for brand name drugs is the greater of either:

- 15.1% of the average manufacturer price (AMP)[11]
- The difference between the AMP and the best price offered by the manufacturer to nonfederal purchasers[12]

For generic drugs, the rebate amount is 11% of the AMP. According to the Centers for Medicare and Medicaid Services (CMS), these rebates totaled about $6.4 billion in FY 2003.[13] In addition to these mandatory federal rebates, some states also receive supplemental rebates (discussed further below).

What Types of Prescription Drug Cost Containment Strategies Are States Implementing?

Most strategies being used by state Medicaid programs to contain prescription drug spending can be characterized as tools that either limit prescription drug use or control the costs of medications or the dispensing fees.[14] The types of strategies receiving the most attention from state legislatures in recent years:

- Instituting aggressive generic substitution policies
- Increasing cost sharing or copayments
- Implementing comprehensive drug utilization review programs
- Decreasing dispensing fees
- Requiring prior authorization for certain medications
- Developing preferred drug lists (PDL) or formularies
- Requiring supplemental rebates from manufacturers
- Entering into multistate purchasing pools[15]

North Carolina has adopted measures that incorporate the first five of the above strategies. For example, the state:[16]

- Requires pharmacists participating in the Medicaid program to substitute less expensive generic drugs for brand name drugs (with limited exceptions)
- Imposes the highest cost sharing allowed under federal law ($1/ generic and selected over-the-counter products and $3/brand name), although several categories of beneficiaries are exempt from copayments under federal law (e.g., child, pregnant woman, nursing home resident)[17]
- Established a prior authorization program for high cost specialty drugs. When a pharmacy is asked to fill a prescription for one of these drugs, it must contact the state agency (or its contractor) for approval and the state must respond within 24 hours[18]
- Operates both prospective and retrospective drug utilization review programs. The prospective program helps pharmacists identify potential problems (e.g., drug interactions, therapeutic duplication, drug-disease contraindications) and cost savings at the point of sale. The retrospective program is a pilot designed to evaluate pharmacy regimens for certain nursing home and adult care home residents

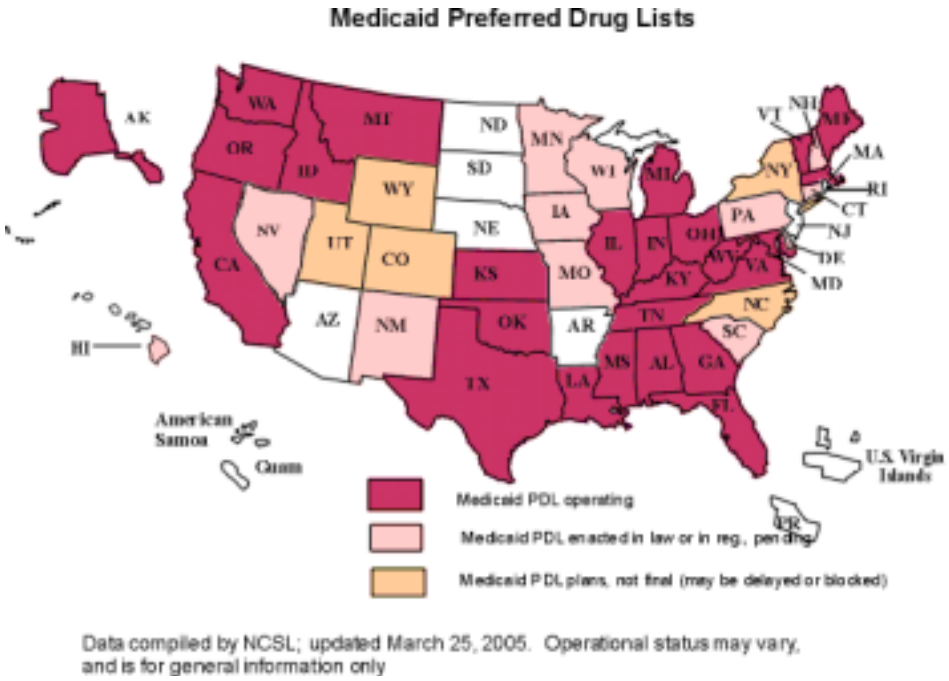
Many of North Carolina's strategies focus on building a pharmacy system that encourages pharmacists and physicians to prescribe the best, cost effective medicines. The state Division of Medical Assistance develops these strategies collaboratively with the provider community, receiving regular policy guidance from the Physician Advisory Group.[19] In addition to these administrative and management tools, North Carolina has implemented several regulatory strategies intended to limit utilization, such as exclusion of certain prescription drugs from coverage (e.g., weight loss and infertility drugs) and placement of restrictions on the numbers of reimbursable prescriptions and pills.

It is important for policymakers to consider how each of these cost containment strategies will affect families – particularly those families that are heavy users of prescription drugs. Families with elderly adults or special needs children, for example, will likely feel the effect of any change to the program, however minor.

In order to familiarize North Carolina policymakers with some of the emerging cost containment strategies that the state has not yet adopted, the remainder of this brief discusses the last three NCSL strategies identified above (preferred drug lists, supplemental rebates, and multistate pools). In addition, because Florida has adopted or considered each of these strategies, its experience will also be highlighted.

What Is a Preferred Drug List and How Can It Save States Money?

A preferred drug list (PDL) is a list of prescription drugs that is selected by the state to receive somewhat special treatment. In general, states agree to provide coverage for drugs on the PDL without requiring prior authorization or approval. Thus, health care providers may be encouraged to prescribe a drug listed on the PDL instead of a drug that is not listed because there are fewer administrative burdens. Drug manufacturers, therefore, usually would like their drugs to be included on a state's PDL. According to NCSL, at least 38 states now have PDL programs in operation or in progress.



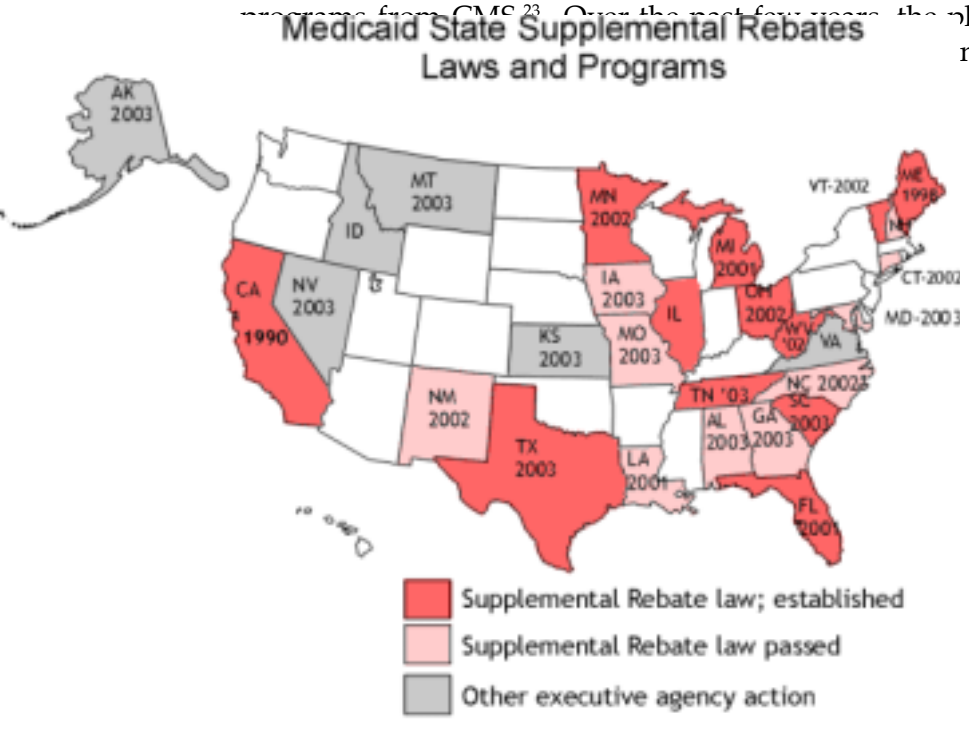
Data compiled by NCSL; updated March 25, 2005. Operational status may vary, and is for general information only

In 2001, Florida was one of the first states to establish a PDL. The state established a committee that determines which classes of drugs may be included on the list based on clinical factors, therapeutic evaluations, and cost considerations. The committee includes heavy representation from clinicians, but also includes a consumer representative and a pharmaceutical industry representative.[20] Many states follow the same process. In Florida and some other states, the PDL is tied directly to a supplemental rebate program. Specifically, once the classes of drugs are identified, the state's contractor (Provider Synergies) negotiates supplemental rebates with the manufacturers of drugs in those classes (see discussion of supplement rebates below).

North Carolina has an established list of preferred drugs that is called the Prescription Advantage List (PAL). The PAL is different from a traditional PDL, however, because the PAL is intended only to provide guidance to providers. In other words, if a provider wishes to prescribe or provide a drug for a Medicaid beneficiary that is not on the PAL, the provider is not required to obtain permission (i.e., prior authorization) from the state agency. Compliance with the PAL is entirely voluntary. The PAL is developed in consultation with an advisory group comprised of health care providers. Within each of the 16 top therapeutic drug classes, the PAL ranks each drug from the least expensive to the most expensive.[21]

What Is a Supplemental Rebate Program and How Can It Save States Money?

As mentioned earlier, all drug manufacturers wishing to sell their products to the Medicaid program must agree to provide rebates of a certain percentage of the drug's cost. States, however, have the option of entering into agreements directly with a drug manufacturer to receive rebates that go above and beyond the federal rebate. These are called supplemental rebate programs. Over 20 states have set up supplemental rebate programs in order to receive additional money or services directly from the drug manufacturers.[22] States must obtain approval for such programs from CMS.[23] Over the past few years, the pharmaceutical nges to these



Some 2002-04 programs are not operational or are in varying stages of implementation
Additional agency initiatives may not be listed. Data as of March 1, 2004. © NCSL

Florida established its supplemental rebate program in 2001. The program is tied directly to the state's PDL. In order for a brand name drug to have the opportunity to be included on the PDL, the drug manufacturer must offer a minimum rebate of 29.1% of AMP.[25] There is no upper limit on the rebate that the state may negotiate. The program is authorized by state law to receive supplemental rebates for generic drugs, but does not yet do so.

When Florida's program was first implemented, the state allowed drug manufacturers to substitute program benefits that have guaranteed savings to the Medicaid program.[26] A couple of manufacturers elected to offer such benefits in lieu of the additional rebate. For example, Pfizer, Inc. funded and operated a disease management program for chronically ill Medicaid beneficiaries in exchange for its drugs being placed on Florida's PDL. Pfizer was not required to pay the supplemental rebate. Florida ultimately concluded that these manufacturer programs were not cost effective and therefore is planning to discontinue this substitution option in the near future. All manufacturers who wish to have products included on the PDL in the future will be required to provide financial rebates.

In 2002, North Carolina began the process of developing a supplemental rebate program tied to a PDL. The General Assembly, however, included a provision in the 2002 budget bill prohibiting DHHS from requesting or requiring supplemental rebates from manufacturers.[27] The General Assembly removed the provision the following year, but the state has not yet exercised its authority to adopt either a PDL or supplemental rebate program.

How Do States Use Multistate Pooling to Save Money?

Several state Medicaid programs have joined forces to form prescription drug purchasing pools. In 2004, CMS approved a plan for seven states (Michigan, Vermont, Alaska, Nevada, New Hampshire, Minnesota, and Hawaii) to participate in a joint purchasing pool that also included a supplemental rebate component. According to CMS, the pool will purchase drugs for 1.1 million Medicaid beneficiaries and generate savings of $19.5 million for FY 2004.[28]

Other states are also considering joining or developing purchasing pools. Smaller states are particularly concerned about their potential loss of purchasing power once they stop covering prescription drugs for the dual eligible population. As discussed earlier, when the Medicare prescription drug benefit goes into effect next year, states will no longer directly pay for the costs of outpatient drugs for low income seniors. At this point in time, Florida has decided not to join in a pooling arrangement. Given the size of its Medicaid population, the state expects to maintain sufficient purchasing power on its own to negotiate reason-

able prices with manufacturers. North Carolina does not currently participate in any Medicaid purchasing pools, although a bill was introduced this session to create a Study Commission on Managing State Prescription Drug Costs. One of the commission's charges would be to evaluate the experiences of other states with "multistate compacts, bulk purchasing, or negotiated discounts."[29]

Endnotes

[1] Fact Sheet: Prescription Drug Trends, Kaiser Family Foundation (Oct. 2004). Available at http://www.kff.org/rxdrugs/3057-03.cfm).

[2] Heffler, Stephen et al., Trends: U.S. Health Spending Projections for 2004-2014, Health Affairs, W5-74 (Feb. 23, 2005) Web exclusive; projections prepared by the Office of the Actuary, Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services.

[3] See Press Release: New Study Profiles "High Users" of Medicaid Prescription Drug Coverage: Elderly, Female with Multiple Chronic Conditions, Pharmaceutical Research and Manufacturers of America (Dec. 9, 2003). Available at http://www.phrma.org/mediaroom/press/releases/09.12.2003.879.cfm.

[4] See Schneider, Andy, The"Clawback": State Financing of Medicare Drug Coverage, Kaiser Commission on Medicaid and the Uninsured (June 2004). Available at http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=39919.

[5] Questions and Answers about the Medicare Prescription Drug Legislation, National Association of State Medicaid Directors and the American Public Health Services Association (Dec. 2003). Available at http://www.nasmd.org/Medicare%20Bill_QA_Revised.pdf.

[6] Committee on Health Care, Review of Medicaid Prescription Drug Pricing, Florida Senate, Interim Project Report 2005-141 (Nov. 2004). Available at http://www.flsenate.gov/data/Publications/2005/Senate/reports/interim_reports/pdf/2005-141he.pdf.

[7] The AWP is intended to represent a national average of list prices charged by wholesalers to pharmacies. It is often referred to as the sticker price and generally represents a price much higher than what a large purchaser might actually pay. In North Carolina, the AWP is usually calculated by adding 20-25% to the Wholesale Acquisition Cost (WAC). The WAC is intended to reflect the price paid by a wholesaler for drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug. See Glossary, Office of Pharmacy Affairs, Health Resources and Services Administration, U.S. Department of Health and Human Services (available at http://www.bphc.hrsa.gov/opa/glossary.htm). See also presentation of Nancy Henley of the North Carolina Division of Medical Assistance to the Blue Ribbon Commission on Medicaid Reform (Oct. 6, 2004). See Appendix E. Available at http://www.ncleg.net/committees/blueribboncommi_/2005report/2005report.pdf.

[8] Many states set their own MAC lists. These lists are similar to the FUL list in that they establish a ceiling that the state will pay. State MAC lists, however, tend to include more drugs and assign lower prices than the FUL list. See Abramson, Richard G. et al, *Generic drug cost containment in Medicaid: Lessons from five State MAC programs*, Health Care Financing Review (Spring 2004). Available at http://www.cms.hhs.gov/review/04Spring/04Springpg25.pdf.

[9] The usual and customary charge is generally the price that the general public would pay for the drug at the retail pharmacy.

[10] For a table comparing North Carolina's formula with those in other southern states, see the presentation of Nancy Henley of the N.C. Division of Medical Assistance to the Blue Ribbon Commission on Medicaid Reform (Oct. 6, 2004). See Appendix E, pages 10-11. Available at http://www.ncleg.net/committees/blueribboncommi_/2005report/2005report.pdf.

[11] The Average Manufacturer Price (AMP) is intended to reflect the price paid by wholesalers to drug manufacturers.

[12] The manufacturer is required to report its best price to CMS. Provost Peters, Christie, *Fundamentals of the Prescription Drug Market*, National Health Policy Forum Background Paper (Aug. 24, 2004). Available at http://www.nhpf.org/pdfs_bp/BP_RxIndustry_08-24-04.pdf.

[13] Testimony of Dennis Smith, Director of the Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services, before the House Energy and Commerce Subcommittee on Oversight and Investigations (Dec. 7, 2004). Available at http://www.hhs.gov/asl/testify/t041207.html.

[14] For detailed information about prescription drug cost containment strategies in Medicaid, see e.g., Crowley, Jeffrey S. et al., *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003* (December 2003). Available at http://www.kff.org/medicaid/4164.cfm.

[15] See National Conference of State Legislatures, *Recent Medicaid Prescription Drug Laws and Strategies 2001-2004* (updated Jan. 2005). Available at http://www.ncsl.org/programs/health/medicaidrx.htm. See also Crowley, Jeffrey S. et al., *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003* (December 2003). Available at http://www.kff.org/medicaid/4164.cfm.

[16] Please note that this is not intended to be an exhaustive list of North Carolina's cost containment measures. For a full description of the state's program, see Division of Medical Assistance, *Outpatient Pharmacy Manual.* Available at http://www.dhhs.state.nc.us/dma/pharmacy.htm.

[17] Federal law prohibits a pharmacist from withholding a medication if the Medicaid beneficiary is unable to pay the cost sharing. As a result, it is often the pharmacy that assumes responsibility for any cost sharing

[18] For more information, see http://www.ncmedicaidpbm.com.

[19] Hooker Odom, Carmen and Wade, Torlen, *The Department of Health and Human Services: Medicaid Pharmacy Management Strategy- 2003-2005.* NC Medical Journal (Nov/Dec 2003), Available at http://www.ncmedicaljournal.com/nov-dec-03/ar110305.pdf.

[20] See Fla. Stat. § 409.91195 regarding the membership and scope of the state's Pharmaceutical and Therapeutics Committee.

[21] North Carolina's PAL list is available on the website for the Division of Medical Assistance. See http://www.dhhs.state.nc.us/dma/pal/pal.xls.

[22] Folkemer, Donna, *Prescription Drugs: Issues for States in 2005*, NCSL Presentation (Feb. 2, 2005). Available at http://64.82.65.67/health/Governing—Rx-Folkemer.pdf. CMS reports that as of September 2004, 33 states are receiving supplemental rebates. Center for Medicare and Medicaid Services, Safe and Effective Approaches to Lowering State Prescription Drug Costs: Best Practices Among State Medicaid Drug Programs (Sept. 9, 2004). Available at http://www.cms.hhs.gov/medicaid/drugs/strategies.pdf.

[23] Letter from Dennis Smith, Director of the Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, to State Medicaid Directors, SMDL #02-014 (Sept. 18, 2002). Available at http://www.cms.hhs.gov/states/letters/smd91802.pdf.

[24] Materials related to a lawsuit in Michigan are available on the website of the National Conference of State Legislatures, http://www.ncsl.org/programs/health/medicaidrx.htm.

[25] If a pharmaceutical manufacturer offers the minimum rebate for a particular drug, the drug is not automatically included on the PDL. It must be reviewed by the advisory committee to evaluate whether it should be included for clinical reasons.

[26] Fla. Stat. § 409.912 (39). See descriptions of Florida's program in the Addenda to *Issue Brief: State Pharmaceutical Assistance Programs*, National Governors' Association Center for Best Practices (May 10, 2001). Available at http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_2420,00.html.

[27] See North Carolina S.L. 2002-126 (budget bill); North Carolina S.L. 2002-159 (technical corrections bill).

[28] Center for Medicare and Medicaid Services, *Safe and Effective Approaches to Lowering State Prescription Drug Costs: Best Practices Among State Medicaid Drug Programs* (Sept. 9, 2004). Available at http://www.cms.hhs.gov/medicaid/drugs/strategies.pdf.

[29] S 424 (sponsored by Senators Boseman and Atwater).

Acronyms and Glossary of Terms Related to Medicaid

Acronyms

ADLs	Activities of Daily Living
ADR	Adverse Drug Reaction
AFDC	Aid for Families with Dependent Children
AL	Assisted Living
AMP	Average Manufacturer Price
AWP	Average Wholesale Price
C/MHC	Community and Migrant Health Center
CMS	Centers for Medicare and Medicaid Services
CON	Certificate of Need
DSH	Disproportionate Share Hospital
DUR	Drug Utilization Review
EAC	Estimated Acquisition Cost
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FFS	Fee-for-service
FMAP	Federal Medical Assistance Percentage
FPG	Federal Poverty Guideline
FQHC	Federally Qualified Health Center
FUL	Federal Upper Limit
HCBS	Home- and Community-based Services
HCFA	Health Care Financing Administration
HMO	Health Maintenance Organization
HHS	Health and Human Services
HRSA	Health Resources and Services Administration

IADL	Instrumental Activity of Daily Living
ICF	International Classification of Functioning, Disabilities, and Health
ICF-MR	Intermediate Care Facilities for the Mentally Retarded
LTC	Long-term Care
MAC	Maximum Allowable Cost
MCO	Managed Care Organization
MNIL	Medically Needy Income Level
NF	Nursing Facility
PACE	Program of All-Inclusive Care for the Elderly
PBM	Pharmaceutical Benefits Manager
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PDL	Preferred Drug List
PMPM	Per Member Per Month
QMB	Qualified Medicare Beneficiary
SCHIP	State Children's Health Insurance Plan
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
UCR	Usual, Customary, and Reasonable Charges
UPL	Upper Payment Limit
URO	Utilization Review Organizations
WAC	Wholesale Acquisition Price

Glossary of Terms

1115 Waiver: A section of the Social Security Act (§ 1115) that gives the Secretary of the U.S. Department of Health and Human Services the authority to approve experimental, pilot, or demonstration projects likely to promote the objectives of the underlying statute. States have used § 1115 waivers in Medicaid to cover services or individuals not otherwise eligible. Section 1115 waivers must be cost neutral over the course of the demonstration, typically five years.

Adjusted Average Per Capita Cost (AAPCC): An estimate of how much Medicare will spend in a year for an average beneficiary. AAPCC is usually calculated at the county level. Medicare uses this estimate as part of a formula to determine the rates it pays to managed care organizations participating in Medicare + Choice.

Adjusted Community Rating (ACR): A system that health insurers use to establish premiums. Under a community rating system, insurers use the average cost of providing health care for everyone in the plan (or community) as the basic premium level. With adjusted community rating, insurers adjust these community rates based on certain allowable demographic factors.

Aid for Families with Dependent Children (AFDC): A joint federal/state welfare program for low income families and children that was the precursor to Temporary Assistance for Needy Families (TANF).

Assignment: A Medicare provider payment system. Providers who accept assignment must agree to accept Medicare's allowed charges as payment in full, and not balance-bill the patient. In return, Medicare pays these providers a higher payment than other providers who do not accept assignment.

Balanced Budget Act (BBA): 1997 Congressional Budget Act that, among other things, changed Medicare provider reimbursement, established the State Children's Health Insurance program, and made it easier for states to establish Medicaid managed care programs.

Balanced Budget Refinement Act (BBRA): 1999 Congressional Budget Act that restores some of the Medicare provider payment cuts originally enacted as part of the BBA. Also made some changes in SCHIP and Medicaid programs. http://tnd.house.gov/CRS_SUMMARY_111699.htm.

Benefits Improvement and Protection Act (BIPA): 2000 Congressional Budget Act that further modifies the BBA. This act generally increased Medicare provider and HMO reimbursement rates. Also created a new prospective cost-based reimbursement rate for federally qualified health centers, adjusted the SCHIP reallocation formula to states, changed the Medicaid upper payment limit rules, and increased Medicaid DSH payments.

Capitation: A fixed periodic payment that the HMO pays to a physician, group practice, hospital, or network of providers. The capitation payment is calculated to cover the expected costs of providing certain services to patients over a period of time. The provider gets the same payment each month (or other fixed time period), regardless of the amount or type of services actually rendered. Capitation payment systems can cover just the cost of providing primary care (primary care capitation), may cover the costs of primary care and some specialty care (partial capitation) or may also include the costs of hospitalization (full or global capitation).

Clawback: Money that the federal government recaptures from state Medicaid agencies that is associated with the federal government's coverage of dual eligibles (Medicaid and Medicare) under the Medicare prescription drug program. The federal government reduces states' Medicaid matching rate to recapture savings that would accrue from the new Medicare prescription drug bill.

Community Rating: A method of setting insurance/health plan premiums according to the health plan's expected costs of providing health care to the community as a whole rather than to any subgroup within the community.

Cost Sharing: A generic term used to describe any payment the enrollee must make for covered services. Different cost sharing methods include deductibles, coinsurance, and copayments.

Diagnostic Related Groups (DRG): This classification system was developed in the Medicare program (but used by some private insurers) to pay hospitals based on a patient's primary and secondary diagnosis, surgical procedures, age, sex, and presence of complications.

Disease Management: Systems to identify, diagnose, and treat individuals with certain chronic health conditions. The goal of disease management systems is to provide the identified individuals with the education and support needed to comply with their prescribed treatments. Disease management programs may cover different chronic conditions such as: arthritis, asthma, HIV-AIDS, lower back pain, or diabetes.

Disproportionate Share Hospital (DSH): A Medicare and Medicaid payment system that provides higher payments to hospitals that serve a disproportionate share of low income or uninsured patients.

Drug Utilization Review (DUR): A system to determine whether drugs are being prescribed and used safely, effectively, and appropriately.

Dual Eligible: A person who is eligible for both Medicare and Medicaid.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): A program that provides well baby and well child screenings to children receiving Medicaid. Children are entitled to receive all the needed health care services or treatment identified as part of the screening as long as the federal Medicaid laws permit states to cover that service.

Emergency Medical Treatment and Labor Act (EMTALA): Originally part of the Comprehensive Omnibus Reconciliation Act of 1986 (COBRA). It requires all Medicare participating hospitals to screen individuals who come to the emergency department requesting treatment. If the screening determines that the person has an emergency, then the hospital must either treat and stabilize the person or appropriately transfer the person to another hospital.

Federal Medical Assistance Percentage (FMAP): The portion of a state's Medicaid expenditure that is paid for by the federal government. Sometimes referred to as FFP or federal financial participation.

Fee-for-service (FFS): Payments to providers are based on the specific services rendered. Fee-for-service systems are typically distinguished from capitation payments, which involve a fixed periodic payment per individual, regardless of what services are provided. Under a fee-for-service system, the provider is paid each time he or she provides a different service.

Formulary: List of pharmaceuticals that a payer will cover. A formulary may limit the type and number of medications available for a physician to select from when treating any given disease, illness, or condition.

Gatekeeper: In managed care systems, a primary care provider who must manage the patient's care. Typically, the gatekeeper is responsible for authorizing treatment by specialists or nonemergency hospitalizations.

Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA): A § 1115 waiver that can be used in Medicaid or the SCHIP program. States can use this waiver to modify the Medicaid benefits package or required cost sharing amounts for optional eligibility groups. States can also use federal Medicaid dollars to enable eligible individuals to purchase private health insurance coverage. The goal is to use program savings to increase the numbers of insured individuals (by expanding coverage to individuals not previously covered by Medicaid or SCHIP). These waivers must be cost-neutral to the federal government.

Home- and Community-based Services (HCBS): Services provided to older adults and people with disabilities that help them remain independent in a home- or community-based setting (as an alternative to institutionalization).

Incentive Payments: Financial awards managed care organizations make to physicians or facilities to encourage certain behavior. Examples of the types of behaviors for which an MCO may provide incentive payments include cost containment or improved quality of care.

Indemnity Insurance: Traditional major medical insurance that pays a percentage of the provider's charges. Typically, indemnity plans pay providers on a fee-for-service or discounted fee-for-service basis. Many insurers, for example, will pay providers 80 percent of the usual, customary, and reasonable charges for a comprehensive array of services. An indemnity plan that includes a network of providers is generally referred to as a Preferred Provider Organization (PPO).

Medicaid: A joint federal-state governmental health insurance program that provides assistance with medical costs for certain low and moderate income individuals and families. The federal government sets broad guidelines for the program. A state is then given latitude to establish eligibility criteria and to determine what services will be covered for the state's Medicaid population.

Medicaid Part D Drug Benefit: A Medicare drug benefit was signed into law in December 2003 as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The coverage includes most FDA approved drugs and biologicals, using the Medicaid coverage decision definitions. There are a few exceptions. Part D includes other items that aren't normally considered covered such as smoking cessation agents, vaccines and insulin, insulin related supplies such as syringes, needles, alcohol swabs and gauze, but not lancets and test strips. The full benefit will go into effect in January 2006.

Medical Loss Ratio: The percentage of the plan's health care related revenues (i.e. premiums) that is used to pay for health care services in contrast to profit or administrative overhead.

Medically Needy Income Level (MNIL): Income level at which individuals in some states can qualify for Medicaid coverage. These are persons who would qualify for Medicaid categorically (e.g., pregnant women, children, families with dependent children, elderly, disabled), but have income in excess of the regular Medicaid income limits. These individuals can qualify for Medicaid by incurring medical bills equal to the difference between their countable income and the Medicaid MNIL.

Medical Savings Accounts (MSA): A health insurance option combining high deductible insurance policies with a tax preferred savings account (like a medical IRA). Individuals in a MSA can pay for health care costs up to the annual deductible out-of-pocket or by using funds from their medical savings account. Once the deductible is met, the insurance policy will pay most or all of the covered services.

Prior Approval/Prior Authorization/Preauthorization: Verification by the health plan or state Medicaid agency that the requested services are appropriate and will be covered. Must be obtained before services are rendered.

Medical Necessity: Term used in insurance/HMO contracts in order to determine whether health care treatment is needed. HMOs/insurers may use clinical guidelines or community standards in determining whether the prescribed care is needed.

Medicare: The national health insurance program provided primarily to older adults (65 or older) and some disabled people who are eligible for Social Security benefits. Medicare has three parts: Part A, which is hospital insurance; Part B, which covers the costs of physicians and other providers; and Part C (Medicare + Choice), which expands the availability of managed care or other insurance arrangements for Medicare recipients.

Medicare + Choice: Part C of the Medicare program. Medicare + Choice gives beneficiaries a choice of enrolling in a coordinated care plan (HMO, PPO, or PSO), private fee-for-service plans, or medical savings account as an alternative to the traditional Medicare fee-for-service system.

Medigap Insurance: Privately purchased health insurance policy designed to supplement Medicare coverage (often referred to as Medicare supplemental policies). Medigap policies typically cover some Medicare cost sharing (such as deductibles or coinsurance), as well as pay for services not covered by Medicare. There are ten different federally standardized benefit packages.

Participating Provider: A provider who contractually agrees to provide health care services to members in return for payments from the managed care organization.

Pharmacy Plus Waiver: A § 1115 Medicaid waiver which gives states the authority to provide prescription drug-only coverage to low and moderate income seniors who would not otherwise qualify for Medicaid. Like other § 1115 waivers, this must be cost neutral to the federal government. States that operate a pharmacy plus waiver must accept a cap on federal Medicaid matching funds for all services provided to older adults. States can develop similar programs for people with disabilities.

Preferred Drug List (PDL): A type of drug formulary based on therapeutic efficacy and cost effectiveness often used in the Medicaid program. For a drug to be placed on a PDL, the state's pharmaceutical and therapeutics committee, comprised of practicing doctors and pharmacists, must review the medications for therapeutic indications and clinical effectiveness.

Primary Care Case Management (PCCM): Primary care case management programs operate within the Medicaid program. In PCCM programs the Medicaid agency usually pays a primary care provider a monthly management fee to manage the patient's care. However, the doctor is reimbursed for the services he or she provides on a fee-for-service basis. The primary care provider acts as the patient's gatekeeper and must authorize all nonemergency visits to the hospital and all referrals to specialists.

Program of All-Inclusive Care for the Elderly (PACE): A Medicaid managed long-term care program for the elderly. The program uses a multidisciplinary team of providers in an adult day health center to provide needed medical and social services.

Prospective Payment System (PPS): A Medicare payment system established in 1983, which is used to pay hospitals for inpatient hospital services. Prospective payment systems set the rates on the costs that would be incurred by an efficiently run hospital in treating a patient with a certain diagnosis. PPS systems are now used by other governmental and private insurers and for other types of providers.

Provider Sponsored Organization (PSO) or Provider Sponsored Network (PSN): PSO plans are basically HMO organizations that are organized by providers. Under Medicare, PSOs may have different licensure rules than traditional HMOs.

Resource Based Relative Value Scale (RBRVS): A system for determining provider reimbursement that was initially designed for the Medicare program. The RBRVS was designed to include all the resources that physicians use in providing care to patients, including physical or procedural, educational, mental (cognitive), and financial resources.

Resource Utilization Groups (RUG): Classification of consumers based on their health care needs and the time and resources required to meet those needs. Medicare uses RUG as the basis for nursing home case mix reimbursement.

State Children's Health Insurance Program (SCHIP): Federal program that expands health insurance coverage to certain low or moderate income uninsured children with family incomes that are too high to qualify for Medicaid.

Supplemental Rebate: Rebates to state Medicaid agencies from pharmaceutical companies that are in addition to those required by the federal Medicaid Drug Rebate Program.

Tiered Copayment Structure: Typically used as part of a pharmacy benefit. The insurer or HMO charges a lower copayment for a drug on a formulary (typically generic) than for those that are not on the formulary. Many have a three-tiered copayment structure, where the insured individual pays the least for a generic, more for a brand name if there is no generic substitute, and the highest copayment for a brand name drug if there is a generic substitute.

Upper Payment Limit (UPL): The maximum amount that a state may pay providers under the Medicaid program. The upper payment limit is generally limited to the total that Medicare would pay for the same services.

Wholesale Acquisition Cost (WAC): The price paid by the wholesaler for drugs purchased by the manufacturers.

Note: Significant portions of this document are from Silberman, P., *Health Policy Resources on the Web*, developed for NCSL/UNC Legislative Health Staff Summer Institute, updated 2004. Portions of this document stem from the glossary of the Michigan Family Impact Seminar's February 2005 briefing report, *Supporting Children and Families While Controlling Medicaid Costs.*

Internet Sites with Relevant Medicaid Information

North Carolina Resources

Cecil G. Sheps Center for Health Services Research
http://www.schsr.unc.edu
The Cecil G. Sheps Center for Health Services Research at the University of North Carolina is a health services research center. The center encompasses an interdisciplinary program of research, consultation, technical assistance, and training focusing on the accessibility, adequacy, organization, cost, and effectiveness of health care services.

North Carolina Division of Medical Assistance
http://www.dhhs.state.nc.us/dma/
The Division of Medical Assistance manages Medicaid and NC Health Choice for Children for the state of North Carolina.

North Carolina Institute of Medicine (NC IOM)
http://www.nciom.org
The NC IOM was created by the North Carolina General Assembly in 1983 as an independent, nonprofit organization that serves as a nonpolitical source of analysis and advice on issues of relevance to the health of North Carolina's population. The institute convenes policymakers, community and business leaders, and healthcare professionals to study complex health issues facing the state in order to identify public and private options to address these issues.

North Carolina Medicaid Enhanced Pharmacy Program
http://www.ncmedicaidpbm.com/
Prior authorization is required for certain drugs prescribed to North Carolina Medicaid recipients. This website is intended to help prescribers and pharmacists understand the process required to obtain prior authorization.

North Carolina Medical Journal
A bimonthly journal published by the NC IOM. Offers peer reviewed articles for communicating health policy among state stakeholders, including:

> **Controlling Pharmacy Costs in the North Carolina Medicaid Program**
> http://www.ncmedicaljournal.com/nov-dec-03/ar110306.pdf
>
> **The North Carolina Health Care Safety Net**
> http://www.ncmedicaljournal.com/mar-apr-05/toc0305.shtml
>
> **Access to Care for the Uninsured**
> http://www.ncmedicaljournal.com/jan-feb-02/toc0102.shtml

National Resources

Alliance for Health Reform
http://www.allhealth.org
The alliance is a nonprofit, nonpartisan organization that organizes forums, produces issue briefs on current health policy topics, provides services to the media regarding health information, and serves as an unbiased source of information on national health care challenges.

American Academy of Pediatrics
http://www.aap.org
The American Academy of Pediatrics provides research on physician participation in Medicaid and SCHIP, state Medicaid reports, including provider reimbursement rates, and findings from surveys on children's health and insurance.

America's Health Care Safety Net: Intact but Endangered
http://books.nap.edu/catalog/9612.html
The Institute of Medicine's book on safety net providers and access to care for the uninsured includes information on competition and cost issues, as well as strategies for maintaining the safety net. The above address leads to a searchable online copy of the publication.

American Health Insurance Plans
http://www.ahip.org/
American Health Insurance Plans is a merger of two separate organizations: Health Insurance Association of America (HIAA) and American Association of Health Plans (AAHP). The AHIP website provides links to research and publications on Medicaid and other health insurance topics.

Center for Studying Health System Change (HSC)
http://www.hschange.org
HSC is a Washington-based research organization dedicated to studying how the country's health care systems are changing and how those changes are affecting people at the community level.

Centers for Medicare and Medicaid Services (CMS)
http://cms.hhs.gov
CMS is the federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). This site provides information related to all of those programs.

Commonwealth Fund
http://www.cmwf.org
The Commonwealth Fund is a private foundation that supports independent research on health and social policy issues. The major national initiatives of the Commonwealth Fund are improving health insurance coverage and access to care and improving the the quality of health care services. The searchable publications directory is located at: http://www.cmwf.org/publications/publications.htm.

Council of State Governments (CSG)
http:www.statesnews.org
CSG provides a network for identifying and sharing with state leaders.

CSG's Medicaid resources:
http://www.csg.org/CSG/Policy/health/health+teleconferences/Medicaid+resources.htm

CSG's Health policy information:
http://www.csg.org/CSG/Policy/health/default.htm

Economic and Social Research Institute (ESRI)
http://www.esresearch.org
ESRI is a nonprofit, nonpartisan institute that conducts research and studies directed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable. ESRI's website provides information on a variety of topics, including the uninsured, the healthcare marketplace, special populations, controlling costs, quality of care issues, and welfare reform and poverty issues.

Health Affairs
http://www.healthaffairs.org
Health Affairs is a bimonthly product of Project Hope and serves as a leading periodical in its field. The periodical focuses on health policy issues and provides information for both professionals and those interested in public health issues. Health Affairs' articles include *Medicaid Cost Containment And Access To Prescription Drugs and Understanding The Recent Growth In Medicaid Spending, 2000–2003*.

Henry J. Kaiser Family Foundation
http://www.kff.org
The Kaiser Family Foundation and the Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/medicaidbenefits/index.cfm, offer information on the major health care issues facing the nation.

Murphy's Unofficial Medicaid Page
http://www.geocities.com/CapitolHill/5974
Includes links to all state Medicaid sites and many other Medicaid resources on the Web.

National Academy for State Health Policy (NASHP)
http://www.nashp.org
NASHP is dedicated to excellence in state health policy and practice. Through this website and the organization's many other activities, NASHP works to disseminate information designed to assist states in the development of practical, innovative solutions to complex health policy issues. Located in the programs and research section, you can find information on the uninsured, children's health, Medicaid, and long-term care.

National Association of State Medicaid Directors (NASMD)
http://www.nasmd.org
The primary purposes of NASMD are to serve as a focal point of communication between the states and the federal government and to provide an information network among the states on issues pertinent to the Medicaid program.

National Center for Policy Analysis (NCPA)—Health Issues
http://www.ncpa.org
NCPA is a nonprofit public policy research institute. It offers a wealth of analysis, debate, and in-depth research from around the world. To find the health issues section, click on the link on the left side of the page for policy issues, then choose health from the menu items.

National Conference of State Legislatures (NCSL)
http://www.ncsl.org
The NCSL web site provides personalized, comprehensive access for state legislators and legislative staff to NCSL information and reports, plus the ability to search more than 500,000 state documents encompassing legislative policy reports, current and past legislation, state statutes, and 50-state surveys. NCSL reports and publications relating to Medicaid include:

> **Medicaid Cost Containment: A Legislator's Tool Kit**
> http://www.ncsl.org/programs/health/forum/cost/containment.htm
>
> **Balancing Health Needs with Resources**
> http://www.ncsl.org/programs/health/balancing.htm
>
> **2005 Prescription Drug State Legislation** (updated 5/10/05)
> http://www.ncsl.org/programs/health/drugdisc05.htm

National Governors' Association (NGA) information on cost containment:
http://www.nga.org/center/topics/1,1188,C_CENTER_ISSUE^D_5122,00.html

National Health Law Program
http://www.healthlaw.org
The National Health Law Program is a national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, the elderly, and people with disabilities.

National Pharmaceutical Council (NPC)
http://www.npcnow.org
NPC is supported by 27 of the nation's major research-based pharmaceutical companies. NPC sponsors a variety of research and education projects aimed at demonstrating that the appropriate use of pharmaceuticals improves both patient treatment outcomes and the cost effective delivery of overall health care services.

> **Publications at npcnow.org include:**
> State Medicaid Resource Kit: Maintaining Quality and Patient Access to Innovative Pharmaceuticals in Challenging Economic Times
> http://www.npcnow.org/resources/PDFs/MedicaidKit.pdf

Pharmaceutical Research and Manufacturers of America (PhRMA)
http://www.phrma.org
PhRMA represents approximately 100 U.S. companies that have a primary commitment to pharmaceutical research. PhRMA presents information on a wide variety of prescription drug topics.

RAND Health
http://www.rand.org/health
RAND assists public policymakers at all levels, private sector leaders in many industries, and the public at large in efforts to strengthen the nation's economy, maintain its security, and improve its quality of life. It does so by analyzing choices and developments in many areas. RAND's mission is to improve policy and decision making through research and analysis.

The Robert Wood Johnson Foundation
http://www.rwjf.org/
The Robert Wood Johnson Foundation funds projects with the mission of improving the health and health care of all Americans. The foundation is committed to encouraging healthier living and the conditions that result in better health to promoting positive changes in the way health care is delivered in this country.

RxAssist
http://livingwithillness.com/id209.htm
RxAssist is a national program supported by the Robert Wood Johnson Foundation. The program provides health care providers and patients with information on accessing pharmaceutical manufacturers' patient assistance programs. It includes information about how physicians can offer free pharmaceuticals for their qualified uninsured patients through the charitable outreach efforts of major drug manufacturers.

The W.K. Kellogg Foundation
http://www.wkkf.org
The W.K. Kellogg Foundation is a nonprofit organization whose mission is "to help people help themselves through the practical application of knowledge and resources to improve its quality of life and that of future generations." Health care is only one of their broad interests. Within the area of health care, the Kellogg Foundation's goal is "to increase access to integrated, comprehensive healthcare systems organized around public health, prevention, and primary care."

Note: Significant portions of this document are from Silberman, P., *Health Policy Resources on the Web*, developed for NCSL/UNC Legislative Health Staff Summer Institute. Updated 2004.