



Wisconsin Family Impact Seminars

and the

University of Wisconsin Population Health Institute

Medicaid: Who Benefits, How Expensive is It, and What are States Doing to Control Costs?

Center for Excellence in Family Studies
School of Human Ecology
University of Wisconsin-Madison
and
University of Wisconsin Extension

UW
Extension

Medicaid: Who Benefits, How Expensive is It, and What are States Doing to Control Costs?

First Edition

Wisconsin Family Impact Seminars and the University of Wisconsin Population Health Institute Briefing Report

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Purpose and Presenters

In 1993, Wisconsin became one of the first states to sponsor Family Impact Seminars modeled after the seminar series for federal policymakers. The Seminars are designed to connect research and state policy and bring a family perspective to policymaking. Family Impact Seminars analyze the consequences that an issue, policy, or program may have for families. Because of the success of the Wisconsin Family Impact Seminars, Wisconsin is now helping 17 other states conduct their own seminars through the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension.

The Family Impact Seminars are a series of seminars, briefing reports, newsletters, and discussion sessions that provide up-to-date, solution-oriented research on current issues for state legislators and their aides, Governor's office staff, legislative service agency personnel, and state agency representatives. The Seminars present objective, nonpartisan research and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

"Medicaid: Who Benefits, How Expensive is It, and What are States Doing to Control Costs?" is the 22nd Wisconsin Family Impact Seminar. For information on other Wisconsin Family Impact Seminars topics or on Seminars in other states, please visit our web site at www.familyimpactseminars.org.

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Or, visit the Policy Institute for Family Impact Seminars Web site at:
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Executive Summary

Every state is grappling with the same problem—how to provide Medicaid benefits for vulnerable populations when costs are increasing faster than state revenues. According to the Urban Institute, Medicaid costs in Wisconsin grew an average of 13% annually between 2000 and 2003. The Medicaid program benefitted 807,000 Wisconsin residents or 15% of the population sometime in Fiscal Year (FY) 2004. Medicaid has proven to be a thorny issue for policymakers because it places demands on the state budget, while bringing benefits to the state’s low-income individuals and families.

The first chapter by **Martha King**, a 20-year veteran of the National Conference of State Legislatures, describes the Medicaid program, why the program costs so much, who it serves, and how some states have controlled Medicaid costs. Medicaid is an optional program, but all states choose to participate because of the large share of costs underwritten by the federal government—about 58% of Medicaid costs in Wisconsin.

From FY 2002 to 2003, Wisconsin’s Medicaid expenditures increased more than \$438 million or 12.6%. King discusses several reasons why Medicaid costs have been difficult to rein in. Because Medicaid is an entitlement program, states cannot exclude anyone who qualifies for coverage. This makes budgeting difficult because the number of eligible people can fluctuate with factors such as the economy and eroding private insurance. Medicaid costs are also high because certain beneficiaries such as the low-income elderly and disabled have high medical and long-term care needs. In fact, in Wisconsin, these two groups make up only about 33% of Medicaid beneficiaries, but account for about 76% of program costs. In contrast, children and adults (mostly poor parents and pregnant women) account for about 67% of participants, but only 24% of costs.

John Holahan of the Urban Institute discusses why it has been difficult for states to cut Medicaid benefits, who is covered by Medicaid, how cost effective Medicaid is, and what questions policymakers can ask to guide difficult Medicaid budget decisions. Policymakers have been reluctant to cut Medicaid benefits for several reasons. Some benefits are popular with citizens because they strengthen families and improve human capital. Making cuts in provider payments is hampered by the political power of these groups. Given Wisconsin’s federal matching rate of 58%, cutting a dollar in expenditures only saves 42 cents, and cutting optional acute care benefits saves little or no money.

Holahan examines who Medicaid serves and compares low-income people covered by Medicaid to their counterparts who are privately insured. The Medicaid population is much poorer, has less education, and is less likely to be married. Medicaid enrollees are also more apt to be sick or in poor health and have more cognitive and physical limitations than the privately insured poor. When per person costs are compared directly, the costs for Medicaid adults are higher than for the privately insured poor (\$4,877 compared to \$2,843). However, when adults with fair or poor mental health or any physical limitations are excluded, the spending for non-disabled Medicaid adults (\$1,752) is significantly lower than for non-disabled adults who are privately insured (\$2,253).

Holahan also examined the services provided by the Medicaid benefit package that are often considered too generous—dental and other optional services. These so-called Cadillac benefits add about 12% to total costs.

Vernon Smith of Health Management Associates discusses what states are doing to control Medicaid costs based on his 2004 50-state survey of state Medicaid administrators. The top drivers of the growth in spending, according to state Medicaid administrators, are Medicaid enrollment growth and the rising costs of prescription drugs, medical care, and long term care. Wisconsin Medicaid officials indicated that the primary driver behind growth in Medicaid expenditures in 2004 and 2005 was an increased caseload. Other important factors were rising costs of prescription drugs and cost-based providers such as long-term care institutions and federally qualified health centers.

Because Medicaid spending in the U.S. in 2004 grew faster than all other state programs, every state adopted at least one cost-containment measure and every state reported plans for additional cost-saving measures for FY 2005. This will be the fourth consecutive year that states have implemented significant cost-containment initiatives, although a few states planned to adopt modest benefit or eligibility expansions.

In 2004, Wisconsin reported plans to control costs by reducing or freezing provider payments, controlling prescription drug costs, increasing copayments, targeting fraud and abuse, and implementing long-term care initiatives. In 2005, the state reported plans to use some of these same strategies (provider payment reductions, prescription drugs savings, managed care expansions, disease management programs, and long-term care initiatives). The Wisconsin Department of Health and Family Services estimates that its cost-containment initiatives saved \$460 million between 2003 and 2005.

The **Legislative Fiscal Bureau** chapter overviews Wisconsin’s Medical Assistance (MA), BadgerCare and SeniorCare programs including eligibility, caseload trends, federally required and optional services, expenditures, and recent cost containment initiatives. Most of the recent growth in caseload trends has been low-income families, whose costs are lower than other beneficiaries. Because of a 2003 waiver, the number of women who participate in MA family planning has also increased, as has the number of individuals who qualify due to disabilities. MA recipients over 65 and the BadgerCare caseload have decreased and the state’s SeniorCare program has stabilized.

The **Wisconsin Family Impact Seminars** encourages policymakers to consider how Medicaid reform may impact the well being of Wisconsin families in intended and unintended ways. Three examples are given here. First, policymakers can use data on families enrolled in Medicaid to help guide difficult budget decisions. In Wisconsin, children and adults (mostly poor parents and pregnant women) are the majority (67%) of Medicaid recipients, but account for only a small percent (24%) of costs. Second, recent measures to control Medicaid costs in Wisconsin have implications for families. For example, Wisconsin reduced nursing home expenditures by providing the options that many seniors prefer—home and community-based care. For families enrolled in BadgerCare, recent increases in premiums and new employer health care verification procedures may have reduced access to care.

Finally, the eligibility criteria that state and federal policymakers set can affect family decisions, such as whether or not to marry. For BadgerCare, if a mother and father live with their child, they are eligible for benefits whether or not they are married. If a parent and a partner (not the other parent) live with the child, the partner does not receive coverage unless they marry. However, if they marry, it is possible that the joint income of the couple could disqualify them from BadgerCare by raising the family’s income above the cutoff. For the SeniorCare program, eligibility is based on federal poverty guidelines, which are based on family size. For an elderly couple, it would probably be easier to meet the income guidelines if they live together rather than marry.



A Checklist for Assessing the Impact of Policies on Families

The first step in developing family-friendly policies is to ask the right questions:

- What can government and community institutions do to enhance the family's capacity to help itself and others?
- What effect does (or will) this policy (or proposed program) have for families? Will it help or hurt, strengthen or weaken family life?

These questions sound simple, but they can be difficult to answer.

The Family Criteria (Ad Hoc) Task Force of the Consortium of Family Organizations (COFO) developed a checklist to assess the intended and unintended consequences of policies and programs on family stability, family relationships, and family responsibilities. The checklist includes six basic principles that serve as the criteria of how sensitive to and supportive of families policies and programs are. Each principle is accompanied by a series of family impact questions.

The principles are not rank ordered and sometimes they conflict with each other, requiring trade-offs. Cost effectiveness also must be considered. Some questions are value-neutral and others incorporate specific values. People may not always agree on these values, so sometimes the questions will require rephrasing. This tool, however, reflects a broad nonpartisan consensus, and it can be useful to people across the political spectrum.



This checklist can be used to conduct a family impact analysis of policies and programs.

For the questions that apply to your policy or program, record the impact on family well-being.

1

Principle 1. Family support and responsibilities.

Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.

Does the proposal or program:

- support and supplement parents' and other family members' ability to carry out their responsibilities?
- provide incentives for other persons to take over family functioning when doing so may not be necessary?
- set unrealistic expectations for families to assume financial and/or caregiving responsibilities for dependent, seriously ill, or disabled family members?
- enforce absent parents' obligations to provide financial support for their children?

2

Principle 2. Family membership and stability.

Whenever possible, policies and programs should encourage and reinforce marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself.

Does the policy or program:

- provide incentives or disincentives to marry, separate, or divorce?
- provide incentives or disincentives to give birth to, foster, or adopt children?
- strengthen marital commitment or parental obligations?
- use appropriate criteria to justify removal of a child or adult from the family?
- allocate resources to help keep the marriage or family together when this is the appropriate goal?
- recognize that major changes in family relationships such as divorce or adoption are processes that extend over time and require continuing support and attention?

3**Principle 3. Family involvement and interdependence.**

Policies and programs must recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members.

To what extent does the policy or program:

- recognize the reciprocal influence of family needs on individual needs, and the influence of individual needs on family needs?
- recognize the complexity and responsibilities involved in caring for family members with special needs (e.g., physically or mentally disabled, or chronically ill)?
- involve immediate and extended family members in working toward a solution?
- acknowledge the power and persistence of family ties, even when they are problematic or destructive?
- build on informal social support networks (such as community/neighborhood organizations, religious communities) that are essential to families' lives?
- respect family decisions about the division of labor?
- address issues of power inequity in families?
- ensure perspectives of all family members are represented?
- assess and balance the competing needs, rights, and interests of various family members?
- protect the rights and safety of families while respecting parents' rights and family integrity?

4**Principle 4. Family partnership and empowerment.**

Policies and programs must encourage individuals and their close family members to collaborate as partners with program professionals in delivery of services to an individual. In addition, parent and family representatives are an essential resource in policy development, program planning, and evaluation.

In what specific ways does the policy or program:

- provide full information and a range of choices to families?
- respect family autonomy and allow families to make their own decisions? On what principles are family autonomy breached and program staff allowed to intervene and make decisions?
- encourage professionals to work in collaboration with the families of their clients, patients, or students?
- take into account the family's need to coordinate the multiple services required? Does it integrate well with other programs and services that the families use?
- make services easily accessible to families in terms of location, operating hours, and easy-to-use application and intake forms?
- prevent participating families from being devalued, stigmatized, or subjected to humiliating circumstances?
- involve parents and family representatives in policy and program development, implementation, and evaluation?

5

Principle 5. Family diversity.

Families come in many forms and configurations, and policies and programs must take into account their varying effects on different types of families. Policies and programs must acknowledge and value the diversity of family life and not discriminate against or penalize families solely for reasons of structure, roles, cultural values, or life stage.

How does the policy or program:

- affect various types of families?
- acknowledge intergenerational relationships and responsibilities among family members?
- provide good justification for targeting only certain family types, for example, only employed parents or single parents? Does it discriminate against or penalize other types of families for insufficient reason?
- identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?

6

Principle 6. Support of vulnerable families.

Families in greatest economic and social need, as well as those determined to be most vulnerable to breakdown, should be included in government policies and programs.

Does the policy or program:

- identify and publicly support services for families in the most extreme economic or social need?
- give support to families who are most vulnerable to breakdown and have the fewest resources?
- target efforts and resources toward preventing family problems before they become serious crises or chronic situations?

The Policy Institute for Family Impact Seminars aims to connect research and policymaking and to promote a family perspective in research, policy, and practice. The Institute has resources for researchers, policymakers, practitioners, and those who work to connect research and policymaking.

- To assist researchers and policy scholars, the Institute is building a network to facilitate cross-state dialogue and resource exchange on strategies for bringing research to bear on policymaking.
- To assist policymakers, the Institute disseminates research and policy reports that provide a family impact perspective on a wide variety of topics.
- To assist those who implement policies and programs, the Institute has available a number of family impact assessment tools for examining how responsive policies, programs, and institutions are to family well-being.
- To assist states who wish to create better dialogue between researchers and policymakers, the Institute provides technical assistance on how to establish your own state's Family Impact Seminars.

This checklist was adapted by the Institute from Ooms, T. (1995). *Taking families seriously as an essential policy tool*. Paper prepared for an expert meeting on Family Impact in Leuven, Belgium. The first version of this checklist was published by Ooms, T., & Preister, S. (Eds., 1988). *A strategy for strengthening families: Using family criteria in policymaking and program evaluation*. Washington DC: Family Impact Seminar.

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Medicaid in a Nutshell

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Medicaid is an optional program, but all states choose to participate because of the large share of costs underwritten by the federal government—58.3% of Medicaid costs in Wisconsin. Medicaid is difficult to budget for because it is an entitlement program that cannot exclude anyone who qualifies for coverage. Some groups have particularly high medical and long-term care needs. For example, in Wisconsin, the low-income elderly and disabled make up only 33% of Medicaid clients, but account for 76% of program costs. In contrast, children and adults (mostly poor parents and pregnant women) account for 67% of clients, but only 24% of costs

Medicaid has become the nation's largest source of funding to provide health services to low-income people, amounting to about \$270 billion in 2003. The program accounts for about 20% of the average state's budget and nearly 70% of state spending on health services and programs. As Medicaid costs rise faster than state revenues, states struggle to rein in costs, while preserving services to their most vulnerable citizens. This chapter summarizes key elements of the program, including what Medicaid is, why legislators should care about it, which people it covers, what services it includes, why the program costs so much, how some states control their Medicaid costs, and new developments in the program.

What is Medicaid?

A federal-state partnership program created by Congress in 1965 (Title XIX of the Social Security Act), Medicaid was designed to finance health care services for the nation's poor people. Its original focus was on recipients of cash assistance through welfare programs. The program expanded to fund health services for approximately 52 million low-income Americans during the 2003 calendar year, according to the Congressional Budget Office.

Although Medicaid is an optional program in which states may choose to participate, the federal government's large financial share provides an incentive. All 50 states participate and administer their own Medicaid plans. The federal government pays at least 50% of the costs of medical services under Medicaid, ranging as high as 80% in the poorest states. In FY 2005, the federal government paid 58.3% of Wisconsin's cost of Medicaid medical services.

Medicaid is sometimes confused with Medicare, a federal program that serves the elderly and certain people with long-term disabilities. Nonetheless, Medicare relies on Medicaid to help it cover certain services for low-income elderly people, such as nursing home care and pharmaceuticals. Approximately 7 million people qualify for dual coverage—under both Medicare and Medicaid—as discussed later.

In FY 2005, the federal government paid 58.3% of Wisconsin's cost of Medicaid medical services.

Medicaid has evolved to become three programs in one:

1. A health financing program for low-income parents (mostly women) and children.
2. A health financing program for people with significant disabilities.
3. A long-term care financing program for low-income elderly people.

Why Should We Care About Medicaid?

We should care about Medicaid for several reasons, including that Medicaid:

- Accounts for nearly 20% of the average state's budget and nearly 70% of all state health expenditures. In FY 2003, Wisconsin spent 12.3% of its total budget and 73.1% of its health care budget on Medicaid.¹
- Serves as the largest health financing source for low-income Americans.
- Accounts for about 43% of federal assistance to states.
- Funds about one-third of all U.S. births.
- Funds long-term care services for nearly one-third of all people age 85 and over.
- Subsidizes state health services for uninsured people.
- Subsidizes graduate medical education in states.

Medicaid has become a vital funding source for health care in this country; it paid for nearly one-half of nursing home care, 17% of hospital services, 17.2% of prescription drug costs, and 16.7% of all personal health services in 2001. Hospitals and clinics that serve a large share of both Medicaid-eligible and uninsured patients receive extra payments through Medicaid's "disproportionate share hospital" (DSH) provisions to help pay for such care.

With most state budgets in financial trouble, Medicaid programs and costs have come under increased scrutiny. Although average state revenues grew only 1.2% in 2002, Medicaid costs soared 12.8% - similar to the increases in the private insurance market. Medicaid costs rose another 9.3% in 2003, and the Congressional Budget Office predicts annual increases of 8% or higher during the next several years. In Wisconsin from FY 2002 to FY 2003, Medicaid expenditures increased 12.6%, an increase of more than \$438 million.²

Medicaid budgeting is difficult because the number of eligible people fluctuates with the economy and other variables.

Which People Does Medicaid Cover?

Federal law requires Medicaid programs to cover certain populations and allows states the option of covering others. Medicaid is an "entitlement" program, which means that states may not exclude anyone who applies for coverage if he or she meets specified eligibility criteria. This provision makes budgeting for Medicaid somewhat difficult because enrollment may not be limited and the number of eligible people fluctuates with the economy and other variables. Although 52 million people were covered by Medicaid at some point during 2003, month-by-month variations exist as people move in and out of the program. For example, 41.2 million people were enrolled in Medicaid during December 2002. In Wisconsin in June 2003, 631,400 people were enrolled in Medicaid.³

Mandatory Populations

Although state participation in Medicaid is optional, states that have Medicaid programs must provide coverage to certain groups or “categories” of people (sometimes referred to as “categorically eligible”). Mandatory groups include the following:

- ◆ AFDC-related populations (certain parents and children).
- ◆ People who receive Supplemental Security Income (SSI), a federal cash assistance program for low-income people with disabilities who meet specified eligibility criteria.
- ◆ Pregnant women with incomes up to 133% of federal poverty guidelines (\$12,382 for a single woman in 2004).
- ◆ Infants of women enrolled in Medicaid at the time of birth, or those in families with income up to 133% of poverty guidelines.
- ◆ Children under age 6 in families with income up to 133% of poverty guidelines.
- ◆ Children ages 6 through 18 in families with incomes at or below the poverty level.
- ◆ Children in adoption or foster care.
- ◆ Some low-income Medicare recipients (for services not covered by Medicare).

Optional Populations

For many years, states had little discretion about covering additional people under Medicaid. The program was mainly designed to assist very low-income, welfare-related populations. However, the program expanded over time, most notably for children and pregnant women. A few of Wisconsin’s optional groups include low-income infants and pregnant women, other low-income children, and certain aged, blind, or disabled adults with income less than 100% of the poverty level. The most common additional populations that states may choose to cover in their Medicaid programs include the following.

- ◆ Infants and pregnant women with family incomes up to 185% of the federal poverty guidelines.
- ◆ Additional families, by disregarding a portion of family income, eliminating asset tests, raising income levels to adjust for inflation, or extending benefits to two-parent working families.
- ◆ Additional Medicare recipients by increasing income eligibility levels.
- ◆ “Medically needy” people (specified low-income people who do not meet income criteria, but who have large medical expenses in proportion to their income).
- ◆ People with disabilities who would lose eligibility because of higher income, who may buy Medicaid coverage under a sliding-scale premium (the “Ticket to Work” initiative).
- ◆ Low-income uninsured women with breast or cervical cancer who have been diagnosed through the National Breast and Cervical Cancer Early Detection Program, for their cancer treatment (see www.ncsl.org/programs/health/bcsnapshot.htm or www.cms.hhs.gov/bccpt/default.asp?).

- ◆ Children under the State Children’s Health Insurance Program (SCHIP). Under the federal SCHIP legislation passed in 1997, states may extend Medicaid coverage to children through age 18 with family incomes of up to 200% of the federal poverty guidelines (or they may create a non-Medicaid insurance option). For background on Wisconsin’s family-based SCHIP program, see the June 2003 Family Matters newsletter at <http://familyimpactseminars.org/fisnews3-1.pdf>.

Figure 1. 2004 Federal Poverty Guidelines for a Family of Three

Income as a Percent of Poverty	48 Contiguous States and D.C.
100%	\$15,670.00
133%	20,841.10
185%	28,989.50
200%	31,340.00

Source: Federal Register, February 13, 2004.

In general, states cover people who meet the eligibility criteria for each of the listed categories, as determined in each state’s program plan. With the exceptions described below, unless people fit one of the categories, they may not receive Medicaid assistance no matter how poor they are. For example, an adult with no income may not qualify for Medicaid assistance unless he or she meets the criteria for one of the listed categories (e.g., welfare-related parent, SSI recipient, pregnant woman).

According to the Kaiser Commission on Medicaid and the Uninsured, Medicaid covered about 40% of nonelderly Americans with incomes below poverty guidelines in 2001, and 23% of Americans with incomes between 100% and 200% of federal poverty guidelines. Of the people enrolled in Medicaid in 2001, about 29% were covered under optional categories, including 21% of children, 41% of parents, 22% of people with disabilities, and 48% of the elderly.⁴

“Waiver” Populations

Some states have received “waivers” from the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers both programs, to expand their Medicaid programs to include other uninsured residents who do not fit into the regular optional eligibility categories. The “1115 waiver,” the most common waiver that allows states to expand eligibility, was created by section 1115 of the Social Security Act. As a “research and demonstration” program, it gives the secretary of the Department of Health and Human Services broad discretion to waive certain federal requirements so that states can test new and innovative ideas. Some examples follow.

Minnesota covers children under age 2 in families with incomes up to 280% of poverty guidelines, pregnant women with incomes up to 275%, and other children through age 18 in families with incomes up to 170% of federal poverty guidelines, and several other categories of people with incomes up to 100% of poverty guidelines.

Oregon covers children and pregnant women in families with incomes of up to 185% of federal poverty guidelines, and parents and childless adults with incomes up to poverty guidelines. Childless adults, covered by a less comprehensive benefits package, pay both monthly premiums and service copayments. In addition, Oregon subsidizes employer-sponsored insurance or individual insurance coverage for certain low-income populations through its Family Health Insurance Assistance Program. The state received a Medicaid waiver in October 2002, which allows it to receive federal Medicaid matching funds for the program.

Such waivers, usually five-year demonstration projects, must be “cost neutral” over the life of the waiver, meaning states must achieve savings in some program areas in order to cover additional people. Early waiver programs achieved savings by enrolling their populations into managed care plans and assessing premiums or copayments. Oregon developed a list of “prioritized” services to achieve savings and cover additional people. Utah’s new 1115 waiver, which covers about 25,000 previously uninsured adults, limits benefits to preventive and primary care. In an effort to save costs, the state reduced benefits for some optional populations and hopes to save money through reduced hospital and emergency room use.

In 2002, the Bush administration announced a new 1115 waiver initiative, the “Health Insurance Flexibility and Accountability” (HIFA) waiver, which allows states additional flexibility to expand Medicaid to their uninsured populations. For more information about 1115 waivers, visit www.cms.hhs.gov/medicaid/1115/default.asp. For more information about HIFA, see www.ncsl.org/programs/health/hifa.htm or www.cms.hhs.gov/hifa.

What are the Pros and Cons of Expanding Medicaid?

Several states have used Medicaid to anchor major health reforms that are designed to reduce their uninsured populations. The key advantages to expanding Medicaid coverage to achieve insurance coverage for low-income people include the following.

- ◆ The federal government pays at least half the costs for medical services under Medicaid.
- ◆ States already have administrative and provider networks in place under their Medicaid programs.
- ◆ With new flexibility, states have more options to create programs that are designed to meet their unique needs.
- ◆ Expanding Medicaid has proven successful in lowering the number of uninsured residents, which also helps reduce the burden of cost-shifting to employers, other purchasers of private coverage, and health care providers.

Concerns about expanding Medicaid eligibility include the following.

- ◆ Some people prefer private sector solutions to cover the uninsured and object to expanding the government’s role.
- ◆ State financing constraints – many states cannot afford the matching funds necessary for expanding their programs.

Expanding Medicaid lowers the number of uninsured residents and reduces cost shifting.

- ◆ Federal requirements limit state options in choosing which people to cover and which benefits to offer.
- ◆ Congress has occasionally imposed a “maintenance of effort” requirement on states that have expanded eligibility, which removes the state’s option to reduce eligibility in the future.

For state-by-state Medicaid enrollment information, see *Medicaid Enrollment in 50 States: June 2003 Update*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2004, <http://kff.org/medicaid/7237.cfm>.

What Services Does Medicaid Cover?

Similar to mandatory and optional populations for Medicaid eligibility, federal Medicaid law requires states to cover certain services and allows states to select from a menu of other optional services. Because Medicaid covers so many low-income elderly people and people with serious disabilities who cannot obtain private sector coverage, its benefits package reflects these special needs. For example, Medicaid covers some services that most private insurance plans do not cover, such as nursing home and other long-term care services, and that can be especially expensive.

Mandatory Services

States that participate in Medicaid must cover the following services, if needed, for all who qualify for the program: (1) inpatient and outpatient hospital services, (2) physician services, (3) dental services (medical and surgical), (4) nursing facility services, (5) home health care (for people who meet the eligibility criteria for nursing facility services), (6) family planning services and supplies (but not abortion), (7) rural health clinic services, (8) laboratory and x-ray services, (9) pediatric and family nurse practitioner services, (10) federally qualified health center (FQHC) services, (11) nurse-midwife services, and (12) early periodic screening, diagnosis, treatment (EPSDT) services for children through age 20.

It should be noted that mandatory coverage of EPSDT includes any “medically necessary” services allowed for federal reimbursement. This means that states must cover all optional services available under the federal menu of services for children who need them, even if the state does not choose to cover those optional services for their other Medicaid-enrolled people.

Optional Services

States may choose to include more than a dozen optional services in their Medicaid programs. Commonly covered services across all states include: (1) prescription drugs, (2) optometrist services and eyeglasses, (3) intermediate care facilities for people with mental retardation (ICF/MR), (4) emergency hospital services, (5) clinic services, (6) nursing facility services for the aged in an institution for mental diseases (IMD), (7) dental services (unless for medical or surgical conditions), (8) prosthetic devices, (9) hospice services, (10) services performed by podiatrists, chiropractors, or other licensed professionals, (11) psychological services, (12) private duty nursing, (13) personal care services, (14) case management, (15) diagnostic, preventive and rehabilitative services, (16) inpatient psychiatric services (for those under age 21 or over age 64), (17) physical and occupational therapies, (18) speech/language/hearing therapies,

(19) dentures, (20) respiratory services for children who use a ventilator, and (21) primary care case management. Wisconsin offers a number of optional services, including dental services, physical therapy, eyeglasses, hospice care, and personal care services.

In addition to requiring states to cover certain services, federal law places certain other constraints on Medicaid services. Covered services must be available statewide, must be comparable (equal for all in a group), and must be sufficient in “amount, duration, and scope” to achieve their purpose. For example, although states may limit the number of physical therapy appointments the state will pay for, they should be “sufficient” to achieve the intended purpose. However, states retain considerable flexibility in defining certain services and setting coverage guidelines. As with the requirements concerning Medicaid eligibility, states may seek waivers from CMS to allow them some flexibility related to providing services.

Services Waivers

The most common services-related waiver, known as the “home and community-based services” (HCBS) waiver, allows states to cover certain health and support services to Medicaid-eligible people who otherwise would be served in an institutional setting, such as a nursing home or intermediate care facility. HCBS waivers allow states to target certain populations and to provide a special menu of services, such as home health aide, homemaker, or respite care services. With such a waiver, states can help certain people live more independently in the community without making such services available to all Medicaid clients around the state. This enables a state to assist defined populations while protecting the state’s ability to cap expenditures by limiting enrollment in a particular waiver program. For more information about HCBS waivers and a related Supreme Court decision (*Olmstead vs. L.C.*), see www.ncsl.org/programs/health/olmstead-home.htm.

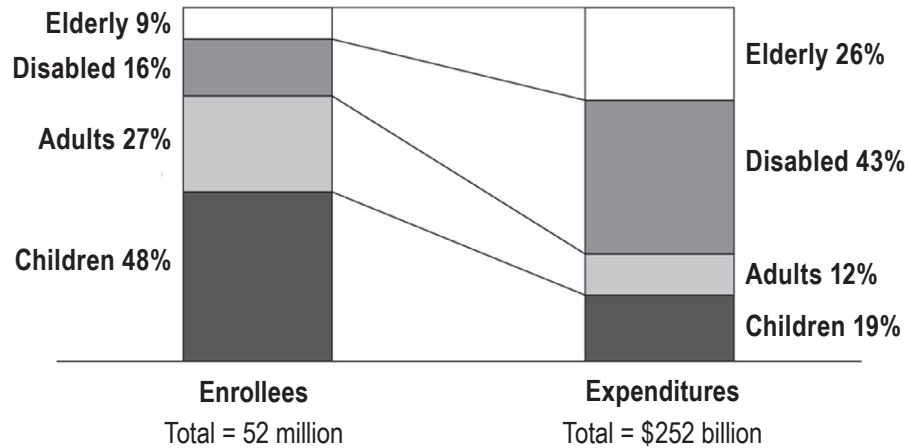
As described in the previous section, 1115 waivers allow flexibility in covering uninsured populations. For example, Utah’s 1115 waiver allows the state to cover only primary and preventive services to the new adults the program covers. For new populations covered under a Health Insurance Flexibility and Accountability (HIFA) 1115 waiver, for example, states may be able to offer only selected services and also reduce optional benefits to other Medicaid populations in the “optional” eligibility categories.

Why Does Medicaid Cost So Much?

Health costs have skyrocketed in this country, and Medicaid is not immune to the same factors that drive up costs in the private sector. However, Medicaid is unique in other ways. The most notable reason Medicaid costs so much results from its coverage of low-income elderly and people with disabilities who have high medical needs, including long-term care. Although these two populations made up only 25% of Medicaid clients in 2003, they accounted for about 70% of program expenditures for medical care (see Figure 2). Not only do the elderly and people with disabilities account for nearly all of Medicaid’s institutional costs, they also account for about 85% of Medicaid spending for prescription drugs.

The primary reason Medicaid costs so much results from its coverage of low-income elderly and people with disabilities who have high medical needs.

Figure 2. Medicaid Beneficiaries and Expenditures, 2003

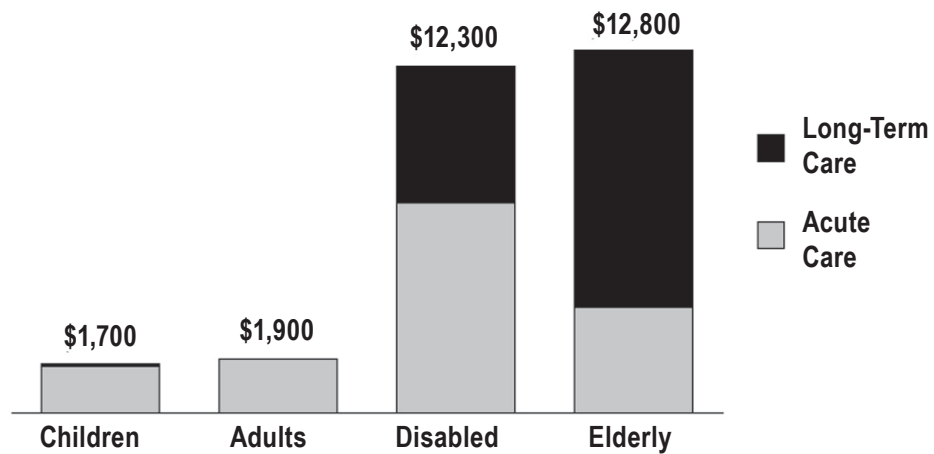


**Note: Expenditures excludes disproportionate share hospital payments
 Source: Kaiser Commission on Medicaid and the Uninsured, January 2005.
<http://www.kff.org/medicaid/upload/The-Medicaid-Program-at-a-Glance-Fact-Sheet.pdf>*

In Wisconsin, children and adults (mostly poor parents and pregnant women) account for 67% of participants but only 24% of costs.

In contrast, children and adults (mostly welfare-related parents and pregnant women) made up 75% of the clientele in 2003, but accounted for just 31% of medical costs. In Wisconsin, these two groups account for about 67% of participants, but only 24% of costs. Many low-income people with significant disabilities or chronic diseases (such as AIDS) rely on Medicaid because they cannot obtain private sector health insurance and they do not qualify for Medicare. Many people in this category require intensive acute care services or long-term care services (see Figure 3).

Figure 3. Medicaid Expenditures Per Enrollee by Acute and Long-Term Care, 2003



Source: Kaiser Commission on Medicaid and the Uninsured estimates based on CBO and Urban Institute data, 2004.

In addition, Medicaid enrolls about 7 million people who are also covered under the federal Medicare program. These “dually eligible” people qualify for Medicaid based on their disability and low-income status. Virtually all elderly Medicaid recipients and about one-third of non-elderly enrollees with disabilities are also enrolled in Medicare. Medicare pays for any Medicare-covered services

(e.g., most acute care and hospital services) and Medicaid acts as a kind of supplemental policy. Medicare covers very limited nursing home care or prescription drugs, both of which have high costs. Medicaid pays for the bulk of long-term care services and prescription drugs for people enrolled in both programs. Nearly one-quarter of dually eligible people reside in long-term care facilities. (For more information, see www.kff.org/medicaid/4091-03.cfm.)

The new Medicare law, signed December 8, 2003, will begin covering prescription drugs in January 2006. However, it will not provide states with much fiscal relief. The federal law requires states to pay back 90% of the prescription drug costs associated with the new Medicare benefit in 2006 for dually eligible people, phasing down to 75% of such costs in 2015 and later years. Because of complexities in the new law and its other effects on state Medicaid programs, it is not yet clear how individual states will fare financially (see www.ncsl.org/programs/health/pharm.htm#new; or www.kff.org/medicaid/rxdrugs.cfm).

How Can States Control Medicaid Costs?

As Medicaid consumes a larger share of state budgets, policymakers seek ways to make the program as efficient and effective as possible. It is important to remember that program costs have risen in response to several factors, including rising health costs, a growing number of elderly people who need long-term care services, and the choice by states to cover millions of optional people under Medicaid who otherwise would not have health coverage. The most obvious ways for states to trim Medicaid costs involve cutting program eligibility, services, or payments to service providers. Each of these options has its drawbacks.

- ◆ Cutting eligibility may shift costs elsewhere, such as to other state or locally funded programs, to emergency rooms, to private insurance plans in the form of higher premiums, and to providers in the form of bad debt or charity care.
- ◆ Imposing overly stringent restrictions on services such as prescription drugs may result in higher costs associated with sicker patients, including expensive hospital or nursing home care.
- ◆ Freezing or reducing provider payments could result in fewer providers participating in the program, making it difficult to ensure that patients receive needed care.

States have undertaken a number of longer-term reforms to help control Medicaid costs, including reforming long-term care, focusing on disease management, emphasizing prevention, reducing prescription drug costs, investigating fraud and abuse, using electronic records, maximizing federal funding, leveraging federal flexibility, and conducting evaluations to identify potential cost savings.

Reform long-term care. Long-term care services consume about 40% of Medicaid budgets. Maine cut the total per-person spending on Medicaid-funded long-term care by 12% by increasing community-based services, cutting the time that Medicaid clients stay in nursing homes, billing Medicare for appropriate services, and tightening medical eligibility standards. Promoting private long-term care insurance also may help lessen future burdens on state budgets.

Long-term care services consume about 40% of Medicaid budgets.

Florida reports a \$42.2 million savings over five years by providing intensive disease management services to certain chronically ill people.

Focus on the sickest people. At least 21 states attempt to “manage diseases” such as asthma and diabetes in their Medicaid programs. Florida reports a \$42.2 million savings over five years by providing intensive services to certain chronically ill people. CMS announced support for disease management initiatives under Medicaid in a letter to state Medicaid directors on February 25, 2004 (see www.cms.hhs.gov/states/letters/smd022504.pdf).

Emphasize prevention. Children make up about half of Medicaid enrollees. By focusing on prevention and timely acute care services for Medicaid-enrolled children, a North Carolina pilot program cut emergency room visits by 20% and also reduced hospital stays.

Reduce prescription drug costs. States have saved millions of dollars by implementing prior authorization, preferred drug lists and supplemental rebates, and by requiring use of generic drugs. (For more information, see www.ncsl.org/programs/health/medicaidrx.htm.)

Investigate fraud and abuse. Florida discovered that a number of fake Miami clinics had billed Medicaid \$25 million over a year’s time. Strengthening investigative and enforcement policies have cut the state’s estimated fraud in half.

Use electronic records. Arkansas saved an estimated \$30 million over 17 months by creating an integrated electronic billing, eligibility verification, payment, data collection and analysis system.

Maximize federal funding. By identifying programs paid for by the state that could qualify for federal matching funds under Medicaid, states could reap significant benefits. For example, certain special education, foster care and substance abuse services may qualify for Medicaid reimbursement. In addition, states that sponsor pharmacy assistance programs for low-income residents may qualify for federal Medicaid assistance under a new Medicaid Pharmacy Plus waiver (see www.ncsl.org/programs/health/pharmplus.htm).

Leverage federal flexibility. Medicaid’s 1115 waivers give states more flexibility to craft Medicaid demonstration projects. For example, Utah expanded its program to cover up to 25,000 additional low-income adults for primary and preventive services. The state projects savings in hospital and emergency room costs for previously uninsured adults. Missouri estimated savings of \$11.4 million in 2002 through its premium assistance program, which subsidizes employer-sponsored insurance for eligible Medicaid workers (instead of enrolling individuals in the state’s regular Medicaid plan).

Evaluate the program. A number of states have achieved savings in their Medicaid programs by conducting studies or audits to identify areas where the program could be refined or improved. For example, South Carolina’s Legislative Audit Council recommended a preferred drug list to save \$12.8 million and an enrollment fee to save an estimated \$1.4 million.

What's New in Medicaid?

The Medicaid program has evolved over time from one that covers specific categories of very low-income people – mostly people associated with cash assistance programs – to one that allows states to cover virtually any groups they desire, as long as they receive a waiver from the Department of Health and Human Services. Major changes include:

Expanded coverage. The average income threshold for Medicaid eligibility for children and their single parents in the mid-1980s was about 40% of federal poverty guidelines. Today, states must cover young children and pregnant women with incomes up to 133% of poverty guidelines and older children up to 100% of poverty; they may set levels even higher.

Creation of the State Children's Health Insurance Program (SCHIP) in 1997 allows states to expand their Medicaid programs to cover additional children in Medicaid with an enhanced federal match. The program targets children in families with incomes up to 200% of federal poverty guidelines and also allows states to cover such children in non-Medicaid insurance plans. A number of states have expanded their SCHIP programs to cover additional children, pregnant women, parents of SCHIP-eligible children, and even childless adults (see www.ncsl.org/programs/health/chiphome.htm.)

Flexibility. Through the flexibility allowed under various waivers, states may extend eligibility to populations never allowed before, including single adults and working poor and near-poor populations. For example, Arizona, Delaware, Hawaii, Massachusetts, Minnesota, New York, Oregon, Utah and Vermont have used 1115 waivers to cover broad populations of low-income people, including single adults who would not otherwise be eligible for Medicaid. (see www.cms.hhs.gov/medicaid/1115/default.asp?). Under the new Health Insurance Flexibility and Accountability waiver, states may cover additional people under a reduced benefits package and increase their cost-sharing requirements (see www.cms.hhs.gov/hifa/ or www.ncsl.org/programs/health/hifa.htm).

New flexibility under Medicaid and SCHIP also allows states to create “premium assistance” programs that subsidize employer-sponsored insurance for employees who cannot afford their share of the premium. By partnering with employers, states can save money by leveraging the employers' share of the premiums and also can help prevent erosion of the employer-based insurance system when expanding Medicaid or SCHIP to cover working poor people. At least 14 states including Wisconsin sponsor such premium assistance (see www.cms.hhs.gov/schip/snapshot.pdf and www.ncsl.org/programs/health/buyin03.htm).

The “Pharmacy Plus” waiver allows states that sponsor pharmaceutical subsidy programs to gain federal matching funds for people age 65 or older with incomes between 100% and 200% of federal poverty guidelines (see www.ncsl.org/programs/health/pharmplus.htm and www.ncsl.org/legis/pubs/203cure.htm).

Medicare changes. As described earlier (under “Why Does Medicaid Cost So Much?”) the new Medicare law's prescription drug benefit will affect state Medicaid programs.

Fiscal relief. The Jobs and Growth Tax Relief Reconciliation Act of 2003 provided \$20 billion in temporary fiscal relief to states, \$10 billion specifically for Medicaid and \$10 billion for unfunded federal mandates or other governmental priorities. The Medicaid funds temporarily increased the FMAP (federal share of Medicaid).

This chapter is based on the following publication.

King, M. (2004). *Medicaid: A snapshot for state legislatures*. Denver, CO: National Conference of State Legislatures.

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Is Medicaid a High Cost Approach For Serving Low-Income Individuals and Families?

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The Medicaid population is much poorer and sicker and has more cognitive and physical limitations than the privately insured poor. When per person costs are compared directly, the costs for Medicaid adults are higher than for the privately insured poor (\$4,877 compared to \$2,843). However, when adults with fair or poor mental health or any physical limitations are excluded, spending for non-disabled Medicaid adults (\$1,752) is significantly lower than for non-disabled poor adults who are privately insured (\$2,253). Services provided by the Medicaid benefit package that are often considered too generous—dental and other optional services—add about 12% to total costs.

States are dealing with the most serious fiscal crises since World War II. State revenues declined in 2001 and for the most part have not kept pace with increasing demands on state coffers.¹ At the same time, states have been faced with shortfalls in elementary and secondary education budgets, increased demand for higher education because of the baby boom echo, and sharply rising Medicaid expenditures.

Between 2000 and 2003, national Medicaid spending grew about 10.2% per year.² In Wisconsin, Medicaid has grown an average of 13.0% annually during this same period. Taken together, plunging state revenues and upsurging costs have made Medicaid a topic of debate in state legislatures across the country.

This chapter will cover why costs are increasing, why costs are so difficult to contain, who is covered by Medicaid, whether Medicaid is a Cadillac program, how cost effective Medicaid is, and what questions policymakers can ask to guide difficult Medicaid budget decisions.

Why Are Medicaid Costs Increasing?

Medicaid costs are being driven by the same pressures that are causing increases in private insurance costs—rising prescription drug costs, hospital price increases, and provider consolidation. Costs are also rising because of increased enrollment and increased spending per enrollee. The Medicaid enrollees who cost the most to treat—those with severe disabilities and the frail elderly—are growing faster than their rate of growth in the U.S. population. Why the aged and disabled are rising so rapidly in Medicaid is not well known, but this trend is expected to continue throughout the decade. This growth could be due to life-saving medical technologies that lengthen life, but leave people with disabilities. The high cost of prescription drugs may make Medicaid more attractive, and their use may contribute to the longevity of people with conditions such as HIV/AIDS. Increased enrollment in Medicaid home- and community-based care may

Between 2000 and 2003, Wisconsin's Medicaid costs grew an average of 13% annually.

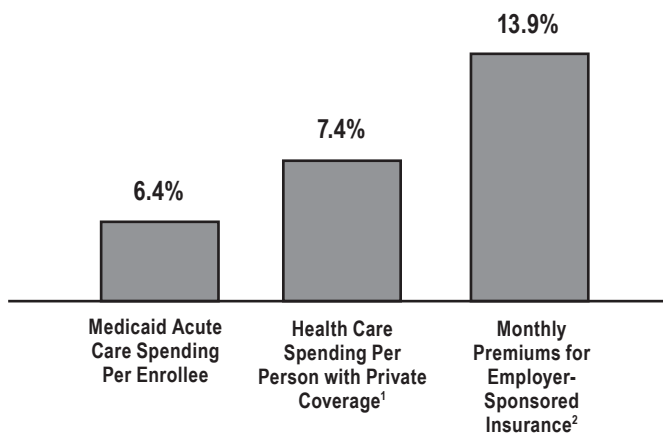
be a factor, and the baby boomers are approaching 55 to 64 years of age, a time when disabilities are likely to appear.^{3,4}

Between 2002 and 2003, per person spending grew 6.4% for Medicaid, 7.4% for private coverage, and 13.9% for monthly employer-sponsored premiums.

Medicaid has also faced increased pressure because of the widespread decline in employer-sponsored insurance. Between 2000 and 2003, employer coverage for the nonelderly dropped 3.9% from about 68% to 64%.⁵ About 5.1 million people lost insurance, but adults and children fared differently. Overall, the number of uninsured children *dropped* slightly due to increases in Medicaid and the State Children’s Health Insurance Program (SCHIP) coverage. On the other hand, the number of uninsured adults grew 2.4% at a time when Medicaid enrollments increased only 2%. Thus, some adults were able to find other forms of coverage, but this was not enough to offset the decline in employer-sponsored coverage.⁶ In 2003, 9.0% of Wisconsin’s population was uninsured for some or all of the year.⁷

Despite these pressures, Medicaid spending grew more slowly than spending for private or employer coverage. Between 2002 and 2003, per person spending costs for Medicaid grew 6.4% compared to 7.4% for private coverage and 13.9% for monthly premiums for employer-sponsored health insurance.⁸

Figure 1: Medicaid’s Growth in Spending was Less Than for Private or Employer Coverage (percent increase from 2002 to 2003)



¹ Strunk, B.C. & Ginsburg, P.B. (2004, June). *Tracking Health Care Costs: Trends Turn Downward in 2003*. (Data Bulletin No. 27). Washington, DC: Center for Studying Health Systems Change.

² Gabel, J. et al (2004, September/October). *Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage*. *Health Affairs*, 23(5): 200-209.

Why Are Medicaid Costs So Difficult to Contain?

Medicaid has proven a thorny issue for state policymakers to grapple with. Medicaid is a huge burden on the budget, but it also brings huge benefits to citizens in the state by providing mandatory and optional services. Nationwide, about 60% of Medicaid expenditures in 2001 were for people and services that states are not required to cover.⁹ Why are states reluctant to cut benefits?

- ◆ **Citizens value Medicaid benefits.** Many benefits, such as those for the chronically mentally ill and developmentally disabled, were covered by states before Medicaid came along.¹⁰ Providing health and long-term care coverage for low-income children, the disabled, and elderly has proven politically popular.¹¹
- ◆ **Some benefits may strengthen families and improve human capital.** According to recent research, good health could increase annual earnings by about 15% to 20% as a result of increased labor force participation and work effort. When people earn more, they pay more taxes and reduce government costs for disability and other health programs.¹² On the other hand, poor health has been linked to lower labor force participation, lower work productivity, and reduced earnings. Children in poor health are more apt to be absent from school, have lower school achievement, and have poorer cognitive skills.¹³
- ◆ **Some benefits can save money, so cuts would be penny wise and pound foolish.** Some benefits such as prescription drugs and physical therapy can substitute for or reduce the costs of more expensive benefits like hospital stays, nursing home care, or physician services.¹⁴ Chiropractic services and podiatry are less costly than orthopedics, just as optometrists are cheaper than ophthalmologists.
- ◆ **Some cuts don't save states much money.** Reducing Medicaid expenditures is not a dollar-for-dollar savings. When states make cuts, they lose federal matching funds. In Wisconsin, the federal matching rate has averaged 58% recently, so cutting a dollar in expenditures saves only 42 cents. What's more, cutting optional acute care benefits saves little money and the benefits are often of great importance to certain participants and providers.¹⁵
- ◆ **Provider groups are politically powerful.** The ability to cut payments to provider groups is hampered by the political power of these groups.¹⁶

Who is Covered by Medicaid?

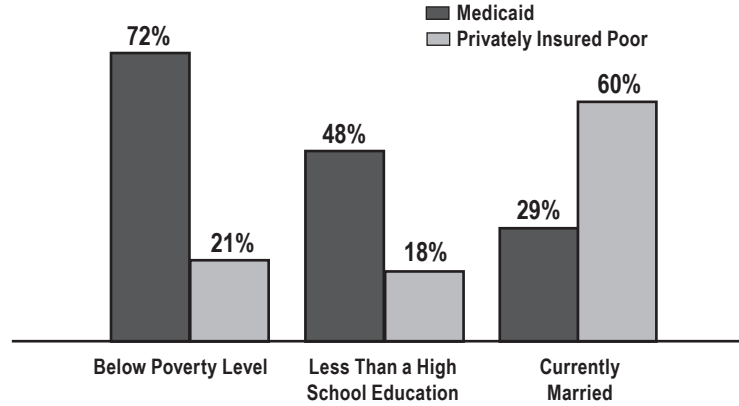
Nationally, Medicaid serves 40 million low-income Americans and in Wisconsin, it served about 807,000 low-income residents or 15% of Wisconsin's population sometime in Fiscal Year 2004. To better understand who benefits, Medicaid enrollees were compared to the low-income poor—those under 200% of the Federal Poverty Level—who were covered by private health insurance.

Medicaid served about 15% of Wisconsin's population sometime in FY 2004.

When compared to low-income people who are privately insured, the Medicaid population is much poorer, has less education, and is less likely to be married (See Figure 2).

Medicaid families are poorer, less educated, and less likely to be married than the privately insured poor.

Figure 2: Medicaid Families are Poorer, Less Educated, and Less Likely to be Married

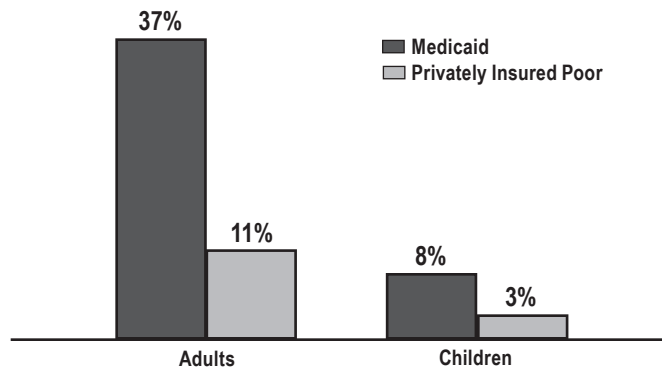


Note: All differences are significant at the .05 level. This chart compares families with income below 200% of the Federal Poverty Level that were covered by Medicaid or private insurance between 1996 and 1999.

Nationally, the family income of a Medicaid family is \$18,644 compared to \$32,677 for a low-income family covered with private insurance. Not surprisingly, those on Medicaid were about 5 times more likely to be living under the poverty level. About 72% of those on Medicaid had family incomes below the poverty level compared to only 21% of low-income families with private health coverage.¹⁷

Of the Medicaid population, almost half (48%) had less than a high school education compared to about a fifth (18%) of their low-income counterparts with private insurance. Those with private insurance were twice as likely to be married as those on Medicaid (60% compared to 29%).¹⁸

Figure 3: Medicaid Recipients are More Likely to be in Fair or Poor Health



Note: All differences are statistically significant at the .05 level. Low income defined as income below 200% of the Federal Poverty Level. "Adults" defined as age 19-64. "Children" defined as age 0-18.

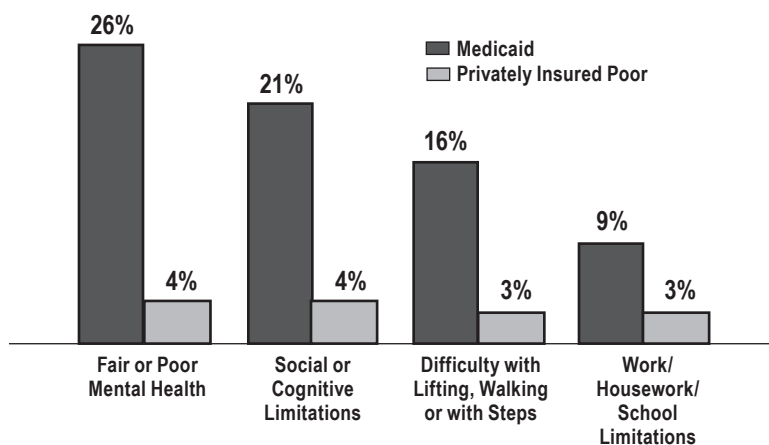
The Medicaid population is more apt to be sick or in poor health than the privately insured poor.

The Medicaid population is more apt to be sick or in poor health. As shown in Figure 3, the differences are quite striking, with over a third of Medicaid enrollees (37%) reporting fair or poor health, compared to only about 1 in 10 (11%) of the poor with private insurance. Conversely, 59% of those with private coverage reported being in excellent or good health, compared to only 34% of those with Medicaid coverage.¹⁹

The health differences were less pronounced in children. Of the Medicaid children, 8% were in fair or poor health compared to 3% for poor children receiving private coverage.

Cognitive and physical limitations are high among the poor with Medicaid coverage (see Figure 4). When compared to the poor who are privately insured, the Medicaid population is more apt to be in fair or poor mental health; have difficulty lifting, walking, or with steps; and have trouble with work, housework, and school. When given a list of 9 limitations, Medicaid enrollees were almost four times more likely to report one of these limitations (43%) compared to the privately insured poor (11%). Moreover, they are more likely to have died or been institutionalized during the year.

Figure 4: Medicaid Adults are More Apt to Have Physical and Cognitive Limitations



Note: All differences are significant at the .05 level. This chart compares families with income below 200% of the Federal Poverty Level that were covered by Medicaid or private insurance between 1996 and 1999.

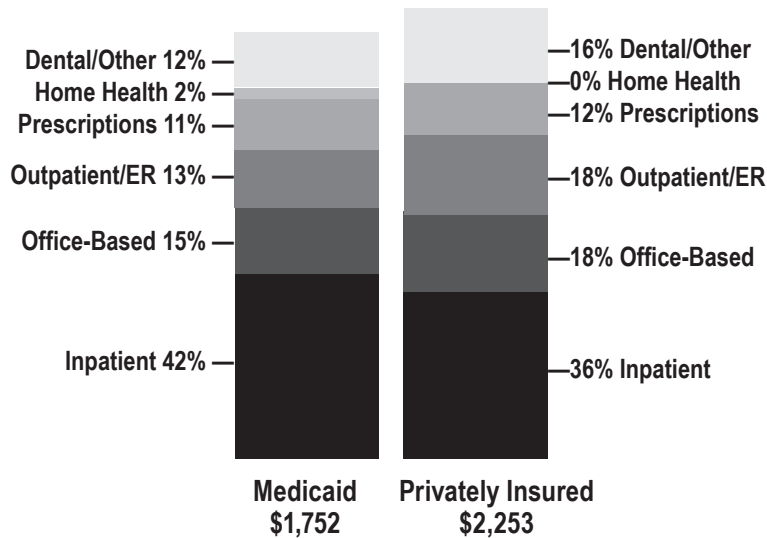
For children, almost 19% of those on Medicaid reported having some type of limitation, compared to 13% of low-income children receiving private coverage. Children with Medicaid coverage are more likely to have asthma and less likely to have infectious diseases than privately insured low-income children.²⁰

Is Medicaid a Cadillac Program?

Because of its long list of benefits, Medicaid has been called a “Cadillac” program.²¹ Are overly generous benefits contributing to Medicaid costs?

The services provided by the Medicaid benefit package that are often considered too generous are dental and other services which states are not required to cover under federal law. As shown in Figure 5, the services thought of as “Cadillac” benefits account for 12% of expenditures in the Medicaid insured group. In fact, per person expenditures for these services were actually higher for the poor covered under private insurance than for those covered under Medicaid. Most of the expenditures for services in both groups are for inpatient care, office services, outpatient and emergency department care, and prescription drugs.

Figure 5: Benefits Considered “Overly Generous” Account for 12% of Medicaid Spending



Note: This chart compares all low income non-disabled adults (excluding those with fair or poor mental health or any physical limitations). Low income is defined as below 200% of the Federal Poverty Level.

The privately insured pay annual out of pocket costs that are twice those of Medicaid (\$585 versus \$266). When disabled adults were excluded from all analyses, the privately insured paid six times more than those on Medicaid (\$508 compared to \$91). Given that Medicaid recipients are sicker and poorer, however, it is not clear how much out-of-pocket spending they can afford or should be expected to pay.²²

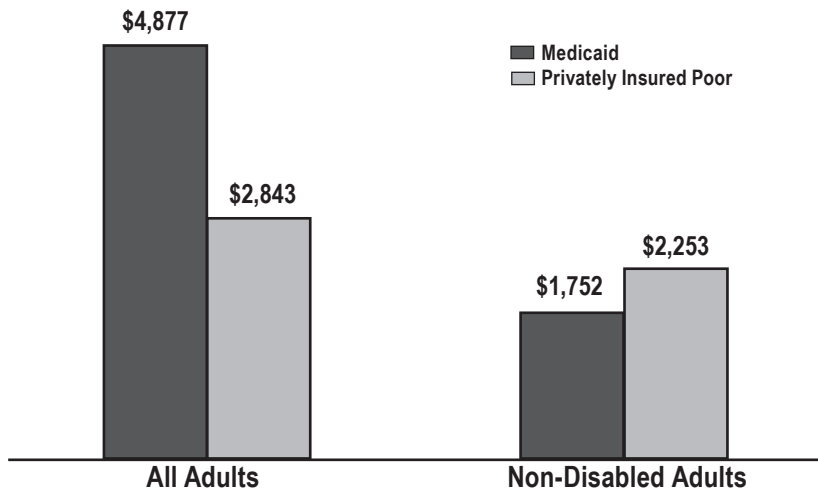
Spending for non-disabled Medicaid adults is less than for non-disabled poor adults covered by private insurance.

How Cost Effective is Medicaid?

Per person expenditures for adults covered by Medicaid are higher than for the privately insured poor. As shown in the left side of Figure 6, Medicaid costs \$4,877 per person compared to \$2,843 for the privately insured poor.

However, when adults with fair or poor mental health or any physical limitations were excluded from all analyses, Medicaid spending dropped by about two-thirds to \$1,752 per person. Thus, spending for non-disabled Medicaid adults is significantly lower than for their non-disabled counterparts who are privately insured (\$2,253).

Figure 6: Medicaid Spending is Higher When All Adults are Included, But Lower When Excluding People with Disabilities/Limitations



Note: All differences are statistically significant at the .05 level. This chart compares all adults and non-disabled adults (excluding those with fair or poor mental health or any physical limitations).

Among poor children, Medicaid was less expensive than private coverage for all children and for non-disabled children; however, these differences did not meet conventional standards of statistical significance and may be due to chance.

This suggests that the higher spending for Medicaid when all adults are included is due, in part, to the much poorer health of the Medicaid population. No evidence emerges that Medicaid's lower costs were due to lower use of services such as office visits, doctor visits, and hospital stays. However, the lower cost for the non-disabled Medicaid population is probably due, in part, to Medicaid's lower provider payment rates. Also, Medicaid enrollees may have less access to specialists and technology/intensive care for those in fair or poor health.²³

Taken together, if those with Medicaid were given private coverage, they would cost considerably more than they do today under Medicaid. If those with private coverage were covered under Medicaid, spending would be lower; however, these savings are not as striking because those covered under private coverage are generally healthier.

What Questions Can Policymakers Ask to Guide Difficult Medicaid Budget Decisions?

State policymakers are faced with a thorny problem. Even though Medicaid appears to be a cost-effective approach for providing health coverage to the poor, the costs are high in an absolute sense and are growing faster than state revenues. Given that most of the optional benefits add only about 12% to total costs, state policymakers face some tough decisions that may have consequences for many years to come.

Clearly, there are no easy textbook answers. The following questions may raise some of the considerations that policymakers may want to take into account as they make these difficult decisions.

Optional benefits add about 12% to total Medicaid expenditures.

Will healthy parents do a better job of raising their children into competent, caring adults?

- ◆ What effects will proposed changes in benefits or eligibility have on the health of Medicaid enrollees? Will those in better health work more and earn higher incomes?²⁴
- ◆ How do Medicaid programs affect the health of children and their future potential to become productive workers? Will healthy parents do a better job of raising their children into competent and caring adults? (For a complete list of family impact questions, see the Checklist for Assessing the Impact of Policies on Families in this report.)
- ◆ Will cuts in Medicaid cause the number of uninsured people to rise?²⁵
- ◆ Is providing care to the uninsured, who often can't pay for services, really free care? Who ends up picking up the costs—providers, cities, counties, states?
- ◆ Will cuts in provider rates affect beneficiaries' access to care?²⁶
- ◆ Will rate cutbacks and eligibility restrictions threaten the financial viability of institutions, such as safety net hospitals?²⁷

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What are States Doing to Control Medicaid Costs and Why is it so Hard?

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Wisconsin Medicaid officials indicated that the primary factor behind growth in Medicaid expenditures in 2004 and 2005 was an increased case load. Other important factors were the rising costs of pharmacy/prescription drugs and cost-based providers such as long-term care institutions and federally qualified health centers. In 2004, Wisconsin reported plans to control costs by reducing or freezing provider payments, controlling prescription drug costs, increasing copayments, targeting fraud and abuse, and implementing long-term care initiatives. The Wisconsin Department of Health and Family Services estimates that its cost-containment initiatives saved \$460 million between 2003 and 2005.

In 2004, Medicaid spending across the U.S. grew faster than all other state programs.

Every state is grappling with the same problem: how to maintain Medicaid benefits to as many people as possible when enrollments and medical costs are increasing but revenues are not. In 2004, for example, Medicaid spending across the U.S. grew faster than all other state programs. It is no surprise that every state has adopted at least one Medicaid cost-containment measure. In Wisconsin, cost-saving measures have included freezing or cutting provider payments, negotiating lower prescription drug prices, adopting a preferred drug list, and increasing premiums for BadgerCare.

After three years of intense fiscal stress, the revenue picture looked better for FY 2005 and enrollments were growing at a slower pace. Despite this improved prognosis, several factors continue to place pressure on states to contain Medicaid costs. The cost-containment strategies states have adopted include reducing provider payments, reducing prescription drug costs and targeting fraud and abuse. The nine most common strategies, which are presented in this chapter, are based on a 50-state survey of Medicaid administrators conducted in the summer of 2004.

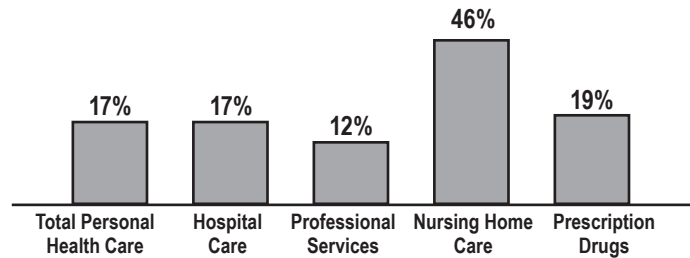
What Is Medicaid and What Role Does It Play in Our Health Care System?

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; it provided health and long-term care coverage to 52 million low-income children and adults in FY 2004, compared to 42 million covered by Medicare. Medicaid also supplements Medicare coverage for 7 million low-income seniors and people with disabilities enrolled in both programs.

Medicaid covered 807,000 Wisconsin residents sometime during FY 2004.¹ This is equivalent to 15% of the state's population. Medicaid plays a major role in our nation's health care system, paying for nearly half of nursing home care and 19% of prescription drugs (see Figure 1).

Figure 1. Medicaid as a Share of National Health Care Spending, 2003

Medicaid pays for nearly half of nursing home care.



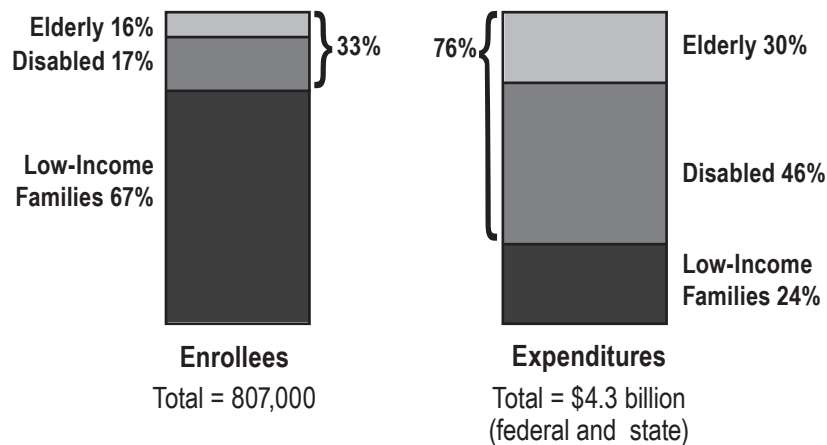
Source: Smith, C. et al. (2003, January/February). *Health Spending Growth Slows in 2003*. *Health Affairs*, 24(1), 185-196

Where Does Most Medicaid Spending Go?

Although low-income children and families represent about 75% of Medicaid beneficiaries nationally, they account for only one-third of the expenditures. On the other hand, elderly and disabled individuals represent just one-quarter of the beneficiaries, but account for 70% of the expenditures, reflecting their intensive use of acute and long-term care services.

Spending in Wisconsin. This pattern holds true in Wisconsin. In FY 2004, children and families represented 67% of the Medicaid recipients while accounting for only 24% of the expenditures (see Figure 2). Elderly and disabled recipients combined accounted for 33% of the recipients and 76% of Medicaid expenditures.²

Figure 2. Majority of Wisconsin's Medicaid Expenditures on Elderly and Disabled, FY 2004



Source: Wisconsin Department of Health and Family Services. (2005, May). *Wisconsin Medicaid Program*.

Are Medicaid Expenditures Increasing or Decreasing?

In FY 2004, average state Medicaid spending increased 9.5% from the year before. This increase was slightly higher than the 9.4% growth rate in FY 2003, but lower than the average growth rate of 11.9% that occurred over the 2000-2002 period. These overall increases reflect the effects of both increasing caseloads and increasing per capita costs. As a comparison, private insurance premiums (which are a measure of per capita costs) increased 11.2% in FY 2004. State administrators cited several key factors as top drivers of Medicaid spending growth in FY 2004. The most frequently mentioned factors included:

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

Expenditures in Wisconsin. Wisconsin Medicaid officials indicated that the primary factor behind growth in Medicaid expenditures in both 2004 and 2005 was an increase in the caseload. The secondary factor was rising costs of pharmacy/prescription drugs. Another important factor was increased costs for services of cost-based providers (such as long-term care institutions and federally qualified health centers).

The primary factor behind recent growth in Wisconsin Medicaid expenditures was an increased caseload.

Is Medicaid Enrollment Increasing or Decreasing?

The average state's Medicaid enrollment has increased each year since 1999, with a peak increase of 9.9% in FY 2002. This enrollment growth trend holds true across almost every state – for example, only three states reported enrollment decreases in FY 2004 (Massachusetts, Oregon, and South Carolina). At the beginning of this fiscal year, Medicaid officials projected an average enrollment growth of 4.7% for FY 2005. Although the pace of enrollment growth has slowed, the growth is still substantial and a significant contributor to the increase in Medicaid spending. State Medicaid officials attributed continued enrollment growth to several factors:

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

Enrollment in Wisconsin. Recent growth in Wisconsin's Medicaid enrollments are due to the increases in BadgerCare enrollment for low-income families and SeniorCare prescription drug coverage for low-income seniors.³

Do States Have Sufficient Revenues for Medicaid?

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

In FY 2005, revenues are growing and this trend is expected to continue. However, many individual states are still experiencing large budget shortfalls at the same time their Medicaid costs continue to increase. Additionally, the temporary fiscal relief to states provided by the federal government through the Jobs and Growth 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.

What Strategies Are States Using to Contain Costs?

Every state implemented at least one cost-containment strategy in FY 2004 and every state reported plans for additional cost saving measures for FY 2005. This will be the fourth consecutive year that states have implemented significant cost-containment initiatives, although a few states planned to adopt modest benefit or eligibility expansions. Most states are implementing a comprehensive set of strategies, rather than a single cost-containment measure, including:

In 2004, every state implemented at least one cost-containment strategy.

- ✓ Reducing or freezing provider payments
- ✓ Controlling prescription drug costs
- ✓ Reducing benefits
- ✓ Reducing or restricting eligibility
- ✓ Increasing copayments
- ✓ Expanding managed care
- ✓ Implementing disease management programs
- ✓ Long-term care initiatives
- ✓ Targeting fraud and abuse

Strategies used in Wisconsin. Wisconsin used a variety of strategies, as reported on the 50-state survey or in the Wisconsin Department of Health and Family Services' May 2005 publication entitled *Wisconsin Medicaid Program*.⁴ In 2004, Wisconsin reported plans to use six of the above nine strategies (provider payments, prescription drugs, eligibility, copays, fraud and abuse, and long-term care). In 2005, the state reported plans to use some of the same strategies as 2004 (provider payments, prescription drugs, managed care expansions, disease management, and long-term care). The Wisconsin Department of Health and Family Services estimates its cost-containment initiatives saved \$460 million in 2003-2005. (See the chapter written by the Legislative Fiscal Bureau for more detailed information about Wisconsin's cost-containment initiatives.)

The following sections discuss the nine cost-containment strategies states are using. (Note: A state may not have reported using a strategy for a particular year, but that does not mean the strategy is not in current use in that state. It may mean the state has not implemented a *new* component of that strategy in either 2004 or 2005.)

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 actually amount to reductions because of cost inflation) can have an impact on the availability of providers who will accept Medicaid and may reduce 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.

- ◆ 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 or freeze reimbursement rates for physicians (42 states in 2004 and 33 in 2005).
- ◆ Despite payment reductions or freezes to at least one provider group, 46 states increased rates for at least one provider group in 2004 and 43 states planned to do so in 2005. These increases were likely due to increased pressure from providers for catch-up rate increases after several years of cuts or freezes.

Strategy used in Wisconsin. Wisconsin froze almost all provider reimbursement rates.

Strategy 2: Control Prescription Drug 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. Drug cost-containment strategies were implemented by 47 states in FY 2004 and by 43 states in FY 2005.

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)
- ◆ Greater discounts in what states pay pharmacists for prescription drugs (8 states)

In FY 2005, only 3 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 reflects the possibility that many states had already reached the upper limit of pharmacy copayments and, therefore, could not increase them any more.

Strategies used in Wisconsin. In FY 2004 and 2005, Wisconsin implemented several prescription drug cost-control measures: obtaining greater discounts on what Medicaid pays for brand name drugs, increasing the number of drugs subject to prior authorization, adopting a preferred drug list and securing additional (“supplemental”) rebates from drug manufacturers.

Medicaid provider reimbursement rates are sometimes below the cost of delivering care.

In FY 2005, fewer states cut benefits and more restored benefit cuts made in previous years.

Strategy 3: Cut Benefits or Restore Benefits Previously Cut

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

- ◆ Only 9 states cut benefits in 2005, compared to 19 in 2004.
- ◆ 14 states intended to restore previous cuts or expand benefits in 2005, compared to 12 states in 2004.

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

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

Strategy used in Wisconsin. In 2004, Wisconsin reported implementing a waiver to add additional coverage for autism services uniquely needed by children with disabilities.

Strategy 4: Reduce or Restrict Eligibility

Reducing eligibility for Medicaid is often difficult for states to do 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, during 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: 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 and Growth Reconciliation Act of 2003, states were required to maintain eligibility through June 2004 at the levels in effect on September 2, 2003. All states maintained their eligibility rules and received the additional funding. Any eligibility restrictions in FY 2004 had to occur before September 2, 2003, but some states did restrict eligibility in various ways. Fewer states are implementing reductions in 2005 compared to 2004, but the changes will affect a larger number of people. The variety of eligibility restrictions in 2004 and 2004 included eliminating continuous eligibility, freezing or reducing income levels for eligibility, or eliminating coverage for people who are more appropriately served in another program.

Ten states expanded coverage in FY 2004 and 15 states did so in 2005. Some states expanded eligibility to previously uncovered groups by increasing the income eligibility level for aged and disabled individuals, eliminating TANF (Temporary Assistance to Needy Families) work requirements in determining eligibility for Medicaid, or enabling disabled workers to buy in to Medicaid coverage.

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 re-determination procedures. In the face of budget difficulties, some states have reversed this trend (10 states in 2004 and 4 in 2005). Major changes included:

- ◆ Requiring the enrollee to re-verify eligibility more frequently
- ◆ 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.

Strategy used in Wisconsin. Wisconsin implemented measures requiring the verification of income and insurance for BadgerCare.

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 rules (Maine)

Strategy used in Wisconsin. Wisconsin increased premiums for BadgerCare.

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. A substantial body of research indicates that even nominal copayments can deter low-income individuals from receiving needed care.⁵

In FY 2004, 20 states imposed new or higher copayments; 9 states did so in FY 2005. The most frequent copayment imposed was for prescription drugs (discussed under Strategy 2 – controlling prescription 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

Even small copayments can deter low-income individuals from receiving needed care.

**Of employers,
15% responded
that disease
management
strategies were
effective in
containing costs.**

Strategy 6: Implement Managed Care Initiatives

As in the 1990s, states are turning to managed care to control Medicaid costs. States continue to regard managed care as an important component to improving access and quality of care, but the costs of managed care have grown in many states, making it a less attractive option. In 2004, 15 states made at least one change to their managed care program. Nine states expanded their service areas, 4 states increased enrollment in managed care programs by making it mandatory for some individuals or in some counties, and 3 states expanded or restored coverage for some beneficiaries.

In 2005, 14 states expanded their managed care programs. Nine states expanded service areas, 6 states increased the level of mandatory enrollment, 4 states expanded risk-based managed care throughout the state, and 4 states incorporated dual eligibles and the SSI population into managed care.

Strategy used in Wisconsin. Wisconsin is currently expanding managed care to people with disabilities in Milwaukee and Dane Counties.⁶

Strategy 7: Implement Disease and Case Management Programs

An increasing number of states are turning to disease and case management initiatives to help contain costs for diseases such as asthma, diabetes, depression, and chronic heart failure. Between 2002 and 2004, 42 states began such 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. Cost savings and quality outcomes from these programs look likely but this is not yet conclusive because there are several challenges: 1) participation is voluntary, 2) turnover is high among enrollees, and 3) payment rates to providers are low.⁷ However, in a recent health benefits survey of employers, 15% of firms responded that disease management strategies were very effective in containing costs.⁸

The trend among states is toward more comprehensive care management programs, rather than having a specific disease focus. In the future, states may have a more difficult time implementing care management programs because persons eligible for both Medicaid and Medicare will receive their drug coverage from Medicare.

Strategy used in Wisconsin. In 2005, Wisconsin reported developing and implementing a program designed to ensure that persons needing mental health prescription drugs receive exactly the medications they need. The program was designed to improve quality of care and also to avoid the possibility of abuse.

Strategy 8: 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. Ten states in FY 2004 and 17 states in FY 2005 implemented cost-containment strategies for *long-term care* including:

- ◆ 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., during holidays
- ◆ 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, 8 states in FY 2004 and 11 states in FY 2005 implemented cost controls on home- and community-based services (HCBS). HCBS services are 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, which reverses the trend of the past five years when states expanded access to community-based support services as a 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 *home- and community-based services* 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

Strategy 9: Target Fraud and Abuse

Many states enhanced ongoing activities or started new activities designed to control fraud and abuse. In some cases, these actions were tied to new management information systems, additional staff, or an increased number of provider audits. Activities included restricting high-use recipients to a single doctor, establishing a new fraud unit, and focusing more efforts on third party liability recoveries. Between 2002 and 2005, 32 states put in place new fraud and abuse mechanisms.

What are the New Challenges to Containing Costs?

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.

Federal Fiscal Relief has Ended

Temporary federal relief that assisted states in 2003 and 2004 has come to an end, greatly increasing the state burden for Medicaid costs. The Jobs and Growth Tax Relief Reconciliation Act of 2003 provided states with an enhanced federal

Temporary federal relief has come to an end, greatly increasing the state burden for Medicaid costs.

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. However, officials in 20 states indicated that the expiration of the enhanced FMAP had been anticipated and the impact minimized.

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 payments or Upper Payment Limit 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.

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). States reported four common concerns:

- ◆ The greatest concern was 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 (39 states).
- ◆ 16 states were concerned about the requirement for states to perform low-income subsidy determinations.
- ◆ 15 states were concerned that they would actually end up spending more for drug coverage for dual eligibles (through the clawback) than they would have in the absence of Part D.
- ◆ 12 states were concerned about the adequacy of Part D plan formularies.

What Is the Outlook for 2005 and Beyond?

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 meet this need. 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.

Increasing poverty and eroding private insurance will continue to put pressure on Medicaid enrollment and spending.

- ◆ Other 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 at the state and federal levels in restructuring federal Medicaid law. A major issue is the way the program is financed and the roles of the 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.

How Might Cost Containment Strategies Affect Families?

Changes to Medicaid naturally affect not only individual recipients, but also the families in which they live. Family members experience the effects of changes whether related to eligibility expansion or reduction, the requirement of prior authorization for prescription drugs, allowable costs for nursing home care, and many other aspects of Medicaid law and policy. As policymakers continue to grapple with containing Medicaid costs, it is important to consider the many ways in which potential and existing cost-containment measures impact families in intended and unintended ways.

It is important to consider ways that Medicaid reform may impact families in intended and unintended ways.

This chapter is based on the following paper. Complimentary copies of the paper can be downloaded from the Kaiser Family Foundation Web site at www.kff.org/medicaid/7190.cfm.

Smith, V., Ramesh, R., Gifford, K., Ellis E., Rudowitz, R., & O'Malley, M. (2004, October). *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

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Dr. Smith has spoken on these issues in over 40 states and before many national and state audiences, including the National Governors Association, the National Conference of State Legislatures, the Council of State Governments, committees of the U.S. Congress, and Medicaid reform groups in several states. Before joining Health Management Associates, Dr. Smith served as Michigan Medicaid director and as budget director for the human services agency during 30 years of public service. He holds a Ph.D. in economics.

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An Overview of Wisconsin's Medical Assistance, BadgerCare, and SeniorCare Programs

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Medical Assistance

Wisconsin's medical assistance (MA) program supports the costs of acute and long-term care services for certain groups of individuals—elderly, blind, disabled, children under the age of 19 and their parents or caretaker relatives, and pregnant women—who meet specified financial and nonfinancial criteria. MA recipients are entitled to receive covered, medically necessary services furnished by certified providers. The program is commonly referred to as “Medicaid” or “Title 19.”

Wisconsin's MA program is authorized under Chapter 49 of the state's statutes and administered by the Division of Health Care Financing in the state's Department of Health and Family Services (DHFS). DHFS administers the program based on state statutes, administrative rules promulgated under HFS 101 to 108, and provisions contained in the state's MA plan. The state's MA plan provides the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) assurances that the state is administering the program in conformity with federal law and policy.

Federal Cost-Sharing. All states' MA programs receive federal matching funds to support covered services and program administration. The federal matching rate for most program benefits, or federal financial participation (FFP) rate, is based on a formula that compares a state's per capita income to national per capita income. In federal fiscal year 2005-06 (the period from October 1, 2005 through September 30, 2006), Wisconsin's FFP rate is 57.65%. Most administrative costs are funded on a 50% state/50% federal basis, although certain types of administrative expenses qualify for greater federal cost-sharing. Federal law does not limit the amount of matching funds states can receive under MA. Consequently, the more funding a state provides to support the program, the more federal funding the state receives to partially support program costs.

Eligibility and Caseload. Federal law requires states to cover certain groups of individuals and permits states, at their option, to provide coverage to other groups of individuals. Table 1 lists the primary groups of individuals that are eligible for services and benefits under Wisconsin's MA program, including groups that federal law requires all state MA programs to cover and optional groups Wisconsin has elected to cover.

Some groups that are considered “optional” under federal law may, in practice, be mandatory due to the consequences of not covering these groups. For example, as a condition of a waiver agreement under which the state's BadgerCare program operates, Wisconsin has agreed to maintain eligibility for children covered under the state's MA program, including the optional groups

of children the state currently covers. In addition, many individuals in nursing homes that qualify for MA because they have income between 100% and 300% of the monthly federal SSI payment amount (in 2005, individuals with income between \$579 and \$1,737 per month) would qualify for MA-supported nursing home care by “spending down” to the state’s medically needy standard if the state no longer used the 300% standard.

Table 1: Wisconsin’s Primary MA Eligibility Groups

Mandatory Groups	Optional Groups
<ul style="list-style-type: none"> • Individuals in families that meet eligibility requirements for the aid to families with dependent children (AFDC) program that were in effect in Wisconsin on July 16, 1996 • Children under age six and pregnant women in families with income less than or equal to 133% of the federal poverty level (FPL)* • Children under age 19 in families with income less than 100% of the FPL • Infants up to age one born to women who were eligible for MA while they were pregnant, as long as the infant remains in the mother’s household and the mother remains eligible , or would be eligible, if she were still pregnant • Children for whom adoption assistance and foster care payments are made under Title IV-E • Individuals who receive supplemental security income (SSI) payments • Certain elderly and disabled individuals that remain eligible for MA but may not be eligible for SSI as their income increases due to earnings from work and Social Security benefits increases • Certain low-income Medicare beneficiaries (who are eligible for certain services not covered under Medicare and premium payments only) 	<ul style="list-style-type: none"> • Pregnant women in families with income between 133% and 185% of the FPL • Children up to age six in families with income between 133% and 185% of the FPL • Certain institutionalized individuals with low income and resources • Certain persons enrolled in home- and community-based services waivers • Individuals who receive state-only SSI payments or who qualify for, but do not receive, federal SSI payments • Individuals with tuberculosis • Certain women diagnosed with breast or cervical cancer • Certain working disabled persons • Certain “medically needy” persons — individuals that incur health care cost that result in their “spending down” to meet MA income eligibility standards • Women that receive family planning services under the family planning waiver program • Certain disabled children who would be eligible for MA if they were in an institution (“Katie Beckett” children) • Pregnant women eligible under presumptive eligibility criteria

**The 2005 FPL is \$9,570 for an individual and \$3,260 is added for each additional person in a family.*

Table 2 provides information on caseload for MA and MA-related programs for each of the last seven state fiscal years, by major groups of recipients. The MA groups in this table include recipients who: (a) are over the age of 65; (b) are blind; (c) are disabled; (e) meet AFDC-related financial eligibility requirements; and (f) are in a group that includes children and pregnant women in families with income that exceeds AFDC-related financial eligibility standards (in Wisconsin, this group is referred to as “Healthy Start”), individuals in home- and community-based waiver programs, children in foster care, and certain refugee groups, among others. These broad categories are used for state budgeting purposes. However, these categories are somewhat misleading, since some recipients share characteristics of more than one group. For example, since some elderly individuals are included in the “disabled” and “other” categories, the category of individuals age 65 understates the actual number of elderly MA recipients. The table also provides annual average caseload information for the BadgerCare and SeniorCare programs.

Table 2 shows several caseload trends. First, most of the recent growth in MA caseload has occurred due to increases in the number of individuals who meet AFDC- and AFDC-related eligibility criteria (low-income families). Second, because women who participate in the MA family planning waiver are included in MA caseload totals, significant caseload growth occurred in the MA caseload totals after the MA family planning waiver was implemented in January, 2003. Third, during the past three years, there has been a significant increase in the number of individuals who qualify due to disabilities. Finally, enrollment in the state’s SeniorCare program appears to have stabilized, and BadgerCare caseload decreased significantly between the 2003-04 and 2004-05 fiscal years.

Table 2: MA-Related Programs Average Monthly Caseload, by Major Group Fiscal Years 1998-99 through 2004-05							
	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05
Medical Assistance							
Age 65 and Older	45,841	44,832	43,657	43,177	42,394	41,192	40,303
Blind	1,152	1,111	1,091	1,058	1,051	1,045	1,022
Disabled	97,813	96,593	96,477	97,983	101,242	105,330	109,245
AFDC-Related	145,579	143,676	146,097	173,113	208,016	229,621	254,137
Other (includes Healthy Start, waiver clients, refugee groups, etc.)	<u>106,040</u>	<u>116,784</u>	<u>134,233</u>	<u>148,304</u>	<u>155,025</u>	<u>165,284</u>	<u>175,096</u>
Subtotal	396,425	402,995	421,555	463,636	507,727	542,471	579,802
MA Family Planning Waiver	0	0	0	0	7,050	36,379	49,388
Total MA Groups	396,425	402,995	421,555	463,636	514,777	578,850	629,191
BadgerCare							
Children	0	11,758	22,069	27,786	34,107	36,854	30,323
Adults	<u>0</u>	<u>30,463</u>	<u>52,492</u>	<u>62,300</u>	<u>69,626</u>	<u>75,887</u>	<u>63,749</u>
Total BadgerCare	0	42,221	74,561	90,086	103,733	112,741	94,072
SeniorCare	0	0	0	0	62,833	89,085	88,145
Grand Total	396,425	445,216	496,116	553,722	681,343	780,676	811,408

Services and Benefits. Federal law defines: (a) services that states must provide to all MA recipients; (b) services that states must provide to some, but not all, MA recipients; and (c) services that states may, at their option, provide to some or all MA recipients.

While some services are designated as “optional” under federal law, they may, in fact, be mandatory for certain groups of MA recipients. For example, any service a state is permitted to cover under MA that is necessary to treat an illness or condition identified through an early and periodic screening, diagnostic, and treatment (EPSDT) must be provided to the child who receives the EPSDT screen, regardless of whether the service is otherwise included in the state’s MA plan. In addition, certain “optional” services, such as drugs and medical equipment and supplies, must be provided to one or more of three groups of MA recipients -- children, pregnant women, and nursing home residents. Further, although “transportation services” is considered an optional service under federal regulations, states must assure necessary transportation of recipients to and from providers.

In Wisconsin, with limited exceptions, all MA recipients are eligible for the same services. However, certain MA recipient groups are eligible for limited benefits and services. For example, women ages 15 through 44 in families with income up to 185% of the FPL that do not qualify for full MA benefits may qualify for family planning services under the state’s family planning waiver program. In addition, individuals who are enrolled in the state’s home- and community-based waiver programs receive certain long-term care services that are not available to MA recipients that do not participate in these programs.

Many states, including Wisconsin, offer some optional services that serve as substitutes for, rather than additions to, services that would be otherwise used by MA recipients. For example, although coverage for rehabilitative services is optional, recipients that use these services could instead receive similar treatment from hospitals, either on an outpatient or inpatient basis, which may be more expensive than providing these services through agencies that specialize in providing these services.

Table 3 lists the federally required and optional services that are available to MA recipients in Wisconsin.

Table 3: Medical Assistance Services Covered in Wisconsin

Mandatory Services	Optional Items and Services
<p>Acute Care</p> <ul style="list-style-type: none"> • Physicians’ services • Laboratory and x-ray services • Inpatient hospital services • Outpatient hospital services • Early and periodic screening, diagnostic, and treatment services for individuals under 21 • Family planning services and supplies • Services provided by federally-qualified health centers • Rural health clinic services • Nurse midwife services • Certified nurse practitioner services <p>Long-Term Care</p> <p><i>Institutional Services</i></p> <ul style="list-style-type: none"> • Nursing facility services for individuals 21 years old and older <p><i>Home & Community-Based Services</i></p> <ul style="list-style-type: none"> • Home health care services 	<p>Acute Care</p> <ul style="list-style-type: none"> • Medical care and remedial care furnished by license practitioners under state law • Prescribed drugs • Diagnostic, screening, preventive, and rehabilitative services • Clinic services • Primary care case management services • Dental services, dentures • Physical therapy and related services • Prosthetic devices, eyeglasses • TB-related services • Other specified medical and remedial care • Community-based psychosocial services <p>Long-Term Care</p> <p><i>Institutional Services</i></p> <ul style="list-style-type: none"> • Inpatient hospital and nursing facility services for individuals 65 or over in an institution for mental disease • Services provided by intermediate care facilities for the mentally retarded (ICFs-MR) • Inpatient psychiatric hospital services for individuals under age 21 <p><i>Home & Community-Based Services</i></p> <ul style="list-style-type: none"> • Home health care services for individuals not entitled to nursing facility care • Case management services • Respiratory care services for ventilator-dependent individuals • Personal care services • Private duty nursing services • Hospice care • Services furnished under a PACE • Home-and community-based services provided under an MA waiver

Distribution of MA Benefits Spending, by Service Category and Type of Recipient. Table 4 identifies MA benefits expenditures, by major service category, for fiscal years 1999-00 through 2003-04. This table indicates several trends over the five-year period. First, total payments for institutional, long-term care have increased slowly, at an average annual rate of 1.8%, while payments for community-based long-term care services have increased at a much greater rate, an annual rate of 6.4% during this period. Second, managed care payments have grown rapidly, at an average annual rate of 23.6% due to caseload increases (particularly with the creation of Family Care), as well as utilization increases, while payments for fee-for-service non-institutional services have increased by

Table 4: Major MA Expenditure CategoriesFiscal Years 1999-00 through 2003-04
(Excludes BadgerCare and SeniorCare)

Service Type	1999-00	2000-01	2001-02	2002-03	2003-04*
Long-Term Care Services					
Institutional Services					
Nursing Homes	\$906,281,500	\$916,181,100	\$980,578,200	\$990,587,000	\$972,160,300
State Centers	<u>135,932,400</u>	<u>115,304,000</u>	<u>126,885,800</u>	<u>123,875,900</u>	<u>143,039,700</u>
Subtotal	\$1,042,213,900	\$1,031,485,100	\$1,107,464,000	\$1,114,462,900	\$1,115,200,000
Community-Based Services					
MA Waivers	\$360,117,400	\$355,360,900	\$356,107,400	\$409,893,900	\$443,314,100
Personal Care	74,380,800	100,427,700	104,476,400	113,096,200	123,040,100
Private Duty Nursing	15,005,900	14,874,200	15,203,700	17,622,900	17,688,300
Other Home Care	<u>49,259,500</u>	<u>51,530,300</u>	<u>52,628,800</u>	<u>52,016,600</u>	<u>52,326,800</u>
Subtotal	\$498,763,600	\$522,193,100	\$528,416,300	\$592,629,600	\$636,369,300
Total Long-Term Care Services	\$1,540,977,500	\$1,553,678,200	\$1,635,880,300	\$1,707,092,500	\$1,751,569,300
Acute Care Services					
Inpatient Hospital	\$270,613,700	\$297,828,400	\$333,197,900	\$332,029,100	\$323,285,700
Outpatient Hospital	<u>55,267,900</u>	<u>58,663,600</u>	<u>69,602,400</u>	<u>75,647,100</u>	<u>80,790,100</u>
Subtotal	\$325,881,600	\$356,492,000	\$402,800,300	\$407,676,200	\$404,075,800
Non-Institutional Fee-for-Service					
Physicians and Clinics	63,184,200	72,401,200	78,703,500	85,194,600	104,007,400
Outpatient Mental Health	35,205,200	40,625,400	47,813,300	57,185,400	35,228,300
Drugs	336,515,300	373,633,500	432,476,000	494,714,400	560,630,800
DME/DMS	32,187,500	33,970,100	37,766,700	37,233,600	35,505,300
SMV Transport and Ambulance	28,886,400	26,767,200	26,280,200	25,942,600	35,712,900
Dental	19,645,600	21,601,600	23,717,300	21,032,100	22,533,200
Other Care	<u>135,912,100</u>	<u>157,102,900</u>	<u>183,639,900</u>	<u>193,066,300</u>	<u>225,468,300</u>
Subtotal	\$651,536,300	\$726,101,900	\$830,396,900	\$914,369,000	\$1,019,086,200
Total Acute Care Services	\$977,417,900	\$1,082,593,900	\$1,233,197,200	\$1,322,045,200	\$1,423,162,000
Managed Care Payments	\$394,389,300	\$523,590,900	\$681,842,400	\$657,888,600	\$887,135,000
Medicare Premiums and Payments	\$131,260,600	\$131,946,100	\$149,951,400	\$162,216,700	\$162,414,200
Total Provider Payments**	\$3,044,045,300	\$3,291,809,100	\$3,700,871,300	\$3,849,243,000	\$4,224,280,500

*DHFS accelerated payments to take advantage of the enhanced FFP rate available in 2003-04.

**Does not include offsetting recoveries and collections, such as estate recoveries and drug rebates, and payments for common carrier transportation services, for CCIs/CCOs, the Bureau of Milwaukee Child Welfare and projects for children with severe emotional disturbances.

an average of 9.9% annually during this period. Total payments to providers have increased at an average annual rate of 8.6% over this period.

As with all state MA programs, Wisconsin's MA benefits expenditures that are attributable to the major groups covered under the program (low-income families, people with disabilities and individuals over the age of 65) are not proportional to the number of individuals in each of these categories. For example, DHFS reports that, in May, 2005: (a) low-income families comprised 67% of MA recipients, but accounted for only 24% of MA benefits costs, (b) people with disabilities comprised only 17% of total MA recipients, but accounted for 46% of benefits costs; and (c) people over the age of 65 comprised 16% of MA recipients, but accounted for 30% of the benefits costs.

MA-Related Programs

The state administers several programs under waivers of federal MA law, including BadgerCare, Family Care, SeniorCare, and multiple long-term care home- and community-based waiver programs, including the community options program (COP) waiver. These programs operate under broad guidelines specified in federal law and under the terms and conditions of the waiver agreements and the state MA plan approved by CMS. This federal/state relationship permits the state to receive significant federal funding to support these programs, but also limits the state's options regarding program eligibility, services, and recipient cost-sharing. BadgerCare and SeniorCare are budgeted separately from MA, but Family Care and COP are partially budgeted in the same MA benefits appropriations that support traditional MA.

BadgerCare. 1997 Wisconsin Act 27 established BadgerCare, a program that funds health services for individuals not eligible for MA in certain low-income families. Individuals and families began enrolling in the program in July 1999. BadgerCare is closely tied to the MA program with respect to eligibility, service delivery, and administration. BadgerCare recipients are eligible to receive the same services that most MA recipients receive. However, MA and BadgerCare are budgeted as separate programs and have a number of significant differences.

BadgerCare is partially funded with federal funds available from two federal programs -- the state children's health insurance program (SCHIP) and MA. Consequently, BadgerCare operates under federal requirements applicable to both programs. Further, Wisconsin received approval of a waiver of certain federal requirements under MA in order to implement BadgerCare. This waiver approval was granted based on a plan submitted by the state and approved by CMS. BadgerCare operates under the parameters established in that approved plan.

Eligibility for BadgerCare is based on both financial and nonfinancial criteria. Individuals in families with dependent children who are not eligible for MA may qualify for coverage under BadgerCare if the family's countable income is below 185% of the FPL. Once enrolled, a family's countable income may increase to 200% of the FPL before family members are no longer eligible for the program. There is no asset test. Families with incomes above 150% of the FPL must pay a monthly premium to be covered under BadgerCare. This premium is equivalent to approximately 5% of the family's income.

A family that meets the financial and demographic eligibility criteria for BadgerCare cannot qualify for BadgerCare if the family has insurance or

access to a group health insurance plan for which an employer subsidizes at least 80 percent of the monthly premium cost. In addition, individuals who had health care coverage any time during the three months before they apply for BadgerCare are ineligible.

SeniorCare. SeniorCare was created as part of 2001 Wisconsin Act 16 to provide assistance to Wisconsin residents who are 65 years of age or older with the purchase of prescription drugs. Program benefits began September 1, 2002.

Any Wisconsin resident who is 65 years of age or older and pays a \$30 annual enrollment fee is eligible for SeniorCare, except for: (a) individuals with prescription drug coverage under MA; (b) individuals who are not U.S. citizens and whose immigration status would make them ineligible for MA services; and (c) inmates of public institutions. Individuals who have other prescription drug coverage are eligible to participate in SeniorCare, although SeniorCare only pays for that portion of the eligible costs that are not payable from other sources.

All SeniorCare recipients partially contribute towards the costs of the program. In addition to paying the enrollment fee, which is required of all recipients as a condition of eligibility, recipients share in the cost of the program by paying copayments and meeting deductible and spenddown requirements, which are dependent on income.

Each SeniorCare recipient receives a SeniorCare card, which he or she must present to a pharmacy when they purchase prescription drugs. By using this card, DHFS electronically tracks each recipient's prescription drug purchases and lets the pharmacy know how much to charge the recipient at the time of purchase.

Copayments. Recipients pay a copayment for each drug they purchase under SeniorCare for which SeniorCare reimburses the pharmacy for the cost of the drug purchased. The copayment is \$5 for each generic drug and \$15 for each brand-name drug. The state's payment to the pharmacy is reduced by the amount of the copayment.

Deductible. Some SeniorCare recipients pay a \$500 or \$850 annual deductible, depending on their income, before SeniorCare pays for drugs they purchase. Recipients receive a discount for drugs they purchase during the deductible period, since they pay the MA rate for these drugs, rather than the usual retail rate. This discount equals the difference between the retail price of the drug and the rate at which SeniorCare reimburses pharmacies.

Spenddown. Individuals and married couples with income above 240% of the FPL are required to meet a spenddown requirement. The amount of the spenddown requirement is equal to the amount that the individual's or couple's household income exceeds 240% of the FPL.

Pharmacies may not charge SeniorCare recipients more than the retail price of the drug during the spenddown period. If a pharmacy accepts a discount available from a separate program for the purchase of a drug that counts towards recipient's spenddown requirement, only the amount the recipient actually pays for the drug counts towards the spenddown requirement.

Once a recipient meets a spenddown requirement, he or she must meet an \$850 deductible before SeniorCare pays for drugs. For married couples with both

spouses participating in the program, the spenddown requirement is a joint requirement -- purchases of prescription drugs for both spouses count towards the spenddown requirement. Once the joint spenddown requirement is met, each spouse must meet the annual deductible and copayment requirements.

DHFS has established four “participation levels” for SeniorCare recipients, which are based on the amount of cost-sharing required of the enrollee.

Level 1 — Copayment. Individuals with income at or below 160% of the FPL are enrolled in SeniorCare at Level 1. There is no deductible or spenddown requirement for these individuals. These individuals pay copayments for each drug they purchase under the program.

Level 2a — \$500 Deductible. Individuals with income above 160% of the FPL but no more than 200% of the FPL are enrolled in SeniorCare at Level 2a. These individuals pay a \$500 annual deductible before SeniorCare pays for drugs on their behalf. Once individuals participating at this level have met their deductible requirement, they only pay copayments for each drug they purchase.

Level 2b — \$850 Deductible. Individuals with income above 200% of the FPL but no more than 240% of the FPL are enrolled in SeniorCare at Level 2b. These individuals pay the \$850 annual deductible before SeniorCare pays for drugs on their behalf. Once individuals participating at this level have met their deductible requirement, they only pay copayments for each drug they purchase.

Level 3 — Spenddown. Individuals with income above 240% of the FPL are enrolled in SeniorCare at Level 3. These individuals are first responsible for the spenddown requirement and then the \$850 annual deductible requirement. Once both of these requirements have been met, they pay copayments for each drug they purchase.

Drugs covered under SeniorCare include prescription drugs that are covered under MA that are produced by manufacturers that have entered into rebate agreement with DHFS. The only over-the-counter medication covered under SeniorCare is insulin.

The list of drugs covered for a SeniorCare recipient depends on whether the recipient is in a family with income less than 200% of the FPL and therefore is part of the state’s demonstration waiver, which is discussed later in this section. For those recipients, the drugs covered are identical to the drugs covered under MA. For those that do not participate in the waiver, the list of covered drugs only includes drugs produced by manufacturers that have signed a separate rebate agreement with the state. Most manufacturers that participate in the MA rebate program have signed rebate agreements for the non-waiver SeniorCare population. Consequently the lists of covered drugs for waiver and non-waiver SeniorCare recipients are nearly identical.

The SeniorCare program operates under the terms and conditions of a federal waiver that is scheduled to terminate on July 1, 2007. This waiver has enabled the state to receive federal MA matching funds to support a portion of the costs of providing benefits to SeniorCare enrollees with income up to 200 percent of the FPL. At this time, it is not known whether CMS will permit the state to continue to receive federal MA matching funds to support program costs after that date.

Recent Cost Containment Initiatives

The state has taken several measures to reduce the rate of growth in the costs of providing benefits under Wisconsin's MA and MA-related programs. Some of these initiatives are listed below.

2003-05 Biennium. In the 2003-05 state budget (2003 Wisconsin Act 33), the following cost containment measures were approved.

- ◆ Reducing or freezing provider reimbursement rates, including:
 - (a) reducing reimbursement for brand name drugs from the average wholesale price (AWP) -11.25% to AWP-13%
 - (b) eliminating MA payments that support hospitals' indirect graduate medical costs
 - (c) changing the method MA pays hospitals for outpatient services provided to Medicare beneficiaries with income at or below 100% of the FPL
 - (d) reducing rates for oxygen, end-stage renal dialysis services and durable medical equipment.
- ◆ Increasing prior authorization requirements for physical, occupational, and speech therapy services
- ◆ Expanding managed care for low-income families and SSI recipients
- ◆ Increasing recipient cost-sharing, including:
 - (a) increasing, from \$1 to \$3, the copayment MA recipients (regardless of their income) and BadgerCare enrollees pay for each brand name drug, and increasing the maximum monthly total amount of copayments for prescription drugs purchased by MA recipients
 - (b) increasing the SeniorCare deductible amount for individuals with income above 200% of the FP: from \$500 to \$850
 - (c) increasing premiums paid by families enrolled in BadgerCare with income greater than 150% of the FPL
- ◆ Reducing prescription drugs costs by establishing a preferred drug list, increasing prior authorization requirements, and negotiating supplemental rebates with drug companies

2005-07 Biennium. In the 2005-07 state budget (2005 Wisconsin Act 25), the following cost containment measures were approved.

- ◆ Reducing or freezing provider reimbursement rates, including:
 - (a) reducing reimbursement for brand name drugs from AWP-13% to AWP-16%
 - (b) reducing the dispensing fee paid to pharmacies from \$4.38 to \$3.88 per prescription
 - (c) reducing payments for certain medications administered by physicians
 - (d) reducing outpatient hospital rates for therapy services
 - (e) reducing rates to certain hospitals that provide end state renal dialysis
 - (f) providing no rate increase for nursing homes

- ◆ Reducing estimated MA payments to nursing homes by providing additional home- and community-based care
- ◆ Modifying policies to reduce costs of providing personal care services
- ◆ Using disease management services to reduce emergency room usage
- ◆ Transferring the costs of providing prenatal care costs for certain unborn children from MA to BadgerCare to increase federal support for these costs
- ◆ Funding projects to expand MA second-party review activities, improve the accuracy of eligibility and benefit determinations, and improving verification activities
- ◆ Contracting to increase fraud prevention and recovery of overpayment activities
- ◆ Contracting to conduct additional third-party liability identification and recovery activities

In addition, the state has implemented several initiatives that increased the amount of federal MA matching funds the state receives without increasing general purpose revenue (GPR) support for the program. These initiatives have included:

- ◆ Claiming certain MA-eligible costs counties incur as the state match for federal MA funds
- ◆ Increasing the nursing home bed assessment, from \$32 to \$100 per bed per month, and applying the assessment on all licensed beds so that the assessment is paid for beds occupied by private-pay recipients, Medicare recipients, MA recipients and unoccupied licensed beds, and using the assessment revenue as the state match for claiming additional federal funds

Program Funding — 2005-07 Biennium

Table 5 identifies the amounts budgeted for the MA, SeniorCare and BadgerCare programs in the 2005-07 biennium, by source of funds, under 2005 Wisconsin Act 25. These sources include: (a) general purpose revenue (GPR), which are state general revenue funds; (b) segregated tax funds (SEG) from the MA trust fund, which includes a portion of the revenue the state collects from the nursing home provider tax, and funds the state receives under the certified public expenditure program; (c) federal funds (FED), including both federal MA (Title 19) and SCHIP funds (Title 21); and (d) PR funds the state receives from manufacturers under SeniorCare and premiums paid by certain families enrolled in BadgerCare.

Table 5: Benefits Funding by Program and Source — 2005-07 Biennium
(\$ in Millions)

	2005-06	2006-07	2005-07 Biennium	2005-07 Biennium % of Total Program Funding
Medical Assistance				
GPR	\$1,360.8	\$1,716.1	\$3,076.9	35.1%
SEG	384.4	110.3	494.7	5.6
FED	<u>2,556.0</u>	<u>2,648.9</u>	<u>5,204.9</u>	<u>59.3</u>
Total	\$4,301.2	\$4,475.3	\$8,776.5	100.0%
BadgerCare				
GPR	\$62.4	\$78.1	\$140.5	34.5%
PR	6.9	7.3	14.2	3.5
FED	<u>121.3</u>	<u>130.9</u>	<u>252.2</u>	<u>62.0</u>
Total	\$190.6	\$216.3	\$406.9	100.0%
SeniorCare				
GPR	\$52.1	\$57.6	\$109.7	36.8%
PR	40.1	44.1	84.2	28.3
FED	<u>50.5</u>	<u>53.6</u>	<u>104.1</u>	<u>34.9</u>
Total	\$142.7	\$155.3	\$298.0	100.0%
Grand Total — All Programs				
GPR	\$1,475.3	\$1,851.8	\$3,327.1	35.1%
SEG	384.4	110.3	494.7	5.2
PR	47.0	51.4	98.4	1.0
FED	<u>2,727.8</u>	<u>2,833.4</u>	<u>5,561.2</u>	<u>58.7</u>
Total	\$4,634.5	\$4,846.9	\$9,481.4	100.0%

Glossary

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 a number of ways, including changing eligibility requirements or the scope of services provided. Section 1115 waivers must be cost neutral over the course of the demonstration, typically five years.

Aid to Families with Dependent Children (AFDC)

A joint federal-state program for low-income families and children that was the precursor to Temporary Assistance to Needy Families (TANF).

BadgerCare

A health insurance program for certain uninsured low-income Wisconsin families that do not qualify for Medicaid and do not have access to a group health insurance program for which an employer subsidizes at least 80% of the monthly premium. Certain families or individuals in families with incomes up to 185% of the federal poverty level may qualify for health insurance coverage under BadgerCare. Those enrolled in the program may remain in the program for a limited time if they exceed 185% of the poverty level but remain below 200% of the poverty level. The program is funded by Medical Assistance (Medicaid) and SCHIP funds and is authorized under a federal 1115 waiver. In some families, children may be covered under Medicaid, while their parents or older siblings may be covered under BadgerCare.

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 costs of primary care (primary care capitation), the costs of primary care and some specialty care (partial capitation), or include the costs of hospitalization (full or global capitation).

Centers for Medicare and Medicaid Services (CMS)

The federal government agency within the Department of Health and Human Services that administers the Medicare program and works in partnership with states to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

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. To recapture these savings, the federal government reduces states' Medicaid matching rate.

Cost Sharing

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

Crowd Out

A situation whereby new public programs or expansions of existing public programs to the previously uninsured prompts some privately insured persons to drop their coverage and enroll in the public program.

Disease Management

Systems to identify, diagnose, and treat individuals with certain chronic health conditions (i.e., arthritis, asthma, HIV/AIDS, lower back pain, or diabetes). The goal of these systems is to provide the identified individuals with the education and support needed to comply with their prescribed treatments.

Disproportionate Share Hospital (DSH) Payments

A Medicare and Medicaid payment system that provides higher payments to hospitals that serve a disproportionate share of low income or uninsured patients.

Dual Eligible

A person who is eligible for both Medicare and Medicaid.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

A mandatory program that provides well baby and well child screenings to eligible children under 21 receiving Medicaid. Eligible children must receive all the needed health care services or treatment identified as part of the screening.

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.

Federally Qualified Health Center (FQHC)

A health center in a medically under-served area that is eligible to receive cost-based Medicare and Medicaid reimbursement and provide direct reimbursement to nurse practitioners, physician assistants, and certified nurse midwives.

Fee-for-service (FFS)

Payments to providers that 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, a 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 patients.

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 require 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).

ICF/MR

Intermediate care facilities for people with mental retardation

Katie Beckett children

Children with disabilities who qualify for home care coverage under a special provision of Medicaid; named after a girl who remained institutionalized solely to continue Medicaid coverage.

Long-term Care

A set of health care, personal care, and social services required by persons who have lost, or never acquired, some degree of functional capacity (i.e., the chronically ill, aged, disabled, or retarded) and provided in an institution or home on a long-term basis. The term is commonly used more narrowly to refer to long-term institutional care such as that provided in nursing homes, homes for the retarded, and hospitals for persons with mental illness.

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. The program is authorized under Title XIX of the Social Security Act.

Medicare Part D Drug Benefit

A Medicare prescription drug benefit that 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 decisions 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; and 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.

Medically Needy Income Level (MNIL)

Income level at which individuals in some states can qualify for Medical coverage. These are persons who qualify for Medicaid categorically (e.g. pregnant women, children, families with dependent children, elderly disabled), but have incomes above 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.

Medicare

The national health insurance program provided primarily to older adults (65 and 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. Part C gives beneficiaries a choice of enrolling in a coordinated care plan (HMO, PPO, or PSO), private fee-for-service plan, or medical savings account as an alternative to the traditional Medicare fee-for-service system.

Olmstead Decision

A 1999 Supreme Court decision in the case of *Olmstead v. L.C.* whereby the Court found that unnecessary institutionalization of individuals with disabilities is unconstitutional under the Americans with Disabilities Act. State Medicaid programs were affected if they provide both institutional and home- and community-based long-term care services; they must have a plan that ensures individuals with disabilities receive services in the most integrated setting appropriate to their needs.

Pharmacy Plus Waiver

A § 1115 Medicaid waiver that 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. *See SeniorCare for information on Wisconsin's Pharmacy Plus waiver.*

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.

Prospective Payment System (PPS)

A system used by Medicaid, Medicare, and other insurance programs in which the amounts or rates of payment to hospitals or other health programs are established in advance for a defined period (usually a year). Institutions are paid these amounts regardless of what costs they incur. These systems are designed to introduce a degree of constraint on charge or cost increases by setting limits on amounts paid during a future period. In some cases, these systems provide

incentives for improved efficiency by sharing savings with institutions that perform at lower than anticipated costs.

SeniorCare

The program approved under the § 1115 Medicaid Pharmacy Plus waiver to provide prescription drug benefits to Wisconsin seniors (aged 65 and older). SeniorCare is administered on a fee-for-service basis and involves pharmacies that participate in the Wisconsin Medicaid program (about 98% of all pharmacies in the state). Enrollees in the program pay an enrollment fee, copayments for drugs, and may have an annual deductible. The federal waiver is scheduled to terminate on July 1, 2007.

State Health Insurance Program (SCHIP)

A federal program (Title XXI of the Social Security Act) that expands health insurance coverage to certain low- or moderate-income uninsured children with family incomes that are too high to qualify for Medicaid. *See BadgerCare for information on Wisconsin's SCHIP program.*

Supplemental Rate

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

Uncompensated Care

Service provided by physicians and hospitals for which no payment is received from the patient or third-party payer. Some costs from these services may be covered through cost-shifting. Not all uncompensated care results from charity care – it also includes bad debts from persons who are not classified as charity cases, but who are unable or unwilling to pay their bill.

Upper Payment Limit (UPL)

The maximum amount that a state may pay providers under the Medicaid program. The UPL is generally limited to the total that Medicare would pay for the same services.

Wholesale Acquisition Cost (WAC)

The price paid by the wholesaler to the manufacturer for drugs that will then be brought to the market by the wholesaler.

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Wisconsin Department of Health and Family Services' Web site: www.dhfs.state.wi.us

Selected Resources for Medicaid

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Interests: State health and family services programs, insurance, state budgeting, the legislative and budgeting process

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Interests: Health, family and medical leave and insurance

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Interests: Administrative rules and health-related legislation

State Agencies

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State Budget Office
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Interests: Health care reform; health care programs at the Department of Health and Family Services (e.g., Medicaid, High Risk Insurance Pool, BadgerCare, SeniorCare); Office of the Commissioner of Insurance, Board on Aging and Long-term Care

Mark Moody, Administrator

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Division of Health Care Financing
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Interests: Medicaid, managed health care, health information, medical assistance, BadgerCare, SeniorCare, international health care

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Interests: Long-term care, regulation and licensing, people with disabilities, mental health and substance abuse issues, elder services

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Interests: Medicaid, health care financing, insurance coverage, access to health care, health care reform, health policy, special populations

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Interests: Family estate planning, elder care, scams and frauds

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Interests: State health policy and population health outcomes

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Interests: Barriers to accessing care for under-served populations and Medicare

Robert Stone-Newsom, Senior Scientist

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Interests: Value purchasing, measurement and evaluation of health care quality, and regional variation in care

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Interests: Health insurance coverage, public insurance, income inequality and health, welfare reform

National Organizations and Associations

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www.academyhealth.org
www.hcfo.net

Report:

“State of the States: Finding Alternate Routes” (2005). Available online at:
<http://www.statecoverage.net/pdf/stateofstates2005.pdf>

Issue Brief:

“Managed Care Mandates Fall Short of Curbing California Medicaid Costs”
(March 2005). Available online at: <http://www.hcfo.net/pdf/findings0305.pdf>

Centers for Medicare and Medicaid Services

U.S. Department of Health and Human Services
<http://cms.hhs.gov/>

Center for Studying Health Systems Change

Paul Ginsburg, President
600 Maryland Ave SW, Suite 550
Washington DC 20024
(202) 484-5261
www.hschange.org

Issue Briefs:

“Public Coverage Provides Vital Safety Net for Children with Special Health Care Needs” (September 2005). Available online at:
<http://hschange.org/CONTENT/778/?topic=topic17>

“Medicaid Cost Containment and Access to Prescription Drugs” (May/June 2005). Available online at:
<http://www.hschange.org/CONTENT/740/?words=Medicaid>

Commonwealth Fund

Karen Davis, President
1 East 75th St.
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Report:

“Stretching State Health Care Dollars During Difficult Economic Times” (October 2004). Available online at:
http://www.cmf.org/publications/publications_show.htm?doc_id=243623

Economic and Social Research Institute

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2100 M Street NW, Suite 605
Washington DC 20037
(202) 833-8877
www.esresearch.org

Report:

“Safety Net Hospitals: A Vital Resource for the U.S.” (November 2004). Available online at:
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Health Management Associates

Vern Smith, Principal
120 North Washington Square, Suite 705
Lansing MI 48933
(517) 482-9236
www.healthmanagement.com

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Kaiser Family Foundation

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www.kff.org

www.statehealthfacts.org - State Health Facts

www.kaisernetwork.org - Webcasts on Health-Related Hearings and Meetings

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www.nashp.org

Issue Brief:

“Making Medicaid Work for the 21st Century: State Options to Control Costs” (November 2004). Available online at:

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Health and Medicaid Information:

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The Urban Institute

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