State Options to Control Costs

The Medicaid program is the second largest item in state budgets (after education), represents about 20 percent of total state expenditures, and continues to grow. In the two years from 2002 through 2003, Medicaid spending increased by about 23 percent. Every state in the nation took cost containment actions in 2003, and all plan to take additional measures to constrain Medicaid growth in 2004. The Congressional Budget Office projects that Medicaid expenditures will total about $296 billion in 2004.

The growth in health care costs is not unique to Medicaid and mirrors trends in the private market. In fact, the 23 percent growth in Medicaid program costs over two years was lower than the rate of growth in premiums for employer-sponsored health insurance which increased by about 27 percent. While spending growth in the private market increased from 12.9 percent in 2002 to 13.9 percent in 2003, the rate of growth in Medicaid decreased from 12.8 percent to 9.3 percent during the same time period. The decrease resulted mainly from cost containment actions taken by states and recent federal restrictions on certain financing strategies that enabled states to maximize federal reimbursement.

One recent study concluded that most of the increase in Medicaid spending has occurred for reasons that are largely outside of state control. Enrollment in Medicaid has increased as a result of declining household incomes and declining rates of employer-sponsored insurance associated with the economic downturn. Other factors contributing to higher Medicaid spending include expanded coverage, prescription drug costs, and increased rates of disability associated with the aging of the population. Some of these factors are expected to moderate as the economy improves. Other factors, such as the aging of the population, will continue to affect not only Medicaid but the health care system as a whole.

Current Policies

Because Medicaid is a federal-state partnership, each state sets its own rules within broad federal guidelines. As a result, states have a variety of options available to them as they seek to provide comprehensive care to those who depend on Medicaid for their health care and long-term care needs, at a cost that state taxpayers can afford. These options include:

1. **Constraining enrollment.** The Medicaid statute identifies categories of people that states must cover. It also identifies groups of people that states may cover (optional eligibility categories). States that choose to cover an optional group must cover the entire group; they cannot cover part of a defined group, and they cannot cap the number of people they will cover within an eligibility group. One means of containing costs is for a state to reduce the number of optional groups it covers or to tighten the income eligibility standards for those groups. Twenty-five states adopted these strategies in 2003, reducing eligibility in response to fiscal crises. State legislatures and Medicaid officials are often reluctant to make such changes, fearing the potential impact on beneficiaries’ health, the expectation of corresponding increases in the cost of uncompensated care, and the difficulty of restoring eligibility when economic conditions improve.

States have other options for managing enrollment. Under federal law, states must re-verify eligibility for Medicaid at least every 12 months, but they can choose to do so more frequently ensuring that those
Reducing covered benefits. The Medicaid statute requires that all Medicaid beneficiaries receive a specific set of services (mandatory services). States may also elect to cover other, optional, sets of services. Comparable services must be offered to most beneficiaries on a statewide basis, regardless of their eligibility category, and services must be offered in sufficient amount, scope, and duration to meet the needs of the population. As a result, states cannot target a specific service to a specific subgroup in need of that service (except through a waiver). Although reducing covered benefits can save money, states are often reluctant to adopt this strategy for many of the same reasons they are reluctant to impose eligibility cuts.

States can reduce costs by eliminating certain optional services or by reducing the scope of the benefits offered (e.g., restricting the number of prescriptions that can be filled in a month or the number of physical therapy visits). But mandatory services cannot be eliminated. For example, under federal early and periodic screening, diagnosis, and treatment (EPSDT) requirements, states must provide any Medicaid-covered service that a child (under age 21) needs to “...correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services,” whether or not these services are covered under the state's plan.

2. Reducing service use. Another way to control the growth in program costs is to reduce service use or to substitute lower cost services for higher cost ones. States have used a number of strategies to control utilization of services including improving care management for high cost and chronically ill beneficiaries, promoting disease prevention, promoting the use of less expensive prescription drugs, and maximizing the use of managed care. In the area of long-term care, states have pursued strategies to prevent the need for nursing home care and to shift the focus to less costly community-based settings. For example, both Georgia and New Hampshire have achieved significant cost savings for frail elderly beneficiaries through programs that help seniors age in place and reduce hospitalizations and nursing home admissions. One risk of such strategies is that efforts to prevent access to inappropriate care can also prevent access to needed care.

States have also used cost sharing to affect utilization. Medicaid rules allow states and providers to charge cost sharing for most services provided to adult beneficiaries, except pregnant women and institutionalized individuals. However, cost-sharing amounts must be nominal; for example, $3 is the maximum copayment that a beneficiary may be charged for a service. Also, providers may not deny a service because a beneficiary cannot pay the copayment.

Clearly, cost sharing affects utilization. One study found that families who bear a percentage of their health care costs reduced their use of ambulatory care by one third as compared with families who receive free care. This reduction caused no significant difference in either parental perceptions of their child’s health or physiological measures of health. States, however, must use cost sharing with care because other research has shown that it disproportionately affects low-income people and reduces the use of beneficial, cost-effective services, preventive care, and prescription drugs.

3. Control the price of care. Few federal regulations govern the amount that states pay to Medicaid providers. States have controlled the growth of program costs through freezing or reducing provider payment rates. However, states must be cautious when lowering or freezing these payments because low payment rates can result in providers leaving the program, which can, in turn, mean a poorer quality of remaining providers and reduced access for beneficiaries.

Generally, states must permit any provider who meets Medicaid's standards to furnish Medicaid services. However, states may restrict beneficiaries' choice among participating providers through a managed care program or through selective contracting under a waiver. States report that they have saved money by moving beneficiaries from fee-for-service to capitated payment arrangements and
Workgroup participants agree that the Medicaid program should support the health and well-being of low-income populations by prudently managing programs that ensure access to quality health care and support services through a federal-state financial partnership. Early in its discussion, the workgroup determined that cost containment efforts should “allow for effective cost controls without sacrificing access to care or quality.”

by the use of selective contracting. When adopting such arrangements, states need to strike a delicate balance between the need to contain costs and the need to ensure adequate access to quality care.

4. **Reduce administrative costs and manage the program more efficiently.** Some of the mechanisms that states can use to achieve this objective include:

- **Hiring freezes and layoffs.** Using more part-time workers and cutting budgets for supplies and travel are effective tools for containing costs, as long as agencies retain adequate resources to manage the program.

- **Improving third-party liability recoveries and program integrity activities.** For example, enhanced efforts to prevent waste, fraud, and abuse in Washington State’s Medicaid program were estimated to save over $60 million in state funds in 2002.³

**What Works Well and What Doesn’t**

State Medicaid programs have made full use of the flexibility afforded them by the federal government. As a result, they have managed to keep Medicaid cost growth below private sector growth while continuing to provide comprehensive services. However, some current policies may restrict states from taking certain actions that could help to further contain costs.

- **Barriers to management of eligibility and enrollment growth.** Some policymakers suggest that states could better manage the size of program enrollment if they were able to redefine eligibility for certain groups, particularly those in need of long-term care services. Current rules only permit the provision of home and community-based services to those in need of an institutional level of care. As a result, states are unable to serve seniors and people with disabilities who do not need nursing home care but would benefit from interventions to prevent deterioration and the resulting need for institutional services. States are also unable to cap the number of eligible people who enroll in Medicaid in order to obtain long-term care services, except through a waiver for home and community-based services.⁴

- **Barriers to management of covered benefits.** Current federal laws prevent states from creating different benefit packages for different groups of beneficiaries. However, many state officials believe that different groups of beneficiaries need different packages of services. For example, beneficiaries with incomes below the federal poverty level are more likely to need certain services (e.g., non-medical transportation to and from outpatient care, intensive behavioral health care, targeted case management) than other beneficiaries.

- **Barriers to management of service utilization.** Medicaid cost sharing rules have not been updated since their promulgation in 1983. The current limitations on who can be charged cost sharing and the amount that they may be charged do not support efforts to affect utilization. They also do not reflect the fact that Medicaid now serves some who are able to contribute more to the cost of their health care.

- **Barriers to management of provider payments.** Federal rules restrict state use of purchasing strategies such as selective contracting which would allow Medicaid agencies to direct beneficiaries to use services from a limited set of providers that offer the greatest value in terms of cost and quality of care.

- **Barriers to management of program and administrative functions.** Some estimate that Medicaid is at risk for billions of dollars in improper payments, although the exact amount lost is not known because few states measure the overall accuracy of their payments.⁵ Some federal Medicaid rules reduce state incentives to identify over-payments. For example, current rules reduce the amount of
How the Current System Can Be Improved

Medicaid costs are growing more slowly than private market costs. However, program managers report that they have encountered barriers that prevent them from doing even better, and workgroup members have identified a number of strategies that they believe could help states further manage program costs. These include:

**Improve eligibility and enrollment management.** One option would be to de-link eligibility for community-based services from that for institutional services. This would help states manage costs by permitting them to provide less expensive community-based services in order to prevent or delay the need for more costly institutional services. The group also discussed the need for more flexible financial eligibility rules for long-term care in order to foster community services instead of nursing home care, when appropriate.

**Improve benefit coverage management.** The workgroup considered whether states should be able to offer different benefit packages to certain populations. The ability to provide a targeted benefit package to some groups could help to control costs by, for example, allowing a more commercial-like benefit package for higher income populations.

**Improve utilization management.** The workgroup explored options for states to direct those who can be served in the community to community care, rather than institutional care. It also examined Medicaid cost-sharing rules.

**Improve provider payment management.** The group considered the use of selective contracting to increase the ability of states to control costs and assure quality. A few states have been permitted to contract selectively (e.g., for hospital services and non-emergency transportation services) through Section 1915(b) (freedom-of-choice) waivers. The group discussed whether to recommend changing Medicaid law to permit some selective contracting without a waiver.

**Program administration and management.** The group identified ways to change current federal Medicaid rules to create more effective incentives for pursuing erroneous payments and fraud. For example, it considered recommending that the rules be changed so that state reimbursements are reduced when the Medicaid agency collects an over-payment instead of when it identifies one. The group also considered other options that include changes to law that would assist states in recovering over-payments from providers in cases of bankruptcy or refusal to repay.

This brief is a product of NASHP's project on Making Medicaid Work for the 21st Century. For more information on the project and a list of advisory group participants and staff, visit the NASHP website at www.nashp.org.

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2Ibid.
3Ibid.
5§ 1905(r)(5).
9Ibid.
10This topic is discussed in more detail in the Making Medicaid Work for the 21st Century issue brief on long-term care.