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Sustainability of Medicaid:
Action Steps for Governors to Achieve Meaningful Reform

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INTRODUCTION: *Medicaid is a budgetary threat to states and a barrier to consistent, quality care for the neediest Americans. To prevent fiscal crises and improve access to care, States can act now to secure a better, more sustainable future for the Medicaid program. This paper outlines immediate and long-term steps governors can take to achieve meaningful Medicaid reform.*

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THE DIAGNOSIS: UNSUSTAINABLE BUDGETS

The Centers for Medicare and Medicaid Services (CMS) recently released the *2010 Actuarial Report on the Financial Outlook for Medicaid.*[i] This report describes the projected trends for Medicaid expenditures and enrollment over the next 10 years. Its findings paint a grim picture for the more than 45 states and the District of Columbia that have projected budget shortfalls for fiscal year 2012:[ii]

- Total Medicaid expenditures for medical assitance and adminsitration are expected to reach $840.4 billion by FY 2019, increasing at an average rate of 8.3 percent per year.
- Federal spending on Medicaid is projected to reach $512.9 bilion by FY 2019, or about 67 percent of total Medicaid expenditures.
- State Medicaid medical assitance payments and administration costs are projected to reach $327.6 billion by FY 2019, increasing at an average rate of 9.8 percent per year (twice the historical rate).
- The Patient Protection and Affordable Care Act (PPACA) will add $26 billion in new administrative costs to Medicaid over the next decade, with $14 billion to be paid by the Federal government and $12 billion by states.

States & Medicaid: Action Needed

Washington is passing the buck on budget leadership and entitlement reform. Governors must rise to the challenge of Medicaid reforms that achieve short-term flexibility and long-term structural improvements:

Medicaid Eligibility

✓Use maintenance of effort waivers to maintain flexibility

✓Modernize and integrate administrative systems for determining eligibility and enrollment

Benefits Package

✓Implement cost sharing mechanisms like copayments, deductibles, and coinsurance

✓Launch demonstrations that reward better resource utilization and lifestyle choices

Service Delivery

✓Expand existing managed care programs and introduce new eligibility groups

✓Start managed long-term care programs to reduce costs and enable home care

Financing

✓Review prescription drug prices and pass generic substitution laws

✓Update payment systems to allow electronic claims submission and processing

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Table 1 – Historical and Projected Medicaid Enrollment (Millions of Person-Year Equivalents) and Expenditures for Medical Assistance Payments and Administration (Billions of Dollars)[iii]

Fiscal Year	Enrollment	Total expenditures	Federal expenditures	State expenditures
Historical data:				
2000	34.6	206.2	117.0	89.2
2001	36.9	229.0	129.8	99.2
2002	40.5	258.2	146.6	111.6
2003	43.5	276.2	161.0	115.1
2004	45.2	296.3	175.0	121.3
2005	46.5	315.9	180.4	135.5
2006	46.7	315.1	179.3	135.8
2007	46.4	332.2	189.0	143.2
2008	47.6	351.9	200.2	151.7
2009	50.1[1]	378.6	246.3	132.3
Projections:				
2010	52.9	404.9	271.4	133.5
2011	54.3	429.5	271.9	157.6
2012	54.8	456.4	260.3	196.1
2013	55.1	490.2	281.3	208.9
2014	67.1	564.3	340.2	224.1
2015	73.0	621.1	378.5	242.6
2016	75.6	676.5	414.6	261.9
2017	76.7	729.6	445.9	283.7
2018	77.4	781.1	477.0	304.1
2019	78.0	840.4	512.9	327.6

Historical State Medicaid
Annual Growth Rate: 4.0 Percent

Projected PPACA State Medicaid
Annual Growth Rate: 9.4 Percent

[1] FY 2009 enrollment is projected.

THE RESPONSE: STATE-DRIVEN MEDICAID REFORMS

Washington is passing the buck on budget leadership and entitlement reform. Thus, governors must rise to the challenge of Medicaid reforms that achieve short-term budget flexibility and enable long-term structural change. Bending the unsustainable budget trajectory will require innovative and solutions-based policies that address eligibility, benefits packages, service delivery, and financing.

Long-term care merits special emphasis. Reducing the anticipated budget costs for long-term care services will be critical to the overall sustainability of the Medicaid program. Medicaid has become the country's largest payer of long-term care services, funding approximately 50 percent of all long-term care spending and nearly two-thirds of all nursing home residents. Several policies could enhance the ability of Medicaid to prepare for the dramatic expansion of the long-term care market. Moreover, it is important to recognize that beneficiaries view quality as the chance to stay at home in their communities in the least restrictive or most integrated setting appropriate to their long-term care needs.[iv]

Every state and every Medicaid program is different, dictating that governors implement solutions that best address their state's needs. In this setting, it is desirable that state officials begin by conducting a comprehensive assessment of their respective Medicaid programs. Such an assessment should include the current or "baseline" outlooks for enrollment, the per capita spending by category and income, and the cost of the PPACA's Medicaid expansion (including administrative costs not provided in the temporary federal funding).[v] This will allow state officials to project the potential impact of a specific proposal and best determine the overall action plan needed to achieve meaningful reform.

MEDICAID ELIGIBILITY

Short-Term Budget Flexibility: Maintenance of Effort (MOE) Waivers

To maintain short-term budget flexibility, states should submit MOE waivers to Health and Human Services (HHS) requesting PPACA's MOE provisions be lifted. The PPACA included two MOE provisions intended to maintain existing Medicaid and CHIP enrollment levels until the Secretary of HHS determines that an insurance exchange is fully operational (the CHIP provision must be maintained until October 1, 2019). MOE provisions prevent states from adopting more restrictive income eligibility standards, methodologies, or procedures that would substantially alleviate budget deficits through reduced Medicaid expenditures.

As evidence of the need for this flexibility, on January 7, 2011, thirty-three governors sent a letter to the Obama Administration requesting the removal of the MOE provisions. Governor Brewer of Arizona has already submitted a formal MOE waiver to the Secretary of HHS, and the Administration is reviewing the Secretary's legal options. As more governors and state officials submit formal MOE waiver requests, the efforts may expedite the Secretary's decision and ensure that states have every policy option at their disposal to address budget crises.[vi]

In addition, States have the option of letting existing Medicaid demonstrations expire to reduce total committed Medicaid expenditures. Secretary Sebelius approved this option in a letter to Governor Brewer, "Waivers are time-limited commitments – both for a state and for HHS – and neither the Affordable Care Act nor Medicaid law or regulations prior to its enactment require a state to renew a demonstration beyond its expiration." Consequently, any reduction in eligibility associated with the expiration of a Medicaid demonstration, whose eligibility derives from the demonstration, would not constitute an MOE violation.[vii]

Long-Term Structural Change: Modernize Medicaid Eligibility and Enrollment Systems

States should invest in improved technology and capabilities for determining Medicaid eligibility and tracking enrollment. PPACA's dramatic expansion of the Medicaid program in 2014 and the launch of state health insurance exchanges will place substantial stress on administrative systems.

The structure of PPACA's insurance expansion creates a costly challenge for states to track individuals and families who are expected to move frequently throughout the year between Medicaid and the federally-subsidized state health insurance exchanges. The "churning" between Medicaid and state exchanges is estimated to impact more than 50 percent of all adults; this includes 28 million Americans, with family incomes below 200 percent of the federal poverty level.[viii] Accordingly, there will be a particular benefit to integrated systems that simultaneously track eligibility and enrollment in both programs.

Among the investments available to improve technological capabilities for determining Medicaid eligibility and tracking enrollment are:

- *Integrated Databases for Medicaid and State Exchange Enrollment* – Combining enrollment data for both programs will reduce paperwork, staff overhead, and technology operating expenses
- *Enrollment Data Management Systems* –Managing real-time enrollment data will inform better public policy decisions related to Medicaid benefit design and service delivery.

- *Predictive Modeling Analytics*– Adopting predictive modeling will allow states to identify high-cost beneficiaries and enroll them in aggressively managed, quality care programs.
- *Front-End Statistical Fraud Analysis* – Building statistical fraud analysis into eligibility and enrollment systems will empower states to better prevent and deter the estimated $18.6 billion in annual improper Medicaid payments.[ix]

MEDICAID BENEFITS PACKAGE

Short-Term Budget Flexibility: Increase Medicaid Cost Sharing

States should study the implications of implementing Medicaid copayments, deductibles, coinsurance, and other similar cost sharing mechanisms. The Deficit Reduction Act of 2005 authorized greater cost sharing for many Medicaid eligible groups above 100 percent of the poverty level, as long as the family's cost sharing does not exceed 5 percent of their income. The following table summarizes the maximum allowable cost sharing amounts for different types of services.

Table 2 – Maximum Allowable Cost Sharing[x]

Services and Supplies (Cost Sharing Subject to a Per-Beneficiary Limit)[a]	**Eligible Populations by Family Income [b,c]**		
	<100% FPL	**101-150% FPL**	**>150% FPL**
Institutional Care (inpatient hospital care, rehab care, etc.)	50% of cost for 1st day of care	50% of cost for 1st day of care, 10% of cost	50% of cost for 1st day of care, 20% of cost
Non-Institutional Care (physician visits, physical therapy, etc.)	$3.65	10% of cost	20% of cost
Non-emergency use of the ER	$3.65	$7.30	No limit
Preferred drugs	$3.65	$3.65	$3.65
Non-preferred drugs	$3.65	$3.65	20% of cost

a. Emergency services, family planning, and preventive services for children are exempt from copayments.
b. Some groups of beneficiaries, including most children, pregnant women, terminally ill individuals, and most institutionalized individuals, are exempt from copays except nominal copays for non-emergency use of an emergency room and non-preferred drugs. American Indians who receive services from the Indian Health Service, tribal health programs, or contract health service programs are exempt from all copays.
c. In some cases for beneficiaries with income above 100 percent of FPL, States may deny services for nonpayment of cost sharing.

Long-Term Structural Change: Alternative Medicaid Benefits Packages

States have an incentive to launch demonstrations designed to test programs that reward beneficiaries who make prudent purchasing, resource utilization, and lifestyle decisions. For example in 2007, Indiana launched the Healthy Indian Plan (HIP), which extends high deductible health plans and health savings accounts to low-income parents of children covered by Medicaid and SCHIP, as well as childless adults. To assist with out-of-pocket costs incurred prior to meeting the deductible, both the individual and the state make contributions to the POWER account. Participant contributions to the POWER account are set on a sliding scale based on ability to pay, but at no more than 5 percent of gross family income. Funds that remain in the account at the end of the year can be rolled over and used the following year, assuming preventative services are obtained.

Indiana and Mercer Consulting have found significant changes in behavior, and consequently lower total costs. In 2009, state workers with the HSA visited emergency rooms and physicians 67 percent less frequently than co-workers with traditional healthcare. HIP enrollees were also more likely to use generic drugs resulting in an annual lower cost per prescription of $18.

Alternative demonstrations that reward beneficiaries could focus on disease management or wellness programs like diabetes management and weight reduction.

MEDICAID SERVICE DELIVERY

Short-Term Budget Flexibility: Expand Existing Managed Medicaid Programs

PPACA increases Medicaid enrollment by a projected 16 million beneficiaries in 2014, exacerbating already-serious access concerns for beneficiaries. In 2008, fee-for-service (FFS) Medicaid reimbursements averaged only 72 percent of the rates paid by Medicare, which are in turn well below the rates paid by private insurers.[xi] The unsustainably low reimbursement rate, even with the pending increase to Medicare levels, has led many primary physicians and specialists to stop accepting Medicaid enrollees. The end result is an expectation for lower quality care, delivered in more costly care setting:

- A June 2010 nationwide survey of physicians found that 54.5 percent of primary care physicians, 45.6 percent of medical specialists, and 49.3 percent of surgical specialists are no longer accepting new Medicaid patients[xii]
- In a separate 2010 survey of 1,800 emergency room physicians, 71 percent of respondents expect emergency visits to increase, and 47 percent anticipate conditions will worsen for patients[xiii]
- Increased overutilization of America's emergency departments by Medicaid enrollees could cost states, hospitals and physicians as much as $35.8 billion over the next decade in unaccounted for expenditures[xiv]

States should examine expanding existing managed Medicaid programs, experiment with managed care in new care settings and extend enrollment requirements to new eligibility groups. Prominent academic studies show that compared to traditional FFS Medicaid, managed Medicaid consistently delivers greater access to medical provider networks[xv], better quality care, and cost savings.[xvi] While percentage savings vary by state and targeted eligibility group, nearly all of the 24 state reports or peer reviewed studies in the last decade have shown demonstrated savings from the use of managed care.[xvii] The evidence is clear and governors should act immediately as only seventeen states currently require Medicaid enrollees to sign up for managed Medicaid care. The projected cost savings and potential for improved access to better care will be essential when enrollment increases exponentially in 2014.

Long-Term Structural Change: Start Managed Long-Term Care Programs

States would benefit from managed long-term care programs that lower budget costs and allow more beneficiaries to stay at home. Traditionally, Medicaid pays doctors and nursing homes directly for individual services, but under long-term managed care, states pay health insurers a fixed monthly fee for each Medicaid patient. The fixed monthly fee includes all of the patient's costs, including physician and potential nursing home costs. Conversely, managed care companies use care coordinators to monitor patients to help ensure they are getting the right care in the most appropriate setting.

USA Today reports that in 2009, about 90 percent of Tennessee's Medicaid long-term care funding went to nursing homes, according to the state's Medicaid agency. As a result, there were long waiting lists for enrollees who wanted home and community-based services. But after Tennessee awarded long-term care contracts to three Medicaid health plans, those waiting lists shrank sharply.[xviii]

Tennessee last year became the sixth state to require elderly and disabled beneficiaries to enroll in managed care plans. California plans to require its Medicaid long-term care enrollees to sign up for plans later this year. An additional 10 other states, including Florida, Maryland, New Jersey, and Rhode Island, are considering introducing or expanding the use of managed long-term care.

MEDICAID FINANCING

Short-Term Budget Flexibility: Review Prescription Drug Prices and Pass Generic Substitution Laws

States should review prescription drug pricing and implement generic substitution laws. Pharmacy costs account for 8 percent of the Medicaid program spending, with states spending $7 billion on prescription drugs in 2009.[xix]

Too many states continue to pay pharmaceutical prices near the Average Wholesale Price (AWP), which is significantly higher than the price actually paid by purchasers of the drug (*e.g.* pharmacies, etc). Instead, it is beneficial to shift to reimbursing the Average Manufacturer Price (AMP), which is closer to the actual acquisition costs of the drugs, to establish pharmaceutical prices. In Alabama, the first state to adopt use of actual acquisition costs as the benchmark for drug reimbursement rates, savings in the first year of implementation are expected to reach six percent ($30 million) of the state's total pharmacy spend.[xx] CMS has stated that it intends to undertake a national survey of pharmacies to create a database of actual acquisition costs for states this year, but states should not wait on the Federal government. Governors considering immediate formulary reviews should begin with high-volume and high-margin Medicaid prescriptions.

To stem further increases in state pharmacy costs, governors could also implement generic substitution laws that require pharmacists to substitute a generic drug for a brand-name medication, if the prescriber did not specify that the brand-name drug should be dispensed. Thirty eight states and the District of Columbia have yet to implement generic substitution laws, and as a result, have 25 percent lower generic use rate than the 12 states that did not require patient consent. If generic substitution laws had been implemented nationally in 2011, state Medicaid programs could have saved more than $100 million in coverage alone from three top selling medications that are nearing patent protection (Lipitor, Plavix, and Xyprexa). If applied to the entire Medicaid drug formulary, governors could enact tremendous savings from generic substation alone.[xxi]

Long-Term Structural Change: Update Medicaid Payment Systems to Save Money and Innovate

States have the option to update payment systems to allow for electronic claims submission and processing. Electronic claims processing is essential for the entire healthcare system, McKinsey and Company estimates that more than half of the transactions between providers and payers, like Medicaid, are still paper-based. The current annual volume of 2.5 billion claims across the healthcare system leads to an estimated administrative waste of $15 billion to $20 billion per year in postage, item processing, and accounting.[xxii]

For State Medicaid programs, electronic processing is essential to efficiently and effectively capture an estimated $18.6 billion in annual improper Medicaid payments.[xxiii] Using advanced statistical modeling fraud management programs can identify and investigate suspect electronic claims prior to Medicaid making a payment. This preemptive approach to combating fraud, waste and abuse is less invasive for medical providers, reduces staff overhead costs for states, and can better protect sensitive patient information.

In addition to the waste and fraud concerns, electronic claims processing will be required for any of the innovative healthcare payment reforms like, bundled payment and pay-for-performance. Governors and states interested in launching Medicaid provider pilots or encouraging state providers to pursue Accountable Care Organizations designs should begin this initiative immediately.

THE CURE: A FIXED DEAL FOR THE NECESSARY REFORM RESOURCES

States should look forward to negotiating a block, or capped, grant from the Federal government to gain the financial and regulatory autonomy necessary to carry out meaningful Medicaid reform that addresses state-specific needs. The current waiver system is too time consuming and costly for states to attempt, and inhibits innovative reforms that address the pending budgetary nightmare and break down barriers to consistent, quality care for the neediest Americans.

A blocked, or capped, wavier provides states with fixed, upfront funding over a predetermined period of time. Preparing to negotiate for the block or capped grant and reaching an agreement to streamline the waiver approval process will infuses a sense of urgency into the Medicaid program and enables states to unilaterally modify benefits, competitively contract, and pay for performance. The upfront funding encourages states to tackle more complex and costly problems through information technology investments and process re-engineering, which is central to achieving sustainable Medicaid reform.

In January 2009, Rhode Island took the lead on this aspect of reform and became the first state in the nation to cap its entire Medicaid program. The state received approval to operate the Rhode Island Medicaid program under an aggregate budget ceiling of $12.075 billion through 2013. The approved Global Consumer Choice Compact Waiver established an expedited 45 day approval process for any changes to benefits or the Medicaid program during; set new levels of care for determination of long term care eligibility; allowed for benefits in any optional or mandatory program to be customized; placed a priority on preventative services; created a healthy choice account to reward healthy behavior; and implemented new purchasing strategies that focused on quality and competition.

In the first 18 months of Rhode Island's global waiver yielded $100 million in savings, staving off eligibility limitations. The state projects that it will have saved $146 million by June 2011 with an additional $50 million gained through program integrity efforts and aggressively tracking fraud, waste, and abuse. Concurrent with the substantial savings, new expenditure growth in the Rhode Island Medicaid program has declined from over 8 percent to 3 percent in the past 18 months.[xxiv]

Governors have the opportunity to build on Rhode Island's lead and begin to implement innovative Medicaid reform plans that address the short-term and long-term needs of their state. The time is now to prevent state fiscal crises and ensure consistent quality care is available to the neediest Americans.

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