In recent years, plummeting tax revenues have forced many states to implement cost control measures, especially in state Medicaid programs. Despite these efforts, Medicaid spending continues to increase more rapidly than other state budget areas. To examine why costs keep going up and what steps states have taken, The Council of State Governments hosted “Medicaid Today: Confronting Costs, Maintaining Quality” as part of its Health Policy Monitor teleconference series. Panelists included:

- Dennis Smith, director, Center for Medicaid and State Operations, Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services
- Greg Vadner, former director, Division of Medical Services, Missouri Department of Social Services
- Vikki Wachino, associate director, Kaiser Commission on Medicaid and the Uninsured.

The Federal-State Partnership

Created in 1965, Medicaid is a joint federal-state program administered by states within federal guidelines. States receive federal matching funds for 50 percent to 77 percent of the program’s cost.

Broad federal guidelines determine who qualifies for the program, and what services states have to cover. Beneficiaries include certain low-income groups, primarily women and children, who receive cash assistance from the government. Medicaid also provides supplemental coverage for low-income disabled and elderly individuals receiving Social Security assistance. Required services include inpatient and outpatient hospital care, physician care, lab and X-ray and long-term care services, among others. States can also opt to cover additional populations and services and receive federal matching funds for these benefits. Among the optional benefits that states frequently cover are prescription drugs, hearing aids, dental care and vision care.

The federal-state partnership has important implications for cost containment. First, joint control of the Medicaid program means that it has neither the uniformity that one might expect from a federally sponsored program nor the flexibility that state leaders would like in order to fit the program to each state’s needs. States are required to submit state plans to the U.S. Department of Health and Human Services for approval. If they wish to deviate from federal rules governing the program, states must file waivers and receive federal approval.

Second, the populations states cover are very expensive, limiting the money available for expanding coverage to additional groups. States spend most of their Medicaid money on providing health care to elderly, blind and disabled populations. Data show that even though families and children make up more than 70 percent of Medicaid’s enrollees, they account for less than 30 percent of spending. The elderly and disabled populations, meanwhile, make up a little more than 25 percent of enrollees but account for more than 70 percent of Medicaid’s program costs.

Spending Growth

Across the United States, health care spending continues to skyrocket. According to data from the Centers for Medicare and Medicaid Services, overall health care spending increased 8.5 percent in 2001 and 9.3 percent in 2002. Growth in Medicaid spending was even greater: 10.2 percent in 2001 and 11.7 percent in 2002.

Several trends account for this increase, including growing enrollment. With the economic downturn and growing unemployment, Medicaid enrollments increased by 8.5 percent in fiscal year 2002 and 8.8 percent in fiscal year 2003.

Spending growth for specific services also contributed to increased Medicaid costs (Table 1 provides expenditure data by type of service). Even though spending for prescription drugs accounted for only 11 percent of total Medicaid expenditures in 2002, its status as the fastest grow-
patient hospital costs are also key drivers of Medicaid cost growth.

**Cost Containment Strategies**

In response to this growth, states have taken a number of steps to keep Medicaid costs down. “The vast majority of states are reducing provider payment rates or putting new controls on their prescription drug spending. At the same time, increasing numbers of states are reducing benefits, restricting eligibility and increasing beneficiary co-payments,” noted Vikki Wachino.

**Prescription Drugs**

In a 2002 survey, forty-five states indicated they are taking steps to reduce prescription drug costs in one or more of the following ways:

- Using prior authorization more intensively (twelve states),
- Using or expanding preferred drug lists (nine states),
- Reducing payments (eight states),
- Using supplemental rebates on drugs (five states),
- Encouraging or mandating use of generics (two states),
- Setting limits on the number of prescriptions (five states),
- Increasing cost-sharing requirements (seven states).9

Several states, including Florida, Michigan and Oregon, are using preferred drug lists as a way to obtain additional rebates from drug makers and to assure that providers are prescribing the most cost-effective medications.

**Changing the Benefit Mix**

Some states are reducing the types of services covered under Medicaid in order to expand coverage without spending additional dollars. Arizona, Maine, Oregon, Washington, Tennessee, and Utah are among the states using this approach.10 Arizona used its HIFA waiver to combine Medicaid and SCHIP funding to provide coverage to more adults. Utah funded a coverage expansion for primary care services to adults below 150 percent of the poverty level by limiting benefits for certain Medicaid eligibles, folding in a state-funded program, and implementing cost-sharing requirements. These new waivers have reinvigorated the debate over the tradeoff between deep and narrow coverage (e.g., traditional Medicaid benefits) versus shallow but broader coverage (e.g., SCHIP or employer-sponsored coverage). Some state leaders believe that states should extend coverage to more people by providing less extensive benefits, but this is a contentious issue with advocates for the poor.

| Table 1. Medicaid Expenditures by Type of Service, FFY 2002 (in millions) |
|-----------------------------------------------|-----------------|-----------|
| **Acute Care**                               | **$139,554**    | **56.1%** |
| Managed Care and Health Plans                | **$34,837**     | **25.0%** |
| Inpatient Hospital                           | **$32,714**     | **23.4%** |
| Prescribed Drugs                             | **$23,398**     | **16.8%** |
| Outpatient Services                          | **$17,179**     | **12.3%** |
| Other (such as dental, physical therapy, and transportation) | **$16,524**     | **11.8%** |
| Physician, Lab, X ray                        | **$9,244**      | **6.6%**  |
| Payments to Medicare (includes premium and cost-sharing subsidies) | **$5,659**      | **4.1%**  |
| **Long-term Care**                           | **$93,219**     | **37.5%** |
| DSH* Payments                                | **$15,949**     | **6.4%**  |
| **Totals**                                   | **$248,723**    | **100.0%**|

*Disproportionate Share Hospital Payments

Source: Kaiser Commission on Medicaid and the Uninsured, www.kff.org/medicaid/kcmu031104pkg.cfm

Joining Forces

States are also lowering costs by rethinking their relationship with employer-sponsored insurance plans. Rhode Island passed legislation that requires commercial insurers to identify members who may also be enrolled in Medicaid. Also, a number of states, including Rhode Island, Illinois, Massachusetts and Tennessee, are using waivers to provide financial assistance to individuals offered employer-sponsored insurance. States help pay the premiums and other cost-sharing requirements for employer-sponsored insurance at a much lower cost to the state than if individuals were enrolled in Medicaid.

New Mexico’s recent HIFA waiver goes a step further by creating a state-designed health insurance package that will be offered by insurance agents along with private insurance. It is financed through federal, state and employer funds for individuals who are income-eligible.11

“New Mexico…is using the HIFA model to develop new private-public partnerships to expand eligibility and really work with employers to make health insurance available to more people,” said Dennis Smith.

**Other Approaches**

Cutting payments to providers remains a popular method for controlling costs. In a December 2003 survey by the Kaiser Commission on Medicaid and the Uninsured, 39 states reported that, in FY 2004, they had taken some action related to reducing provider payments. Reductions affected all types of providers—doctors, hospitals, transportation services, personal care, etc.12

A few states have looked at the use of health care savings accounts within Medicaid, including Florida, Iowa and Vermont. Under these arrangements, states place a set amount of funds into an enrollee’s “account” to purchase health care services. Then, beyond a certain amount, individuals are responsible for a portion of the costs. The idea is to help patients be more cost-conscious in their use of health care services.

To control long-term care costs, several states, including Arkansas, Florida and New Jersey, have initiated “Cash and Counseling” demonstration projects. These programs provide a set amount of funds as well as guidance to elderly and disabled enrollees who then purchase and oversee the services they need to stay in their homes.

Finally, states are expanding the use of managed care and other means to coordinate care for special high-use populations. Rhode Island has focused its efforts on moving children eligible for Supplemental Security Income and children in foster care into managed care and has achieved significant savings.11
Medicaid’s Financial Future

Even with these changes, states are still challenged to fund Medicaid without severely cutting other programs. With few options remaining, many state policy-makers feel that changes must now be made at the federal level.

“Intensive case management for high utilizing members, disease management, and managed care all work, but they don’t save the kind of money that we need in the current fiscal environment,” said Greg Vadner.

“In the last two years, Missouri has cut a little over $600 million out of the program. Disease management—it’s not going to answer that kind of a problem.”

In 2003, the federal government took one step that enabled states to keep programs from being slashed in the face of enormous state budget deficits. Part of the Jobs and Growth Tax Relief Reconciliation Act of 2003 authorized an additional $10 billion for Medicaid, distributed via a temporary 2.95 percent increase in state matching rates. (This increase expired June 30, 2004.) In a survey conducted by the Kaiser Commission on Medicaid and the Uninsured, state officials reported that this additional match was critical in resolving budget problems and allowed their states to postpone making additional program cuts.

Federal Changes Ahead

Medicare Modernization Act of 2003

The passage of the Medicare Modernization Act of 2003 means many changes for state Medicaid programs. The most significant is the transfer of drug benefits for dual eligibles (individuals eligible for both Medicaid and Medicare) from state Medicaid programs to Medicare. Most state leaders supported the addition of an outpatient drug benefit to Medicare. What they weren’t prepared for was the role that states would be forced to play in paying for and administering it.

In the final version of the legislation, states are required to make a “phased-down state contribution” (commonly known as the “clawback”) to the federal government to assist with the cost of covering dual eligibles. In 2006, states will pay 90 percent of the estimated costs of covering dual eligibles. This number will decrease to 75 percent over the next nine years. After that, the percentage will remain at 75 percent.

States also have additional administrative responsibilities. The law requires states to assist with determining who qualifies for the drug benefit’s low-income subsidies. This may require states to hire and train additional staff or modify computer systems, but they will only receive the regular 50-percent Medicaid matching payment for these administrative costs. States are also required to screen applicants for eligibility for Medicaid programs that provide Medicare premium or cost-sharing assistance. If a significant number of the individuals who step forward to enroll in the drug benefit qualify for assistance but had previously not applied, then state Medicaid programs may see an upsurge in enrollment and costs.

The Congressional Budget Office estimates that states will experience some savings after implementation of the drug benefit: $17.2 billion between 2004 and 2013. However, most of the savings will come in the later part of that period. The CBO estimates that between 2004 and 2006, the MMA will cost states $1.2 billion.

Block Grants for Federal Funding

In the spring of 2003, the Bush administration proposed changing how the federal government administers and funds state Medicaid programs. For those states that opted into the program, instead of the federal government matching state spending on a percentage basis, each state would receive a capped amount based on the amount the state received in 2002 adjusted annually. While states would still be required to cover mandatory populations, they would gain greater flexibility in determining what benefits to cover and what cost-sharing (i.e. co-pays) they could institute. “It provides greater flexibility for states to redesign their programs…and to change the way they deliver services,” said Smith.

For the most part, states were wary of the proposal and worried that eliminating the entitlement would shift too much of the financial risk for providing care onto states. The proposal did not move forward as outlined originally by Secretary Thompson, but since then individual states have explored working out just such an arrangement with HHS. A letter from U.S. Senators Charles Grassley and Max Baucus dated June 16, 2004 expressed concern that CMS was conducting negotiations with several states that would essentially use a 1115 state demonstration waiver to block grant federal funding.

State Funding Mechanisms

As the Medicaid financial crisis has deepened, states have turned to alternative mechanisms for raising revenue for Medicaid, including special provider taxes, intergovernmental transfers (IGTs), use of upper payment limits (UPLs) and other legal, but controversial, methods that maximize federal dollars. Officials in the administration and Congress have placed greater scrutiny on the use of these types of financing mechanisms and have threatened to eliminate them completely.

In January 2004, the Bush administration issued an emergency rule authorizing CMS to change the way it collects information about state

Additional Resources

funding. With the change, CMS would have the opportunity to review state sources of Medicaid funding, even prior to a governor or state legislature reviewing or approving funding for the program. Following a huge outcry from states and state associations, including CSG, the administration delayed implementation of the requirement and agreed to work with states to come up with a more workable solution.

On another front, the House Subcommittee on Health held a series of hearings in the spring of 2004 that examined the use of intergovernmental transfers by states. State representatives argued that IGTs are legitimate means of sharing revenue between a state and its counties. A Government Accounting Office report, though, seriously questioned some states’ use of the transfers.

CMS is also vigorously reviewing any use of alternative financing mechanisms when states submit state plan amendments and waivers. Several states have gone through lengthy negotiations to receive approval for changes to their Medicaid programs.

Conclusion

It is doubtful that the state struggle to control Medicaid costs without sacrificing quality will be over anytime soon. Even though economic indicators point to recovery and growth, the outlook for state budgets remains gloomy. Nevertheless, response to the current fiscal crisis has revealed states’ ability to rethink benefit design, coordinate coverage with other payers and providers, and search for ways to leverage funds from a variety of sources. These skills will be critical as states continue to work to maintain coverage and protect the quality of their Medicaid programs while encouraging and dealing with policy changes at the federal level.

3Ibid.