States pursue new Medicaid cost-containment strategies

by Tim Anderson

The rising cost of Medicaid and its impact on state budgets has sometimes overshadowed another story that health care experts say is worth telling.

The public health insurance program has been relatively cost-efficient in providing care.

During the first three years of this decade, for example, per-enrollee spending rose by an annual average of 6.1 percent — a rate that compares favorably with the yearly increases of 10.1 percent in the private health insurance market.

"It's not Medicaid that is driving runaway health care costs," says Greg Moody, a principal at Health Management Associates Inc., a health care research and consulting organization. "Instead, the program is operating in the context of a broader issue.

"Health care costs are consuming a greater share of our country's productivity, whether it's coming out of a paycheck or a state budget."

This trend, while out of the control of states, has only intensified policymakers' efforts to find more efficiencies and cut costs in Medicaid where they can.

An October 2004 study by the Kaiser Commission on Medicaid and the Uninsured illustrates the wide array of cost-containment strategies being employed. In fiscal year 2005, for example, most states cut or froze provider payments and developed new plans to control prescription drug costs. Other strategies have included expanding the use of managed care among Medicaid participants, cracking down on abuse and fraud, cutting benefits or eligibility, and implementing new co-payment requirements.

The report also found that more and more states are focusing efforts on their high-cost Medicaid populations — the elderly and disabled — through new long-term care and disease management programs.

These various strategies have been credited as one reason that spending growth in the program dipped below double digits in 2003 and 2004.

But despite efforts to improve efficiency and cut costs, numbers still aren't adding up for states. Rises in Medicaid expenditures continue to outpace tax revenue growth.

"Unless we can do more to control the costs, it will eat our budget alive," Kansas Republican Sen. Jim Barnett of Emporia says.

Number of states undertaking new Medicaid cost-containment strategies (fiscal years 2002 to 2005)

Cost-containment strategy	2002	2003	2004	2005
Curb prescription drug costs	32	46	48	43
Cut/freeze provider payments	22	50	50	47
Reduce/restrict eligibility	8	25	21	15
Reduce Medicaid benefits	9	18	19	9
Increase co-payments	4	17	20	9
Disease/case management	11	13	18	28
Long-term care initiatives	7	10	14	17

Source: Kaiser Commission on Medicaid and the Uninsured

Ideas in Medicaid reform

This is the second in a three-part series examining how states are trying to contain costs and improve care in their Medicaid programs. The first article examined Iowa's attempt to expand and improve its program. The third article in the series will focus on the future of Medicaid and state-federal relations in health care.

Reflecting that concern, policymakers around the region have continued this year to seek ways of reining in Medicaid spending growth.

Ideas from 3 Midwestern states

This year, Barnett helped shepherd a bill through the state Legislature that creates a new Kansas Health Authority. In addition to overseeing the state's Medicaid program, the authority — made up of gubernatorial and legislative appointments — will be in charge of various other state health care services.

The most immediate savings are expected to come from improving administrative efficiencies and bolstering Kansas' buying power in the health care market. But Barnett expects a long-term payoff as well.

"We have had multiple parts of state government dealing with health care, but there has not been a single group looking at how we spend our money," he adds.

"With the authority, we now have a platform for a group to focus on finding efficiencies, scrutinizing spending and developing new health care strategies for the state."

Ohio also wants to take a more coordinated approach to Medicaid spending and services. One idea being pursued in that state is to make administration of the program a cabinet-level agency.

Meanwhile, as part of the new budget approved by lawmakers, Ohio will move forward with a slew of other Medicaid reform ideas.

• All families and children covered under Medicaid must participate in a managed care program, eliminating the fee-for-service model. While there will be up-front costs involved in the transition, the state expects to save money both during and after the current biennium.

States' tax revenue growth vs. Medicaid spending increases

Fiscal year	Tax revenue	Medicaid spending
1997	+5.0%	+3.9%
1998	+5.9%	+6.8%
1999	+5.0%	+7.1%
2000	+4.9%	+8.5%
2001	+1.0%	+10.9%
2002	-6.8%	+12.9%
2003	-3.4%	+9.4%
2004	+3.4%	+9.5%

Source: Rockefeller Institute of Government (data used in Kaiser Commission on Medicaid and the Uninsured report)

• Ohio revamped its estate recovery process. With the change, the state can now recover more assets from a deceased Medicaid recipient.

• Several long-term care initiatives have been established in the budget, many of which address the state's goal of encouraging the use of home and community-based services instead of nursing homes. Changes include making assisted living a Medicaid option and improving the pre-screening process for future program recipients. A long-term care resource center also will be created to make the elderly and disabled more aware of their health care options.

• Some of the strategies highlighted in the Kaiser Commission report also are part of Ohio's new budget. Medicaid benefits were changed, provider rates were frozen, eligibility requirements were stiffened, new co-payments for services were created, and tougher statutes against fraud and abuse were enacted. In addition, Ohio will encourage greater use of generic prescription drugs and initiate more audits of Medicaid providers.

Many of the recent steps taken in the state reflect recommendations made earlier this year by the Ohio Commission to Reform Medicaid — a group created by the governor and Legislature in 2003.

A recently created legislative committee in Wisconsin has just begun its task of trying to find Medicaid savings.

"The real expenses and costs, and therefore the opportunity for improvement and innovation, is in long-term care," says Curt Gielow, a Republican from Mequon and chair of the Wisconsin Assembly Committee on Medicaid Reform. "That is what our committee is going to focus on in the coming months, particularly opportunities to de-institutionalize care.

The committee also will look at other emerging issues in this area, including encouraging or requiring the purchase of long-term care insurance and more closely scrutinizing cases of asset divestment.

"We're very concerned about situations in which people have money, they give it to family members, and then they expect the state of Wisconsin to pay for [their long-term care costs]," says Rep. Sheldon Wasserman, another member of the committee.

The Milwaukee Democrat hopes the state pursues several other ways to contain costs in its Medicaid program. For example, he believes greater scrutiny of durable medical equipment purchases could yield significant savings. He and Gielow also say the state can be more aggressive in requiring use of generic prescription drugs by Medicaid recipients.