Medicaid and State Budgets

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Agenda

- Background
- Options
- What states are doing
Medicaid: America’s Largest Health Program

- 71 Million enrolled nationally at some time, for any length of time, in 2010
- 58 Million Average Monthly Enrollment

Medicaid 2010 Spending: $412 Billion
1/6 of $2.6 Trillion in U.S. Health Spending

Medicaid Total Annual Spending = 2.4% of GDP


Annual growth rate:

10.2% 7.1% 5.1% 3.4% -0.6% 1992 1993 1994 1995 1996 1997 1998 Annual growth rate: 9.3% 7.5% 3.2% 4.3% 3.2% 0.2% 2002 2003 2004 2005 2006 2007 2008 2009 (Proj.) 5.4% 3.0% 6.6% 2010 (Proj.)

Figure 6

Total Medicaid Spending Growth, 1996-2010

NOTE: Data for State Fiscal Years, for total Medicaid spending, including state, local and federal funds.

Figure 7
Total and State Funds Medicaid Spending Growth
FY 2000 - FY 2010


ARRA Enhanced FMAP (2009-2010)
End Of ARRA FMAP in July 2011

- States will see increase non-federal share by over 30% due to loss of FMAP inflation and enrollment growth
- Ca. with 50% FMAP could see a 30% growth
- Arkansas with 71.37% FMAP could see 44%
- Florida at 55.45% FMAP could see a 36% growth

Examples assume just a 5% cost growth
Options
Types of Budget Reductions

- Eligibility
- Provider Rates
- Benefits
- Utilization Controls
- Improved Purchasing
- Cost Sharing
- Anti-Fraud
Types of Revenue

- State taxes
- Provider taxes
- Intergovernmental transfers
- Revenue Maximization
- Third Party Liability
Eligibility

- Normally an option states use to control budget
- Option is prevented by maintenance of effort requirements
  - ARRA
  - PPACA until 2014
- Cannot adopt more restrictive standards, methodologies or procedures
Provider Rates

- Most common reduction by states
- Many rate reduction options
- Considerations
  - Reducing rates in one area may cause cost increases in another
  - Federal Litigation-9th Circuit Court Decision
  - CMS approval of SPA
  - Impact on access and quality of care
  - Managed care rates must be actuarially based
  - Provider taxes affect state’s ability to reduce rates
Benefits

- States that provide optional benefits can eliminate them for adults
  - EPSDT and nursing facility requirements
- States can establish limits on benefits for certain adults
  - Can be soft or hard

Considerations
- Reducing benefits in one area may cause cost increases in another
- Federal Litigation-Medicaid Rules and Olmstead
- May need to address transition issues
- CMS approval of SPA
- Impact on access and quality of care
Utilization Controls

- States may impose utilization controls to ensure appropriateness of treatment being funded
- Wide range of controls and screens
  - Prior Authorization
  - Step care therapy
  - Post payment reviews
  - Hard or soft edits
  - Bundling and unbundling and order of billing
  - New edits and audits for FFS
Improved Purchasing

- Medicaid has significant market share
- Can be used to reduce cost and increase quality
- Range of benefits including drugs, DME, medical supplies, etc
- Provider and manufacturer contracting
- Centers of Excellence
Cost Sharing

- Having enrollees pay a share of the cost of services
- Personal Responsibility-reduction in inappropriate utilization
- Enrollee assumes portion of responsibility for services
- Considerations
  - May cause care to be delayed resulting in higher cost care later
  - Medicaid Rules complex and prescriptive
  - May result in a reduction in provider reimbursement
Anti-Fraud

- In some states may be a untapped area for savings
- Fraud in Medicaid is a reality
- Numerous methods and vendors
- Fraud undermines the entire program
- Politically popular reduction
Provider Taxes

- Provides a means to generate revenue specific to fund Medicaid
- Use is growing as budgets decrease
- Can provide needed provider rate increases/avoid decreases
- Can provide money for the state
- Some provider types work better than others
- Federal rules complex but taxes can work
- Federal categories need updating
Intergovernmental Transfers

- Still allowed by Medicaid
- Specific federal rules
- Must now be voluntary by a local entity
- Provides an opportunity to obtain non-federal share of program
- UPLs and managed care
Revenue Maximization

- While most states have focused on this, still may be opportunities.
- Allowable federal funding can replace state funding
- States should make sure their reviews are current
- Opportunities with state and local programs and certain inmate care
Third Party Liability

- Provides an opportunity to shift cost or collect money from other liable 3rd party entities
- Wide range of programs and activities
- Electronic matches can improve effectiveness
- Contingent fee contracts are matchable
What States Are Doing
Figure 24
Shortfalls Forced Most States to Slow Medicaid Spending, Mainly Provider Payments

States with Improvements

States with Program Restrictions

Provider Payments | Eligibility | Benefits | Long Term Care

33 | 1 | 10 | 8
39 | 0 | 15 | 12
48 | 1 | 15 | 32
44 | 0 | 13 | 35

NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals. Eligibility includes eligibility and application expansions/restrictions.

Figure 25
States with Provider Rate Changes
FY 2007 – FY 2010

States with Rate Increases

States with Rate Restrictions

Any Provider  Inpatient Hospital  Physicians  MCOs  Nursing Homes

2007  2008  2009  Adopted 2010

NOTE: Past survey results indicate adopted actions are not always implemented. Any provider also includes outpatient hospital, dentist, home health, and home and community service providers. Rate restrictions include rate cuts for any provider and also frozen rates for inpatient hospitals and nursing homes.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008 2009. Data from 50 states.
Figure 26

States Cutting Medicaid Rates for Inpatient Hospitals, Physicians, Nursing Facilities or Managed Care Organizations

Number of States

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<th>FY 04</th>
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<th>FY 06</th>
<th>FY 07</th>
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Figure 27

States Cutting or Restricting Benefits
FY 2003- FY 2010

Figure 28

Medicaid Pharmacy Cost Containment Measures in Place by FY 2009

- Prior Authorization Program (outside PDL): 46
- Preferred Drug List: 45
- Supplemental Rebates: 44
- State MAC Program: 44
- Member of Multi-state Purchasing Coalition: 26
- Script limits: 16

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009.
## Medicaid Prescription Drug Policy Changes FY 2008 -- FY 2010

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<th>Policy Change</th>
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<th>2009</th>
<th>Adopted 2010</th>
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<td>New/Expanded Preferred Drug List</td>
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<td>Seek/Enhance Supplemental Rebates</td>
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<td>New or Lower State MAC Rates</td>
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<td>More Rx Under Prior Authorization</td>
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**SOURCE:** KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008 and 2009.
Medicaid Managed Care Changes
FY 2008 -- FY 2010

Note: Changes to long-term care managed care not asked in 2008 survey.