

# MEDICAID: 10 FIXES THAT WORK

OF ALL THE REFORMS STATES HAVE TRIED, THESE ARE THE ONES THAT HOLD THE MOST PROMISE.



By Martha King and Dianna Gordon

The national economy hit states hard. Most cut their budgets, and Medicaid wasn't spared. States have trimmed services, cut provider payments and taken people off the rolls. Yet Medicaid continues to consume a larger and larger slice of revenues.

Over the past 15 years, Medicaid's piece of the budget has doubled from about 10 percent to 20 percent of spending.

State budgets grew an average of 1.2 percent in 2002, but Medicaid costs increased by 12.8 percent. The 2003 increase was 9.3 percent. And experts see no relief in sight. The Congressional Budget Office anticipates Medicaid costs will keep growing by at least 8 percent a year.

All 50 states and the District of Columbia have worked to contain

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costs and slow growth over the past couple of years, specifically by targeting provider payments and drug expenditures. In addition, nearly half the states have restricted eligibility, reduced benefits and increased copayments.

These approaches may be necessary in the short term. But many quick fixes could trigger costly consequences:

- ◆ Patients denied certain services may get sicker and ultimately seek more expensive treatments (e.g., people with diabetes or mental illness may need hospitalization if they cannot get needed medications.)
- ◆ Shifting costs to providers could cause them to drop out of the program. Or they may charge insured patients more, driving up private insurance premiums.

## IMPORTANT TO THE BIG PICTURE

However costly, states aren't ready to scrap their Medicaid programs entirely, even if they could. Medicaid contributes substantially to every state economy. According to the Kaiser Commission on Med-

icaid and the Uninsured, it accounts nationally for:

- ◆ 17 percent of total personal health care.
- ◆ 48 percent of nursing home care.
- ◆ 17 percent of prescription drug payments.
- ◆ 17 percent of hospital care.

Medicaid—at least 50 percent of each state's spending is paid by the federal government—pays for about 35 percent of the nation's births. It also funds services to nearly one third of all Americans over the age of 85, including prescription drugs and long-term care not covered by Medicare.

So states keep searching for longer term reforms to meet the needs of their most vulnerable citizens. Below are the top 10 fixes:

## 1. REFORM LONG-TERM CARE

States can save a lot by fixing expensive long-term care for low-income people with serious medical needs. Up to 40 percent of a state's Medicaid spending can go to long term care.

In just a few years, Maine cut the time Medicaid clients stay in nursing homes by 44 percent. The state also reduced the percentage of long-term care clients who live in nursing homes. And the total per person spending on Medicaid-funded long-term care has dropped by 12 percent.

Maine tightened medical eligibility standards, substantially increased service capacity in the community and controlled administrative costs and per person expenditures. Because home care and assisted living generally cost less than institutional care, Maine has been able to serve more people with only modest increases in total spending. The number of people using long-term care services has increased by 30 percent since 1995, while total spending has increased only 17 percent.

"It's not often you have the opportunity both to save money, and respond to consumer preferences," says Christine Giano-poulos, Maine's director of Elder and Adult Services.

## 2. FOCUS ON THE SICKEST PEOPLE

People who are seriously and chronically ill account for a significant amount of Medicaid spending, even though they are a small percent of all Medicaid patients. By giving patients more intensive ongoing services, states can prevent or reduce serious problems later and save money.

At least 21 states have programs to manage diseases—mainly asthma and diabetes—of chronically ill Medicaid beneficiaries. The goal is to improve their health and control costs. The jury is still out on how much is saved, but the theory is that the initial investment will pay off down the road.

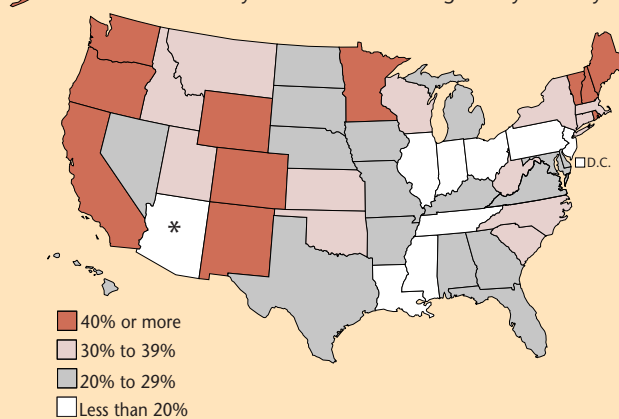
Florida, one of the first states to experiment with disease management, had hopes of saving \$112.7 million over four years. Although that proved too ambitious, the state did realize \$42.2 million in savings over five years.

"We tried a number of approaches and programs, and are pleased with the results so far," says Heidi Fox, an administrator for the Florida Agency for Health Care Administration.

Despite the mixed results on savings, other states are testing new approaches to disease management and evaluating them.

## PERCENT OF MEDICAID LONG-TERM CARE SPENDING USED FOR COMMUNITY-BASED SERVICES

The U.S. Supreme Court's 1999 Olmstead decision encourages states to provide more long-term care for people with disabilities in their homes and communities. Some states have been very successful at this. It is generally a money saver.



\* Comparative data for Arizona's managed long-term care program was not available.  
Source: The MEDSTAT Group, 2002. U.S. territories were not included in the study.

## 3. EMPHASIZE PREVENTION

States that invest in keeping people healthy can avoid more costly health problems down the road. How? An investment in prenatal care, well-child visits and immunizations can prevent costly illnesses among Medicaid patients.

A pilot program in North Carolina is one example. The Community Care Plan of Pitt County, which started with 12,000 Medicaid clients, increased preventive health check-ups by 330 percent and sick visits by 60 percent between 2000 and 2001. While Medicaid costs continued to rise around the state, the Pitt County project saved money.

"The savings came from reducing emergency room visits and hospitalizations," says Dr. Charles Willson, president of the state's chapter of the American Academy of Pediatrics.

The physicians focused on health and safety, making sure children were immunized and their parents were aware of such things as using car seats, locking cabinets and having kids wear bike helmets. The project also offered an after-hours pediatric clinic and worked with a local hospital to provide a 24-hour nurse hotline.

"By focusing on prevention and giving our patients an after-hours option, we saw a 20 percent decline in ER visits our first year," says Willson. Today, the pilot has expanded to become Community Care of Eastern North Carolina, serving more than 50,000 children and youths.

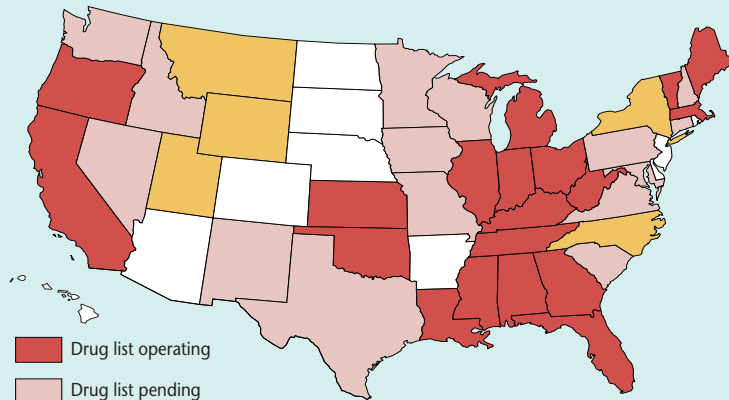
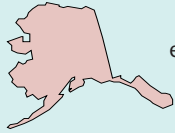


SENATOR  
**BURT SAUNDERS**  
FLORIDA

## PREFERRED DRUG LISTS AIM AT MEDICAID SAVINGS

Prescription drug costs have risen dramatically over the past several years and now account for at least 11 percent of Medicaid spending—an estimated annual increase of 18.8 percent.

To save money, states have developed by law or regulation lists of less expensive, medically sound medicines from which physicians can choose for their patients.



■ Drug list operating

■ Drug list pending

■ Plans not final (may be delayed or blocked)

Note: Operational status may vary. November 2003. Source: NCSL

4.

### REDUCE PRESCRIPTION DRUG COSTS

States have saved millions of dollars by implementing prior authorization, preferred drug lists and supplemental rebates, and by requiring generic drugs.

And that's important when prescription drug costs now account for 11 percent of Medicaid spending with annual increases of 18.8 percent through 2002.

Maine is saving \$15 million a year after adding 70 frequently prescribed medicines to its list of drugs that require prior authorization. Michigan saved \$44 million from an annual pharmaceutical budget of \$540 million in 2002 by requiring doctors to seek prior authorization for any medications not on a list of medically sound and cost-effective drugs.

Some states have sought rebates from manufacturers. These are in addition to the federal rebates established in 1990 that return nearly 20 percent of the total price back to Medicaid (about \$4.9 billion in 2000). Florida and Michigan were convinced they could negotiate even better prices if increased rebates led to a spot on the list of preferred products.

Courts have upheld the approach, if rebates are approved in advance through amendments to state Medicaid plans. At

least 20 states are now investigating or using such supplemental rebates. Many states also explicitly require generic drugs for patients.

Since federally qualified health centers are allowed to purchase pharmaceuticals through the 340B Drug Pricing Program at a deeply discounted price (even below the Medicaid price), states may save by expanding their use. Massachusetts estimates a savings of between \$15 million and \$27 million, if just 25 percent to 50 percent of their current Medicaid prescriptions are filled by qualified health centers.

Some states have hired management firms to help them trim the cost of medicines. Virginia and California, for example, just signed on with AmeriHealth Mercy, which has managed to keep its average Medicaid pharmacy increases to 8.8 percent compared to the national trend of 18.8 percent. They call their program PerformRx.

5.

### INVESTIGATE FRAUD AND ABUSE

Florida was losing \$1 billion a year before lawmakers began to crack down on fraud.

"The pressure on Medicaid is to receive bills and pay them as quickly as possible because providers need the cash flow," says Senator Burt Saunders. Unfortunately, that

makes it hard to investigate possible fraud.

So the Legislature authorized hiring specialists to design a Medicaid fraud software program that analyzes medical bills. More enforcement staff were hired, adding "a hundred people to find fraud, investigate and prosecute" he says.

The beefed-up investigative and enforcement policies led to the discovery of a number of fake Miami clinics that had billed Medicaid \$25 million over a year's time. "We found out there were no clinics, no doctors, no patients. Some smart person had rented a P.O. box and simply started billing Medicaid," the senator says. Now an on-site inspection is conducted before any Medicaid license is issued.

Saunders says that, so far, fraud has been cut in half. "That's a huge savings."

6.

### USE ELECTRONIC RECORDS

Arkansas saved an estimated \$30 million over 17 months by creating an integrated electronic billing, eligibility verification, payment, data collection and analysis system.

"Medicaid cannot continue to grow by double digit funding without deep cuts," says former state Medicaid director Ray Hanley who now works for Electronic Data Systems Corporation, a private firm that designs electronic billing and data collection systems. He says getting smart with technology can help avoid those cuts.

Arkansas developed one of the country's first "decision support systems. That's a data warehouse that can hold three to five years' worth of claims," Hanley says. "A staff member can sit down and do reports far faster from the computerized database than the old ledger system."

The state now runs an e-business system that includes photo ID cards with patient information on their magnetic strips. At a doctor's office, the patient's card is swiped through a computer terminal, and eligibility and benefits are verified. The system also confirms payment and electronically deposits it in the physician's bank account.

Other firms such as First Health Services and ACS also offer this technology and are competing for these lucrative state contracts.

In Arkansas, the technology has:

◆ Reduced the time for processing claims from 15 days to 3.5.

◆ Cut collection expenses for Medicaid claims.

◆ Dropped claim denials from 12 percent to 1 percent at a large children's hospital due to more efficient processing.



### 7. GET THE MOST OUT OF FEDERAL FUNDING

States have tapped additional federal funds by identifying services they already pay for that qualify for matching money.

In the past, states have used creative financing schemes, such as taxing providers and tapping intergovernmental transfers, to “draw down” additional federal funds. In recent years, however, Congress has made it tougher for states to be creative. Other state approaches to leveraging additional funds have been limited.

So by identifying matching programs, states can save more. For example, some special education programs, services for foster care children or substance abuse treatments may qualify for federal Medicaid reimbursement if the people served meet certain criteria. Oregon recently converted its state-funded insurance program for low-income families to Medicaid to take advantage of federal funding to help finance it.

A new Medicaid 1115 Pharmacy Plus waiver allows states that run pharmaceutical subsidy programs to gain federal matching funds for people age 65 or older with incomes between 100 percent and 200 percent of federal poverty guidelines (\$12,120 to \$24,240 for a family of two). Depending on the size of the state, this option can save millions in pharmaceutical costs and allow additional people to be covered.

Florida, Illinois, Indiana, Maryland, South Carolina and Wisconsin have received waiver approval as of November 2003. At least nine others have filed applications. However, new budget neutrality requirements make it more difficult for states to qualify for these 1115 waivers.

Rhode Island, which has applied for such a waiver, plans to combine three existing state-funded groups and get a 55 percent federal match. “This waiver program should be a win-win for the people of Rhode Island,” says former Senate President William Irons. However, the new Medicare law puts the future of this program into question, and the status of existing programs is under review.

## STOP-GAP SOLUTIONS 2002-2003

	Eligibility Limits	Optional Services	Reimbursement Rates	Cost-Sharing
Alabama				
Alaska	•	•	•	
Arizona	•		•	•
Arkansas				
California	•	•	•	
Colorado	•	•	•	•
Connecticut	•	•	•	•
Delaware		•	•	•
Florida	•	•	•	•
Georgia	•	•	•	•
Hawaii			•	
Idaho		•	•	
Illinois			•	•
Indiana		•	•	•
Iowa		•	•	•
Kansas		•	•	•
Kentucky			•	•
Louisiana		•		
Maine			•	•
Maryland	•		•	•
Massachusetts	•	•	•	
Michigan		•	•	•
Minnesota	•	•	•	•
Mississippi		•	•	•
Missouri	•	•	•	•
Montana		•	•	•
Nebraska	•	•	•	•
Nevada		•	•	•
New Hampshire				
New Jersey	•	•	•	•
New Mexico		•	•	•
New York	•		•	
North Carolina	•		•	
North Dakota		•	•	•
Ohio		•	•	•
Oklahoma	•	•	•	•
Oregon	•	•	•	•
Pennsylvania		•	•	
Rhode Island			•	
South Carolina			•	•
South Dakota			•	
Tennessee			•	
Texas	•	•	•	•
Utah		•	•	•
Virginia		•	•	•
Vermont		•	•	•
Washington	•	•	•	•
West Virginia				
Wisconsin		•	•	•
Wyoming				•

Source: Health Policy Tracking Service



### 8. LEVERAGE FEDERAL FLEXIBILITY

States have never had more flexibility to craft Medicaid reforms, especially in covering additional people through the 1115 waiver process. Expanding the number of people covered by Medicaid can save state, local and provider contributions that go toward other programs to cover the uninsured.

Utah received a first-of-its-kind federal waiver in March 2002 to cover up to 25,000 additional low-income adults. The “firsts” are a benefit

package for new enrollees limited to primary and preventive services financed in part by savings from a reduction in benefits to the already enrolled Medicaid population.

Rod Betit, former director of the Utah Department of Health, described the program as an investment in “front-end” services with the potential to save the state money on hospitalizations and emergencies down the road. “The state wanted to meet the day-to-day needs for uninsured adults, provide access to primary care providers and encourage them to use the health care system more appropriately,” he said.

Another potential way to gain funds by expanding coverage is to define eligibility for the federal category known as “aged, blind and disabled” to include people with incomes up to 100 percent of federal poverty. Since a high percentage of these individuals have Medicare coverage for most primary and catastrophic illnesses, this change mostly allows access to pharmaceuticals, reimbursable by the full federal matching funds. At least 20 states have adopted the 100 percent standard (\$8,980 per year for an individual in 2003).

**9. EVALUATE THE PROGRAM**

Seeing rising costs and plummeting resources, South Carolina lawmakers asked the Legislative Audit Council to examine the Medicaid program for the state Department of Health and Human Services. The result: \$22.9 million in potential savings that included using a preferred drug list (\$12.8 million) and starting a Medicaid enrollment fee (\$1.4 million).

Many of the council recommendations have passed the House and are now before



REPRESENTATIVE  
**ADAM TAYLOR**  
SOUTH CAROLINA

the Senate Committee on Medical Affairs. Representative Adam Taylor says House members spent more time debating Medicaid reform than the budget.

“We passed this bill with one purpose in mind: Clean up the Medicaid system,” he says. One of the major provisions of the bill is tightening eligibility for recipients, says Taylor, “which is key.”

He also wants accountability. “Before I put any more money in this program, I wanted an audit of the [health and human services] department.”

**10. MAKE MEDICAID THE PAYER OF LAST RESORT**

By law, Medicaid can pay only for services not covered by other public or private insur-

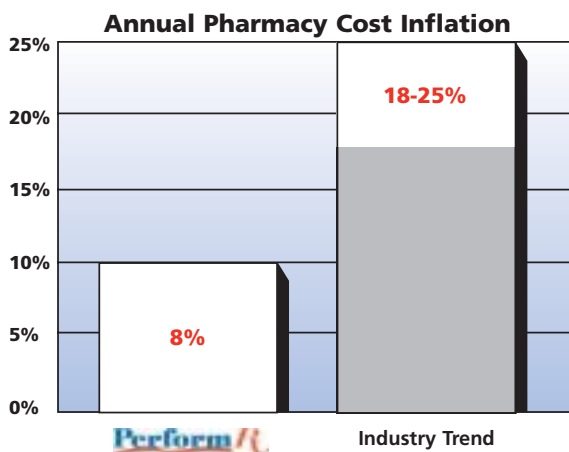
ance or other payers. Sometimes states have to be creative in maximizing the role of other payers.

In crafting its long-term care reforms, Maine was able to shift more of the state’s nursing home costs from Medicaid to Medicare. Since Medicare’s funding comes from the federal government, Maine was able to save state money. “Requiring nursing homes to certify beds for both Medicaid and Medicare payment ensures that residents use their Medicare skilled nursing facility benefit for the initial part of the nursing facility stay, rather than having Medicaid pay from Day 1,” said Christine Gianopoulos. The result: The number of admissions Medicare paid for increased 559 percent between 1993 and 2001, while the number of Medicaid admissions increased only 40 percent.

**FRESH APPROACHES**

You cannot reform your Medicaid programs overnight. But if you can assess the current situation, learn from other states, determine how you may improve people’s health while achieving efficiencies, you may accomplish reforms that will save money over time.

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