

MEDICAID COST CONTAINMENT: RECENT PROPOSALS AND TRENDS

Medicaid cost containment is a dominant theme in governors' proposed fiscal 2012 budgets

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Summary

Funding ongoing Medicaid programs is one of the greatest challenges for states. In governors' proposed budgets for fiscal 2012, cost containment in Medicaid is a dominant theme. Medicaid spending is estimated at \$354 billion in fiscal 2010, according to NASBO's *2009 State Expenditure Report*. As a result, Medicaid surpassed elementary and secondary education as the largest component of total state spending for the first time since 2006 based on estimated fiscal 2010 spending data. Based on feedback from various budget officers, there are still significant opportunities to save money and contain costs within the Medicaid budget. NASBO will continue to monitor and report on cost containment ideas in Medicaid and other health care spending.

Background

The confluence of the end of the enhanced Medicaid funds from the Recovery Act, the less than stellar revenue growth, and the rapid growth in health care costs creates an enormous challenge for governors as they manage state budgets in fiscal 2012 and 2013. The release of the *2010 Actuarial Report on the Financial Outlook for Medicaid* by the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary in December 2010 underscores the challenges ahead. As stated in the report, Medicaid costs will almost certainly continue to increase as a share of gross domestic product (GDP) in the future and will be a serious strain on states' budgets. Medicaid is projected to increase at an average annual increase of 8.3 percent over the next 10 years according to the CMS Office of the Actuary.

Medicaid cost containment proposals follow on the heels of state actions to address Medicaid costs the past several years. While past strategies primarily focused on reducing and freezing provider reimbursements, states also reduced optional benefits, imposed increased taxes and fees on providers, limited prescription drugs, eliminated benefits, and expanded managed care in the past two years. Due to the maintenance-of-effort requirement that was extended under the *Affordable Care Act*, changes to eligibility, processes and procedures are prohibited with a limited exception.

In governors' budget proposals for fiscal 2012, Medicaid savings may be a target figure rather than a specific set of proposals. In many cases there will be a negotiation about specific actions and policies to achieve the savings. While some of the strategies include a continuation of recent actions to reduce provider reimbursements and benefits, there are also longer-term strategies that include market reforms.

Below are some examples and trends of Medicaid cost containment in governors' budget proposals for fiscal 2012 as well as general trends in state actions to contain Medicaid spending. NASBO will continue to monitor and report on governors' proposals to contain Medicaid costs as part of the forthcoming spring *Fiscal Survey of States* report.

States Consider Reducing Provider Reimbursements

Many states, including California and Texas, are proposing to reduce provider reimbursements for fiscal 2012. In California, the governor's budget proposes

to reduce provider payments by 10 percent for physicians, pharmacy, clinics, medical transportation, home health, Adult Day Health Care, certain hospitals, nursing facilities, and long-term care facilities. Based on a preliminary review of governors' fiscal 2012 budget proposals, at least a third of the states proposed either a reduction or freeze in provider reimbursement rates. To address cost concerns, 39 states in fiscal 2010 implemented a provider rate cut or freeze compared to 33 states in fiscal 2009. In fiscal 2011, 37 states have planned provider rate restrictions, according to the Kaiser Commission. Provider rates are linked to economic conditions and under budget pressure states are often forced to reduce rates until economic conditions improve.

Expansion of Managed or Coordinated Care

Increased focus on managing care, including increased use for populations not traditionally in managed care, is a theme in governors' budget proposals for fiscal 2012. There are potential significant savings through the expansion of managed care. A number of states, including Florida, are considering significant expansions of managed care plans in an attempt to control costs. States are also focusing on Medicaid recipients with chronic conditions through the use of medical homes as a means to coordinate care. Wisconsin, for example, is looking at giving fixed "bundled payments" to providers to oversee all aspects of care for people with chronic diseases. Thirteen states in fiscal 2010 and 20 states in fiscal 2011 implemented or planned to expand managed care by expanding service areas, adding eligibility groups, requiring enrollment into managed care or implementing managed long-term care initiatives. Sixteen states in fiscal 2010 and 13 states in fiscal 2011 are implementing new or expanded disease management programs according to the Kaiser Commission.

Strategies to Decrease Utilization

Increases or instituting new co-payments, limits on doctors' visits and limits on prescriptions are all strategies used to decrease utilization. The approach is to require beneficiaries to share in the costs of services as a means to decrease utilization. California's budget, for example, proposes utilization controls at a level that ensures that 90 percent of beneficiaries who utilize a particular service remain unaffected, which is consistent with federal Med-

icaid law. Iowa, for example, may consider using more generic drugs and increasing co-payments for some enrollees. States have had success in lowering costs through increased utilization of generics where appropriate. Some recent research has shown that there is still capacity in Medicaid programs to save money by creating incentives, or instituting requirements, to increase the use of generics.

Pharmaceuticals

States continue to look for savings in pharmaceuticals with key strategies involving greater use of generic drugs. States also look at the appropriateness of specific pharmaceuticals and seek the most appropriate dosage and combination of therapies, particularly for chronic diseases such as asthma which require ongoing medication. CMS is working with states to drive down pharmaceutical costs, such as relying more on generic drugs, mail order, management relating to over-prescribed high cost drugs, and use of health information technology to encourage appropriate prescribing and avoidance of expensive adverse events.

There are examples of alternative forms of pharmaceutical therapies that are not only cheaper for states but also safer for Medicaid enrollee patients. Several years ago, managed care entities like Kaiser Permanente found that they could save significant amounts by encouraging the use of cheaper pain killers like ibuprofen than costlier COX-2 inhibitors that can have significant side effects. In another example, in the treatment of asthma, which represents nearly \$10 billion in health care spending per year, there are other opportunities to increase the use of less expensive but safer treatments. The Food and Drug Administration (FDA) has recommended certain expensive treatments for asthma as second line therapies because of a higher risk of death associated with the use of those products.

With 20 million Americans suffering from asthma, there is presumably significant cost savings possible and states could encourage the use of first line therapies to reduce costs and improve outcomes. These are just few examples of instances in which less costly treatments are in many cases actually safer than the costlier treatments. Medicaid policies should be examined to ensure that costs are being contained and the least problematic treatments are being prescribed.

According to the Kaiser Commission, 30 states implemented cost-containment initiatives in the area of prescription drugs in fiscal 2011 with the majority of actions involving additions, expansions or refinements of existing prior authorization programs, preferred drug lists, supplemental rebate programs, and state maximum allowable cost programs.

Eligibility Changes

Arizona was granted a waiver from the maintenance-of-effort requirements under the *Affordable Care Act* in order to reduce Medicaid eligibility for certain non-disabled adults as a way to preserve its underlying Medicaid program. Arizona is one of only six states that currently covers childless adults in its Medicaid program, so it is not necessarily clear that many states would see significant savings in this area.

Elimination of Optional Benefits and Programs

States are continuing to propose the elimination of optional benefits. Georgia, for example, proposes to end Medicaid coverage of dental, vision and podiatry treatments for adults. In Washington, the governor's budget proposes to reduce in-home Medicaid personal care hours to 45,000 individuals for an average reduction of 10 percent based on the acuity of the client and to eliminate the state's Basic Health Plan which provides subsidized health insurance. Fourteen states have planned benefit restrictions in fiscal 2011 which include the elimination of covered benefits as well as the application of utilization controls or limits for existing benefits.

Program Integrity

States are also looking at processes to increase savings through use of fiscal accountability tools. Pennsylvania, for example, has saving estimates in the proposed fiscal 2012 budget for increased use of financial controls and tools to prevent and detect fraud, waste and abuse. States are encouraged to re-examine their financial tools to ensure they are focusing on the most likely and costliest fraudulent activities. With limited resources, anti-fraud and waste efforts should be directed where they will be most effective.

Provider Taxes and Assessments

States also look at provider taxes or assessments as a means to generate additional resources for Medicaid or to replace existing sources. Michigan, for example, proposes a health care insurance claims assessment of one percent applied to all health insurers in the state. This assessment will replace the existing use tax on Medicaid health maintenance organizations and support Medicaid provider reimbursement and services. Thirteen states increased or planned to increase provider taxes and fees in fiscal 2011.

Market Reforms and Longer-Term Changes

Some states are looking at payment reform, such as bundling services versus reimbursing on a fee-for-service basis, as a means to address costs and improve quality over time. However, budget officials noted that these types of changes will not necessarily generate immediate budget savings, but may lead to significant future savings.

In Ohio, the governor has created the Governor's Office of Health Transformation to carry out the immediate need to address Medicaid spending issues and to improve the state's overall health system performance in Ohio. In the first 6 months, the Office will advance the Administration's Medicaid modernization and cost-containment priorities of the operating budget as well as engage private sector partners to set clear overall expectations for overall health system performance. For Medicaid, the budget proposes to align policy and funding priorities across all Medicaid-related agencies to improve care coordination, integrate behavioral and physical health care, rebalance long-term care, and modernize reimbursement, with the more immediate savings stemming from changes in reimbursement policies.

In Massachusetts, the governor's budget proposes to emphasize the power of competition and innovative contracting to promote continued access to coverage and high-quality care while achieving significant cost savings.

The Administration's goal is to leverage the state's purchasing power as a means to reward models that provide cost-effective, high-quality coverage and care to those who rely on state health insurance and better coordinate government's health care purchasing decisions.

Minnesota's budget proposes increased competition and moving to a payment system focused on costs and outcomes. The state is seeking greater transparency from health plans.

Changes Through Redesign Team Approach

New York's executive budget proposal reflects savings anticipated from the proposals of the Medicaid Redesign Team established through Executive Order. The team's 27 members are charged with conducting a comprehensive review of New York's Medicaid program and to report findings and recommendation for cost reductions to the governor by March 1, 2011 for consideration in the budget negotiation process. On February 24, 2011, the Governor accepted the Medicaid Redesign Team's recommendations to reform the Medicaid program and amendments to the executive budget include the legislation necessary to implement specific savings proposed by the Redesign Team. A similar approach was used in Wisconsin.

Conclusion

NASBO will continue to monitor governors' proposals to contain Medicaid costs. The upcoming *Fiscal Survey of States* will provide information on Medicaid growth rates, enrollment projections, cost containment proposals as well as initiatives planned under the *Affordable Care Act*. State budget officers that have additional information to share with their colleagues should forward it to Stacey Mazer at NASBO.

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