

# Confronting Costs

Medicaid spending is at the top of many legislative agendas.

BY MELISSA HANSEN

**E**ven in this era of partisan deadlock over many issues, there is one thing almost all legislators can agree on: Medicaid is overwhelming state budgets.

The state's share of the joint state-federal program accounts for an average of 15 percent of state general funds and about 21 percent of total state spending when federal funds are added to the mix. In 2009, the states' share of the Medicaid tab reached \$123 billion, a hefty expenditure, given that states faced \$117.6 billion in budget gaps that year.

The fiscal situation is brighter now, but budgets remain under pressure, and Medicaid costs continue to grow.

"We need to be looking at Medicaid," says Oklahoma Representative Mark McCullough (R). "We've added more than 204,000 people to our Medicaid program over the past five years and have more than doubled our state share of Medicaid expenditures in the last 10 years. This current trajectory is totally unsustainable. Our costs on a chart are at a 45 degree angle."

Ten states—California, Colorado, Louisiana, Maine, Maryland, North Carolina, Pennsylvania, Tennessee, Washington and West Virginia—were forced to make mid-year revisions to close 2012 Medicaid budget gaps. The states' fiscal situation, coupled with the opportunities and challenges in federal

health reform, have pushed Medicaid cost containment to the top of many legislative agendas.

Oklahoma is opposed to the federal health reform law, says McCullough, "but the best thing it did was to get everyone talking about health care and Medicaid."

## No More Low-Hanging Fruit

Cutting benefits, limiting eligibility and reducing provider reimbursements have been the three "usual suspects" used by states for short-term Medicaid cost containment. Federal health reform requires states to maintain their March 2010 Medicaid eligibility levels, however, eliminating a key tool from the legislative arsenal. At least 46 states made a benefit or provider reimbursement change in 2012 to reduce program costs.

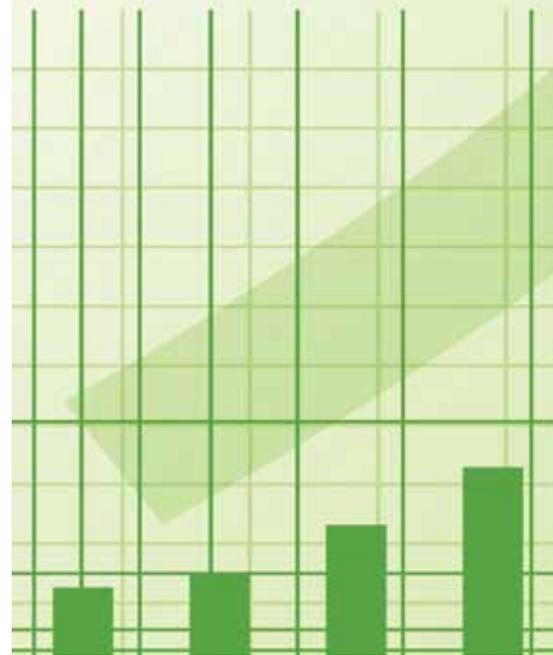
The 2014 expansion of Medicaid required by the Patient Protection and Affordable Care Act makes everyone with an income at or below 133 percent of the poverty level—\$23,050 for a family of four in 2012—eligible for the program. That expansion could be derailed by a challenge to the federal reform law now being considered by the U.S. Supreme Court. A ruling is expected later this month.

If the expansion is upheld, it will add more than 16 million people to the Medicaid rolls, increasing the total cost of the program by about 8 percent over projections of Medicaid spending without the impact of federal health reform. Almost all of this increase is projected to be paid by the federal government (\$434 billion, or about 95 percent). Nevertheless, states will continue to face the dual challenges of carrying out health reform while coping with uncertain fiscal conditions.

As in the private health care market, easy solutions to contain costs are elusive. States are

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experimenting with some promising approaches, however, in an effort to lower costs over time, including coordinating patient care, changing how providers are paid, focusing on high-cost patients, and reducing fraud and abuse.

## Maintain and Contain

Short-term fixes to Medicaid, including cuts in services, won't do the trick. Lawmakers need to focus on how to bring down the costs of Medicaid for the long term, says Vermont Representative Mike Fisher (D).

"The Medicaid budget and the cost of health care are eating us alive, year after year," he says. "Vermont had to do something to reduce the rate of growth in Medicaid and in our entire health care system. These costs are overwhelming every budget, from the individual family level to the state level."

Vermont's Blueprint for Health—an initiative to transform health care delivery by creating medical homes statewide—focuses on providing the right level of care at the right time in the right setting.

"Having a patient in a hospital bed for too



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McCullough (R)  
Oklahoma



Representative  
Mike Fisher (D)  
Vermont

## Medicaid By the Numbers

### Less than 7%

Medicaid's administrative costs, half the rate typical in the private sector.

### 25%

Medicaid enrollees who are elderly or disabled.

### 68%

Share of Medicaid spending for the elderly and disabled.

### 16%

Medicaid's share of all health care spending.

### 17%

Medicaid share of all hospital spending.

### No. 1

Medicaid rank as source of coverage for nursing home care, childbirth and for people with HIV/AIDS.

### 25%

Children covered by Medicaid.

### 7%

Enrollment increase in Medicaid in 2009.

### 10%

Reduction in states' share of Medicaid spending in 2009 because of the enhanced Federal Medical Assistance Percentage that expired on June 30, 2011.

Sources: The Centers for Medicare & Medicaid Services and the Kaiser Family Foundation.



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long or in the emergency room too often or using an ambulance many times is not only costly, it is also poor quality care,” says Fisher. “Containing costs was only one motivator for our reform. An equal motivator was improving the quality of care for all Vermonters.” Vermont is also moving forward establishing Green Mountain Care, which is a state-funded and managed insurance pool that would provide near-universal coverage to residents. The state’s expectation is that it will reduce health care spending over time.

Like Vermont, at least 47 other states are turning to medical homes—an approach in which a team coordinates all aspects of care for a patient—as a way to improve care and reduce the costs in their Medicaid programs.

### Bang for the Buck

Overhauling Medicaid is no easy task and requires everyone involved to buy into the solution.

“Start with the steps people can agree on,” says Scott Leitz, Minnesota’s assistant commissioner for health care administration at the Department of Human Services. “It is important to build trust between providers and Medicaid. Providers need to know they are supported, and states need to know they have willing partners and are going to save money.”

Leitz says part of building trust is changing how Medicaid pays providers. Some states are beginning to

reward the value, rather than the volume, of health care services. Minnesota, for example, moved away from the common fee-for-service payment model to ones that reward efficient and effective care, such as medical homes and accountable care organizations. These are based on the belief that better coordination of care will lead to more logical and efficient use of services and better health for patients.

“By adopting payment approaches that are more rational, states can reduce Medicaid costs over the long run and help stabilize the program,” Leitz says.

### Sharing the Risk

In addition to changing how providers are paid, state lawmakers are exploring new ways to work with traditional partners such as managed care organizations. Minnesota, for example, moved to a competitive bidding for contracts with managed care organizations and saved the state \$175 million this year. All that was needed, Leitz says, was a more competitive environment to produce the savings.

Most states are considering teaming up with managed care organizations to expand services to more high-cost patients with the hopes of reducing cost of care for these people.

Nationally, about 71 percent of all Medicaid beneficiaries are enrolled in managed care organizations. The most expensive beneficiaries—the elderly and dis-

abled who account for 68 percent of Medicaid spending—are traditionally left out of managed care because of multiple health conditions and needs for long-term care. As a result, payments to managed care organizations account for only about 20 percent of total Medicaid spending on services.

The shift to managed care for these patients isn't a silver bullet to contain cost, according to Allan I. Bergman, president and chief executive officer of High Impact Consulting, which provides Medicaid consulting on behalf of people with disabilities.

"States need to develop a plan based on patients' needs, but it takes time to develop a managed care contract that meets the extensive provider capacity of specialists and subspecialists of the elderly and people with disabilities," he says. "The risk of moving too fast is that patient care and health status will suffer."

Bergman is hopeful states can work with managed care companies to develop an approach based on quality care coordination that will prevent expensive health complica-

tions and unnecessary hospitalizations for these groups of patients. "Most states spend a considerable amount of money on Medicaid. If states are willing to restructure how they invest Medicaid dollars, states could get a better return on investment in about two years—better health outcomes and quality of life at a reduced cost."

Even if a state is willing to restructure Medicaid, barriers remain to wide-sweeping changes, McCullough says.

"States and the federal government need to have a much, much more meaningful and serious conversation about the future of this important program," he says. "Although waivers are allowed, in practice, it is very difficult to get meaningful flexibility from CMS. Medicaid is off-putting to most legislators, who are already swamped with many and varied issues, but states can no longer afford to avoid the complexities of wading into this subject." 

**SL ONLINE**

Learn more about Medicaid and the effect of federal health reform at [www.ncsl.org/magazine](http://www.ncsl.org/magazine).

## Medicaid Fraud By the Numbers

**\$1.9 billion**

Amount New York avoided spending on Medicaid through various initiatives.

**\$450 million**

Amount New York recovered in inappropriate payments.

**861**

Providers excluded from participating in Medicaid in New York.

**536**

Allegations of provider fraud, waste and abuse investigated in Texas.

**\$397 million**

Amount Texas recovered in inappropriate payments.

**\$348 million**

Amount Texas avoided spending on Medicaid through various initiatives.

Sources: NY Office of Medicaid Inspector General, Texas Health and Human Services Commission, Office of Inspector General, 2010

## Medicaid Fraud Fighters

States have historically dealt with Medicaid fraud and abuse using the "pay and chase" model. They pay Medicaid claims first and then chase suspected wrongdoers later.

Increasingly, however, states are focusing on preventing and detecting possible fraudulent claims early on. Washington state, for example, passed legislation that tries to anticipate fraud and improve efficiency and cost savings by moving away from the old model. Kentucky uses a centralized processing system to screen providers against several state and federal databases prior to enrolling them in its Medicaid program.

Florida, Illinois, Kansas, New York, Texas and Utah have established independent offices to lead Medicaid integrity efforts. Michigan's Legislature is currently considering this option. In 2010, New York's Medicaid inspector general recovered more than \$450 million in inappropriate payments, about 1 percent of the state's total Medicaid spending. State recovery rates range from less than 0.01 percent to around 1 percent.

The federal government also is getting in on the action to prevent Medicaid fraud and abuse before it occurs. The Patient Protection and Affordable Care Act created new tools and requirements to help states head off fraud.

To prevent fraudulent providers from entering the system, the act requires more rigorous screening, such as license verification, medical site visits and criminal background checks before enrolling certain providers. States are now prohibited from paying providers and suppliers who are under investigation for fraud, and risk losing federal Medicaid matching funds for doing so.

The federal law also has new reporting requirements to help identify providers who defraud Medicaid in multiple states. When a state bans a provider from its Medicaid program, state officials must enter the information into a web database searchable by other states. This database contains data on providers excluded from Medicare as well, and ensures that those guilty of fraud in one state are unable

to participate in Medicaid in another state.

Not all efforts required by the law to keep costs down are focused on prevention, however. States must contract with a private entity to regularly audit providers, review claims and identify improper payments after they have been paid.

The act also requires an initial state investment for some programs. Federal matching money is available to help states develop the necessary technology and infrastructure to identify and recover overpayments. For example, a 90 percent federal match is available for the design, development and installation of new claims coding methodologies, and a 75 percent match is offered for system maintenance and operations.

At least 19 states have introduced legislation to fight fraud and abuse in Medicaid, including nine states with wide-ranging bills to comply with various federal health reform requirements. Two states have enacted laws in response to requirements outlined in the Patient Protection and Affordable Care Act.

— Megan Comlossy, NCSL