



Medicaid Cost Containment: Approaches and Challenges



September 23, 2010

1



Goals of Presentation

Review traditional Medicaid cost containment strategies and discuss considerations.

Talk about health reform and Medicaid--and cost containment.

Discuss level of uncertainty about cost estimates across states.

Review longer term Medicaid cost containment strategies.

2



Some Medicaid Background

The country's largest health insurance program.

60 million enrolled in average month.

Pays for 41% of all births, 27% of all mental health,
41% of long term care.

Set to grow by 16 to 20 million by 2019 after health
reform implemented.



Widely Used Cost-Control Approaches

Eligibility Changes

Pricing Changes

Benefit Changes

Management Strategies



Eligibility

Maintenance of effort requirements in ARRA and PPACA prevent eligibility reductions until 2014.

States cannot adopt more restrictive standards, methodologies or procedures.



Pricing Changes

Reducing provider rates most common strategy used in states to respond to budget challenges. Rates of at least one provider type restricted in 33 states in 2009 and 29 in 2010, according to Kaiser Family Foundation.

To think about: Federal law requires reimbursements consistent with efficiency, economy and quality of care. Proposal must assure quality and access maintained.

To think about: Rate reductions for one provider type may affect use of another.

To think about: Managed care rates must be actuarially sound.



Changes in Benefits

Alter optional benefits for adults by reducing scope of coverage or setting benefit maximums. Ten states reported using in 2009; fifteen in 2010.

Strengthen utilization controls to ensure appropriateness of services: Prior authorization, post-payment reviews, bundling and unbundling services.

To Think About: Altering scope of one benefit may affect use of another. May be impact on access and quality of care.



Management Strategies

Improved Purchasing: Using Medicaid market share to get better prices for drugs, equipment, supplies.

More attention to fraud.

More attention to third-party recovery and cost avoidance.

Expanded use of contracts to manage care.



Revenue Strategies

Revenue Maximization: Can federal money replace state \$ for additional services?

Provider Taxes

Intergovernmental Transfers

9



Important Provisions in PPACA Affecting Medicaid

Eligibility Related Changes

Adds Childless Adults.

Sets minimum mandatory income level at 133% of FPL.

Modifies Income Counting Rules.

Outreach and Enrollment Provisions

Requires procedures to streamline enrollment, improve outreach, and coordinate with Exchanges.

10



Important Provisions in PPACA Affecting Medicaid Benefits Reforms

New Mandatory coverage: Free-standing birth clinics; Tobacco cessation services for pregnant women.

New Optional Coverage: Preventive services for adults and health home for persons with chronic conditions.

New options for coverage of home and community-based services with increased federal matching rate.

11



Important PPACA Provisions Payment and Financing Reforms

Increases in FMAP for newly eligible individuals up to 133% poverty.

Reductions in DSH allotments.

Bonus pay for increasing home and community based services compared to institutions.

Altered reimbursement for prescription drugs.

Reductions in expenditures for hospital acquired infections.

Temporary increases in Primary Care physician payment rates with increases covered by federal funds.

12



Important Provisions in PPACA Affecting Medicaid

Program Integrity Reforms

Implement National Correct Coding Initiative.

Implement Recovery Audit Contract Program.

New Data Reporting and Oversight Requirements for States and Providers.

13



State Cost Estimates Related to Reform

"State specific cost estimates vary. This variation is a function of the fact that each state analysis employs different methods and assumptions, and considers different sets of variables in producing coverage and cost estimates."--Congressional Research Service. September 8, 2010

"...challenges with respect to producing state-level cost estimates [include] pre-reform variation across states; uncertainty about future federal guidance and regulations relating to health reform implementation; state preferences regarding implementation; data issues; and factors outside of health reform."--CRS, September 8, 2010

14



Controlling Medicaid Costs Long Term

Reform delivery system to improve quality.

Reform payment approaches to connect pay and outcomes.

Coordinate care for Dual-Eligibles (People eligible for both Medicare and Medicaid).

Advance community based long term care and align with nursing home admission and stays.

15



Themes in Delivery System Reform

Medical Homes/Accountable Care Organizations

Health Information Exchange to support quality

Increased integration of physical and behavioral health services.

16



Themes in Medicaid Payment Reform

Hospital readmissions and hospital-acquired conditions

Bundled payments.

Tackling payment reform across payers.

17



Themes in Managing Dual Eligibles

18% of Medicaid enrollment; 46% of dollars.

Financial incentives misaligned between Medicare and Medicaid.

Slow progress thus far but new opportunities may be coming through CMS.

18



Themes: Community Based Long Term Care

Challenge from cost perspective is to assure Medicaid community care investments are made for people who would otherwise enter a nursing home.

Difficult to integrate people into community after long nursing home stay so attention to reducing admissions and planning discharge early is important.

Experimentation with managed models is underway and needs to continue.

19



Cost Control/Quality Opportunities in Health Reform That are Especially Relevant to Medicaid

List that follows is from Carolyn Ingram, Center for Health Care Strategies. Presented on NGA Call with States, September 7, 2010

20



100 % FMAP to increase primary care rates for two years.

Health homes for enrollees with chronic conditions (90% FMAP for 2 years).

Demonstrations for bundled payments and ACOs.

Grants/contracts for community health teams to support medical homes.



Grants/contracts for medication management for chronic disease.

Grants for state to provide incentives to Medicaid enrollees to participate in programs to prevent chronic disease.

CMS Innovation pilots to test payment and system reforms.

Federal Coordinated Health Care Office for dual eligibles



NCSL

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

Donna Folkemer
National Conference of State Legislatures
(no longer at NCSL, effective 9/24/2010)

9/17/10 final