Approaches to Cost Containment in State Medicaid Programs

There are four avenues to cut or control costs in state Medicaid programs: pricing reductions, benefit limitations, eligibility reductions, and management strategies.

Pricing Reductions

- Federal Medicaid law imposes several significant requirements on states. As with other federal laws, these requirements are supreme, and supersede any conflicting state laws or rules on the subject.

- Federal Medicaid law describes the specific payment methods for the following providers:
  - Rural health clinics
  - Hospice
  - Federally qualified health clinics
  - Indian health services
  - Home health
  - Premium payments for Medicare Parts A&B
  - The methodology for the Part D (State's share of Medicare's pharmacy payments)
- For other service providers, states have some flexibility, contingent upon federal requirements and approval to :
  - Introduce new pricing methodologies (e.g., fee for service, bundled, capitation)
  - Freeze certain provider rates (certain providers receive inflation adjustments)
  - Target pricing cut backs for certain providers
  - Provide payment incentive options that reward quality and performance

- Federal Medicaid law requires states to provide payment procedures that assure reimbursements are consistent with efficiency, economy, and quality of care. Reimbursement must attract enough providers so that Medicaid services are available to the same extent as non-Medicaid services.

Benefit Limitations

- Federal Medicaid law imposes certain mandatory services that every state must provide, but also permits optional services that a state can add to its Medicaid State Plan.

- Federal mandatory benefits include:
  - Inpatient hospital (excluding inpatient services in institutions for mental disease)
  - Outpatient hospitals and rural health clinic services
  - Other laboratory and X-ray services
  - Federally qualified health centers and other ambulatory services
  - Certified pediatric and family nurse practitioners
  - Nursing facility services for individuals younger than 21
  - Early and periodic screening, diagnosis, and treatment (EPSDT) for those younger than 21
  - Family planning services and supplies
  - Physician services
  - Medical and surgical services of a dentist

- Home health services for those entitled to nursing facility services
- Nurse mid-wife services
- Pregnancy-related services
- 60 days postpartum pregnancy-related services
- Medicare Parts A&B premiums for certain eligible individuals
- Indian health services
- Medical transportation
- Durable medical equipment and supplies

- States have authority to determine whether to provide coverage for the following services except in cases when the services fall under federal requirements (e.g. dental and mental health coverage requirements for CHIP) that are primarily related to children's medical necessity needs.

  - Chiropractors
  - Podiatrists
  - Optometrists
  - Psychologists
  - Nurse anesthetists
  - Private duty nursing
  - Dental
  - Physical therapy
  - Occupational therapy
  - Therapy for speech
  - Hearing
  - Language disorders
  - Prescription drugs
  - Dentures
  - Prosthetic devices
  - Eye glasses
  - Diagnostic services
  - Preventive services
  - Mental health rehabilitation
  - Intermediate care facilities for the mentally retarded
  - Inpatient psychiatric care for persons younger than 21
  - Personal care services
  - Targeted case management
  - Primary care case management
  - Hospice
  - Respiratory care
  - Non-emergent medical transportation
  - Nursing facility care < 21
  - Emergency hospital services in non-Medicare participating hospitals and critical access hospitals

  All changes are subject to federal approval. Current health reform legislation moves some of the state optional benefits to federally mandated Medicaid coverage (e.g., podiatry, some dental, optometry, non-emergent medical transportation).

- Within any given service, whether mandatory or optional, the state has some discretion to set reasonable limits on the extent of services it will provide. Some approaches include:

  - Reducing allowable benefit maximums
  - Subjecting benefits to certain authorization standards (e.g., assessments, medical necessity standards)
  - Eliminating certain benefits (children's services are mostly exempt from this option)
  - Establishing individualized budgets for certain community-based services
  - Re-designing benefits

Eligibility Reductions

Medicaid currently has two-tiered criteria: individuals must fall within one of the following "categorical groups" and must meet the financial tests of eligibility (states have some flexibility

to modify income standards and define "countable income"). Idaho has been ranked the third most restrictive Medicaid program in the country with respect to eligibility.

Under the American Recovery and Reinvestment Act (ARRA), state Medicaid programs are subject to Maintenance of Effort requirements in order to receive the increased federal matching percentage (in Idaho, this is now approximately 80%). After ARRA ends and the federal share returns to its standard (approximately 70%), states may have flexibility to make changes in optional eligibility categories unless other federal requirements are imposed.

- The state must cover the following federally mandated groups:
  - Aid to Families with Dependent Children (AFDC) eligible individuals, as of July 16, 1996.
  - Poverty-related groups: must cover all pregnant women and children younger than age 6 with incomes up to 133 percent of the federal poverty level (FPL).
  - All children born after September 30, 1983, with incomes up to 100 percent of the FPL. This requirement covers poor children younger than age 19.
  - Current and some former recipients of the Supplemental Security Income (SSI): states have some latitude to use more restrictive standards if states were using those standards before 1972.
  - Individuals who need foster care and adoption assistance.
  - Certain Medicare beneficiaries: eligible for Medicaid assistance to pay for Medicare premiums, deductibles and cost-sharing. The lowest income levels are also entitled to full Medicaid benefits.

- States normally have the option to add the following populations:
  - Poverty-related groups: may cover pregnant women and infants with family incomes up to 185 percent (Idaho does not include under Title XIX).
  - Medically needy: may cover individuals who don't meet the financial standards for program benefits but fit into one of the mandated groups and have income and resources within special "medically needy" limits (Idaho does not include).
  - Recipients of State Supplementary Payments: may include individuals who don't receive SSI but qualify for other state cash payments (some use in Idaho).
  - Long-term care: individuals eligible for long-term institutional care who receive services in the community and have incomes less than 300 percent of SSI (Idaho has two waiver programs).
  - Working disabled: individuals who are disabled but would not qualify due to income (Idaho's "buy-in" program allows individuals to retain coverage by making premium payments).
  - Persons with specific diseases: individuals with specific medical diagnoses may be covered under certain conditions (Idaho covers women with breast and cervical cancer. Idaho does not cover individuals with tuberculosis unless they otherwise financially and categorically qualify).
  - Some parents who have disabled children: allows parents who have disabled children to "buy-in" to Medicaid if they have family income less than 300 percent of the FPL (Idaho doesn't allow).
  - Other groups: this is a broad category that includes state waiver programs (Idaho has two Home and Community Based Services Waivers (1915(c)) and a Research and Demonstration Project Waiver (1115) for its premium assistance program. Idaho also provides coverage to disabled children who require certain levels of care but no financial criteria, known as the Katie Beckett program).

Management Strategies

- Enhancing efforts to reduce waste, fraud, and abuse
- Enhancing efforts to recover funds through third party recovery
- Establishing managed care contracts (e.g., dental coverage)
- Administrative contracts for utilization managements (e.g., hospital reviews)
- Streamlining administrative approaches (reducing duplication, eliminating management interventions that are not value added, improving quality assurance systems)
- Improving technology supports (new Medicaid Management Information System (MMIS))
- Improving decision support tools
- Improving purchasing decisions (buy rather than rent)
- Pooling purchasing resources with other states (e.g., pharmacy multi-state collaborative)
- Implementing allowable cost-sharing requirements
- Implementing incentive programs to encourage better health choices