

CHAPTER 2

Addressing Growth in Medicaid Spending: State Options

Addressing Growth in Medicaid Spending: State Options

Key Points

- The rate of growth in Medicaid spending reflects not only decisions made by federal and state policymakers, but also factors beyond the control of government officials, including changes in the economy and the health system. Although the availability of federal Medicaid funding may give states an incentive to increase program spending, states also have incentives to limit growth in per-person spending and overall Medicaid costs.
- The federal government sets minimum requirements that states must comply with to receive federal Medicaid funds, reflecting statutory and regulatory decisions about how federal dollars can be used and how states can be held accountable. However, the federalist structure of the program also provides states with many options for the design and administration of their programs.
- Current authorities allow states to use many different policy levers to reduce spending and achieve other program efficiencies. In designing their programs and responding to changing economic conditions, states take advantage of this flexibility to decide whether to cover optional eligibility groups and services, determine provider payment methods and rates, define coverage parameters for covered services, and adopt strategies to address the volume and intensity of services.
- Different policy approaches have different effects on the magnitude and direction of spending changes, as well as on other aspects of the program. Typically states seek first to minimize direct effects on beneficiaries. For example, states have kept Medicaid provider payments low compared to other payers rather than rolling back eligibility.
- States increasingly seek to avoid blunt benefit and payment cuts by contracting with managed care organizations and developing other value-based purchasing approaches to better tie payments to measures of quality and outcomes.
- There are practical and policy limits on a state's ability to obtain further savings, including minimum federal standards for coverage and access and the technical and administrative resources needed to implement more sophisticated payment models.

CHAPTER 2: Addressing Growth in Medicaid Spending: State Options

As described in Chapter 1, Medicaid program spending has grown in absolute and relative terms and become a larger share of both federal and state budgets, leading policymakers to express concerns about the sustainability of the program. There are differences of opinion, however, as to what is driving growth, and these differences in the diagnosis of the problem lead to different solutions being offered for the future. Some, including the chairs of committees with interest in Medicaid, have pointed to Medicaid's financing structure, under which the federal government will match allowable state expenditures, as a root cause of expenditure growth. Alternatives to this approach are discussed in detail in Chapter 3, with the Commission noting that the extent to which these approaches would incentivize states towards greater efficiency and value, and how such constraints will affect beneficiaries, providers, health plans, and others, depends upon how federal dollars would flow to states and the tools that states use to hold down expenditure growth.

The analysis in Chapter 1 shows that about 70 percent of growth in real Medicaid spending (adjusted for health care price inflation) can be attributed to enrollment, which has increased as a result of both policy decisions and economic and demographic changes. Current public discussion of Medicaid enrollment has focused on changes brought about by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), which include expansion to the new adult group in more than half of the states, as well as increased enrollment among individuals previously eligible for Medicaid but not enrolled (sometimes referred to as the woodwork or

welcome mat effect). Historically, however, from 1975 to 2012, the major source of growth has been from enrollment of people with disabilities.

Slightly less than one-third of growth in real Medicaid benefit spending has been due to increases in spending per enrollee, reflecting policy decisions as well as broader changes in the health system, including medical price inflation and changes in disease patterns and treatment modalities. The average cost per enrollee is determined by the benefits covered, the prices paid for those benefits, and how efficiently those benefits are delivered. Within the Medicaid program, the federal government sets minimum requirements in each of these areas, which states must comply with to receive federal funds. These requirements reflect statutory and regulatory decisions about how federal dollars can be used and how states can be held accountable.

Although the availability of federal Medicaid funding may give states an incentive to increase program spending, states also have incentives to limit growth in per-person spending and overall Medicaid costs. The federalist structure of the program provides states with many options for the design and administration of their programs. Options include covering non-mandatory eligibility groups and services, determining provider payment methods and rates, and adopting strategies to address the volume and intensity of services. Many cost containment strategies are intended to minimize direct effects on beneficiaries; for example, states have kept Medicaid provider payments low compared to other payers. States have also become more sophisticated purchasers, trying to avoid blunt benefit and payment cuts by contracting with managed care organizations to implement care management programs and by developing value-based purchasing approaches to better tie provider payments to measures of quality and outcomes. These different policy approaches have different effects on the magnitude and direction of spending changes, as well as on other aspects of the program.

In this chapter, we describe the range of policy drivers that affect Medicaid spending at the state level, from the federal requirements that create a spending floor in every state, to areas where states have flexibility in the design and administration of their programs. The sections are organized according to the choices available under current authorities (e.g., managing enrollment, limiting benefits, determining provider payments, changing delivery systems, and strengthening program integrity). Given the limits on state flexibility, even under demonstration authority afforded the Secretary of the U.S. Department of Health and Human Services (the Secretary), the chapter also describes requests by states for additional program changes not currently allowed under federal statute.

Clearly, there are also many federal policies that affect Medicaid spending. For example, federal categorical eligibility policies that drive overall program enrollment are the single largest contributor to Medicaid spending, as described in Chapter 1 of this report. Benefit rules, such as the requirements for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and the entitlement to nursing facility services (but not home and community-based services), limit delivery options, and federal payment rules, including upper payment limits and actuarial soundness rules, constrain state autonomy in setting provider payments. Changes to these policies, or the introduction of new policies established under new authorities, could change the trajectory of program spending as much or more than the state policy levers discussed in this chapter. Investigation of these options could be an area for future Commission work.

Eligibility

As noted above, program enrollment is the largest factor contributing to increases in Medicaid expenditures, accounting for over two-thirds of spending growth over the last 35 years. Enrollment has increased as a result of new federal

requirements, state options, and changes in the economy, as well as a result of overall population growth. Reductions in eligibility can result in immediate cost savings for states but also in loss of coverage for those eliminated from the rolls, because most Medicaid enrollees cannot afford alternative sources of health insurance. For this reason, Congress has imposed maintenance-of-effort (MOE) requirements on states that prevent them from closing budget gaps during recessions by reducing Medicaid eligibility.

Reflecting Medicaid's historical links to cash assistance programs, state Medicaid programs must cover certain mandatory eligibility groups, including low-income children and pregnant women, individuals receiving Supplemental Security Income (SSI), and low-income Medicare enrollees (Box 2-1). The explicit link between Medicaid coverage and cash assistance was eliminated in 1996 with passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, P.L. 104-193). Congress added many eligibility groups over time, including additional groups of low-income children in 1984 and 1987, qualified Medicare beneficiaries in 1988, higher-income working disabled individuals in 1999, and uninsured women needing treatment for breast or cervical cancer in 2000 (MACPAC 2011a).

Most recently, the ACA extended Medicaid eligibility to all adults under age 65 (including parents and adults without dependent children) with incomes below 138 percent of the federal poverty level (FPL), although a subsequent Supreme Court ruling in June 2012 effectively made the expansion a state option.^{1,2} As of January 2016, 31 states and the District of Columbia have chosen to adopt the adult expansion, some through alternative approaches using Section 1115 waivers. States that have chosen not to implement the expansion have raised concerns about the state share of costs for the expansion group, among others (Scott 2012).

States also have the option to cover many other eligibility categories, including adults with

BOX 2-1. Mandatory Medicaid Eligibility Groups, 2016

- Low-income families
- Families receiving transitional medical assistance
- Children with Title IV-E adoption assistance, foster care, or guardianship care
- Extended Medicaid due to child or spousal support collections
- Mandatory poverty level-related pregnant women
- Qualified pregnant women and children
- Mandatory poverty level-related infants
- Deemed newborns
- Mandatory poverty level-related children age 1–5
- Working disabled under 1619(b)
- Mandatory poverty level-related children age 6–18
- Qualified disabled and working individuals
- Individuals receiving SSI
- Qualified Medicare beneficiaries
- Blind or disabled individuals eligible in 1973
- Qualifying individuals (Medicare-related)
- Institutionalized individuals continuously eligible since 1973
- Specified low-income Medicare beneficiaries
- Disabled adult children
- Individuals who are essential spouses
- Aged, blind, and disabled individuals in 209(b) states
- Individuals receiving mandatory state supplements
- Individuals who lost eligibility for SSI or SSP due to an increase in OASDI benefits in 1972
- Individuals who would be eligible for SSI or SSP but for OASDI COLA increases since April 1977
- Disabled widows and widowers ineligible for SSI due to increase in OASDI
- Disabled widows and widowers ineligible for SSI due to early receipt of Social Security

Notes: SSI is Supplemental Security Income. SSP is state supplemental payment. OASDI is old age, survivor, and disability insurance. COLA is cost-of-living adjustment.

Sources: Centers for Medicare & Medicaid Services (CMS) and the Social Security Act.

disabilities with employment income greater than permitted under SSI limits, children and pregnant women with income above 138 percent FPL, and individuals eligible for long-term services and supports with incomes up to 300 percent of the SSI benefit rate.³ States also have the option to cover the medically needy, that is, individuals with incomes too high for Medicaid who must spend down to a medically needy income level by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes (MACPAC 2016a).

State decisions about covering optional eligibility groups directly affect Medicaid spending, and states vary according to which optional groups they cover. For example, almost every state covers the optional group of women needing treatment for breast or cervical cancer, but only 13 states extend Medicaid coverage to youth who age out of foster care in other states (CDC 2016, Brooks et al. 2016).⁴ Although states can drop optional eligibility groups when budgets are tight, most states that restrict eligibility do so only when other opportunities for cost containment, such as

cutting provider rates or reducing benefits, have been exhausted. For example, in 2003, in response to state budget pressure resulting from the economic recession, 18 states restricted benefits, but only 2 eliminated their medically needy programs completely (Smith et al. 2003).

Federal requirements also affect a state's ability to cut optional groups. As noted above, at various times, Congress has imposed MOE provisions that prevent states from reducing eligibility below a certain historical threshold for both mandatory and optional groups. For example, the ACA includes an MOE provision effective through fiscal year (FY) 2019 that prevents states from reducing children's eligibility below levels in place on the date of its enactment on March 23, 2010.

States have more frequently used changes to eligibility standards and processes to reduce eligibility without dropping entire groups (Smith et al. 2003). For example, during the recession of 2008 and prior to the imposition of MOE requirements under the 2009 stimulus bill (American Recovery and Reinvestment Act of 2009, P.L. 111-5), states implemented measures intended to reduce Medicaid enrollment including adding asset tests, changing the effective date of retroactive eligibility, increasing documentation requirements, and requiring face-to-face interviews for enrollment (Smith et al. 2007). The ACA removed much state flexibility in this area by introducing the uniform modified adjusted gross income (MAGI) eligibility standard for low-income families, effective in 2014, and by eliminating states' ability to use income disregards, asset tests, certain application procedures (e.g., face-to-face interviews) as tools to manage enrollment.

Recently, a few states have used Section 1115 waiver demonstration authority to test alternative eligibility requirements in conjunction with the optional expansion of Medicaid to cover previously ineligible adults (MACPAC 2016b). Five states (Iowa, Michigan, Arkansas, Indiana, and Montana) require new adult enrollees to pay premiums or

make monthly contributions toward payment for services. Three states (Iowa, Indiana, and Montana) have been granted waiver authority to disenroll enrollees with incomes above 100 percent FPL for non-payment of premiums. In Iowa, individuals may re-enroll at any time; in Indiana, disenrolled individuals can be denied re-enrollment for six months; and in Montana enrollees are able to re-enroll once they pay overdue premiums or after three months (MACPAC 2016b). However, the Centers for Medicare & Medicaid Services (CMS) have not approved state requests to waive Medicaid rules limiting aggregate out-of-pocket spending to 5 percent of income, or to make a work requirement or referral a condition of Medicaid eligibility (Rudowitz and Musumeci 2015).

Benefits

Increases in the cost of providing Medicaid benefits also contribute to the overall growth in Medicaid spending. States exercise considerable control over spending by choosing whether or not to cover optional services, defining coverage parameters for covered services, implementing utilization management tools, and imposing nominal cost sharing. However, federal waiver authority is needed for states to implement certain types of benefit changes, such as enhanced cost sharing or selective provider contracting.

States must cover certain mandatory services, such as inpatient hospital and physician services (Box 2-2), but have discretion in coverage decisions about a wide range of optional services, such as physical therapy, personal care services, and adult dental services. States vary widely in the degree to which they cover services classified as optional: 42 states covered hospice in 2012, but only 15 states offered the health home benefit in 2014 (KFF 2012, Moses 2014).⁵ In addition, although coverage for some services is considered optional in the statute, in practice, coverage is needed to provide access to appropriate care. For

BOX 2-2. Mandatory Medicaid Benefits, 2016

- Inpatient hospital services
- Laboratory and X-ray services
- Outpatient hospital services
- Nursing facility services (for persons age 21 and over)
- Physician services
- Federally qualified health centers
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under age 21
- Certified pediatric or family nurse practitioner services (to the extent authorized to practice under state law or regulation)
- Family planning services and supplies
- Rural health clinic services
- Tobacco cessation counseling and pharmacotherapy for pregnant women
- Nurse-midwife services (to the extent authorized to practice under state law or regulation)
- Freestanding birth centers (when licensed or otherwise recognized by the state)
- Non-emergency transportation to medical care
- Home health services (for those who qualify for an institutional level of care)

Notes: Federal regulations at 42 CFR 431.53 require states to provide non-emergency transportation services; they may do so as an administrative function or as part of the Medicaid benefit package. EPSDT services include screening, vision, dental, and hearing services and any medically necessary service listed in the Medicaid statute, including optional services that are not otherwise covered by a state if needed to treat an illness or condition detected during screening.

Sources: Centers for Medicare & Medicaid Services (CMS) and the Social Security Act.

example, prescription drugs are considered an optional covered item in Medicaid but are covered by every state because they are integral to the practice of medical care and are needed to avoid other costs associated with conditions that can be treated pharmaceutically. Although most home and community-based services (e.g., private duty nursing, personal care services) are optional, states must cover many of these services to meet their legal and strategic goals as they rebalance the delivery of long-term services and supports (LTSS) between institutions and the community.

Although benefits generally must be equivalent in amount, duration, and scope for enrollees within a state (known as the comparability requirement) and offered throughout the state (the statewideness requirement), the breadth of coverage for individual benefits—including mandatory benefits—can

vary significantly across states.⁶ For example, as documented in MACPAC's June 2015 report to Congress, the 26 states that provide optional restorative dental benefits to adults impose a variety of coverage limits, including annual limits on the number of fillings and crowns an enrollee can get, the types of crowns that can be used on certain teeth, and how often root canals can be performed (MACPAC 2015a). States also place limits on annual dollar amounts or the number of adult dental services they will cover within a certain time frame. Finally, states can limit services based on medical necessity criteria or implement prospective, concurrent, and retrospective utilization control procedures. For example, many states require prior authorization for services such as medical equipment, certain prescription drugs, certain physician procedures, and non-emergency hospital admissions.

States can make incremental changes to benefit coverage to contain costs, or they can add or drop entire categories of optional benefits from Medicaid in response to changing economic conditions; however, such changes on their own typically do not lead to meaningful budget savings. Here, state policies on adult dental benefits are illustrative. Between 2003 and 2012, 20 states made at least one large-scale change in dental benefits for adult Medicaid enrollees, including three states (California, Idaho, and Illinois) that eliminated coverage of non-emergency dental services for adults and then later reinstated that coverage as state revenues improved (MACPAC 2015a). While as noted above, every state covers prescription drugs, which are optional by statute, nearly all states have developed sophisticated programs to manage drug utilization within the parameters allowed by federal rules (NCSL 2016).

The Deficit Reduction Act of 2005 (P.L. 109-171) created a new way for states to manage benefits by enrolling certain groups, primarily non-disabled adults and children, in alternative benchmark or benchmark-equivalent benefits, also known as alternative benefit plans (ABPs). ABPs are permitted to cover different benefits than traditional Medicaid and may therefore be less costly to the state.⁷ States can provide coverage equivalent to specified benchmark plans, such as those offered to state or federal employees, or define a benchmark benefit appropriate for the targeted population, subject to approval by the Secretary. Although benchmark coverage for Medicaid enrollees must meet certain federal requirements, including coverage of essential health benefits (EHBs), states can establish ABPs that do not include all mandatory Medicaid benefits (e.g., they can omit coverage of nursing facility services) if those benefits are not included in the coverage against which the alternative benefit plan is benchmarked.⁸ Still, even though the ABP option has been available for over 10 years, few states have chosen to implement it.

A few states have sought waivers of coverage requirements for certain required benefits, particularly in conjunction with the optional expansion of Medicaid to cover previously ineligible adults. Two states, Iowa and Indiana, have received time-limited waivers of the requirement to provide access to non-emergency medical transportation (NEMT) as part of a demonstration to evaluate the effect of not covering NEMT on access to other services (MACPAC 2016b). These waivers were allowed because while states are required by federal rules to provide necessary transportation, NEMT is not defined in statute as a benefit. CMS did not approve a request by Iowa to waive the requirement to provide EPSDT services to newly eligible 19- and 20-year olds (Rudowitz and Musumeci 2015). CMS's decision on the Iowa request reflects the agency's position that it does not have the authority to waive benefit requirements, including EPSDT rules.

States, like private insurers, can also use cost sharing to discourage use of certain services. For example, to encourage the use of lower cost generic drugs, many states require copayments for branded drugs but not for the generic equivalent. States can also impose higher copayments when beneficiaries visit a hospital emergency department for non-emergency services. There are federal limits regarding who may be charged these fees, the services for which they may be charged, and the amount allowed. Certain vulnerable groups, such as children and pregnant women, are exempt from most out-of-pocket costs (CMS 2016).

In some cases, states have been granted authority under 1115 demonstration waivers to test different approaches to the use of cost sharing for Medicaid beneficiaries. As part of their waivers to expand Medicaid to cover previously ineligible adults, Arkansas, Indiana, and Michigan use an approach similar to a health savings account, in which enrollees make monthly or quarterly contributions toward payment for services (MACPAC 2016b).

However, CMS did not approve a request by Michigan to waive the Medicaid rule limiting aggregate out-of-pocket spending to 5 percent of income by raising cost-sharing obligations for persons with incomes above 100 percent FPL to 7 percent of their income (Dickson 2015).

Provider Payments

States have considerable flexibility in determining fee-for-service provider payment methods and amounts (MACPAC 2015b). Although states are required to demonstrate that payment changes do not jeopardize access to care, for the most part federal rules do not specifically direct payment amounts or limits.⁹ Medicaid programs typically pay less than other insurers for most services; a recent comparison of rates paid for physician services by Medicaid and Medicare found that state Medicaid programs paid 66 percent of Medicare rates, on average, although the differential varied across states (KFF 2014).

Within current federal rules, states can develop provider rate-setting processes and fee schedules for different services and programs and can establish supplemental payments to providers, subject to the upper payment limit (which prohibits Medicaid from paying more than Medicare would pay for the same service, in the aggregate). As a result, states vary widely in how they pay providers, a situation that reflects individual state policy decisions, practice patterns, and geographic differences in markets and costs. For example, a MACPAC review of inpatient payment policies for all state Medicaid programs found that states use a wide range of payment methods, including cost-based reimbursement, payment based on diagnosis-related groups (DRGs), and per diem payments (MACPAC 2014). States can also manage prices through pay-for-performance programs, state-negotiated supplemental pharmacy rebates, competitive bidding, and other practices.

When facing fiscal pressures, states often prefer to reduce or freeze provider rates before making other program cuts—like benefit or eligibility changes—that affect beneficiaries more directly (Smith et al. 2015). During the economic downturn from 2001 to 2004, every state froze or cut provider payment rates to control costs (Smith et al. 2010). During the next recession, from FY 2008 to FY 2010, despite the availability of stimulus funds, states again cut or froze provider rates, particularly for hospitals and nursing facilities (Smith et al. 2010). As economic conditions have improved, states have been less willing to implement provider rate cuts, and many have begun restoring rates to previous levels and increasing rates. A 2015 survey of recent legislative actions found that—in contrast to the majority of states in prior years—only three states in FY 2015 and five states in FY 2016 had implemented or planned inpatient hospital rate reductions, while a similar number of states planned or implemented reductions in nursing home, outpatient, physician, and dental rates (Smith et al. 2015).

There are limits to how much states can constrain provider payments. As noted above, the federal equal access provision requires Medicaid programs to ensure that payments are sufficient to ensure access comparable to that available to the general population in that geographic area.¹⁰ Other federal rules affect payments to federally qualified health centers and hospitals serving a disproportionate share of low-income patients (MACPAC 2011a). In addition, market dynamics and the payment policies of other payers (particularly Medicare) can affect providers' willingness to participate in Medicaid. Moreover, to improve quality and outcomes, some states are implementing more sophisticated payment mechanisms, such as bundled payments for certain surgical procedures or pay-for-performance arrangements based on achievement of specific quality metrics. These mechanisms can require investments in additional administrative or technical capacity, not only by the state Medicaid agency, but also by providers.

Payment rates for Medicaid managed care plans are evaluated by CMS using different criteria than those used to evaluate fee-for-service payment methodologies. For example, capitation rates must be developed in accordance with generally accepted actuarial principles and practices, they must be appropriate for the population and services included in the managed care program, and they must be certified by qualified actuaries. In certifying rates, actuaries consider whether the rates are expected to cover all reasonable, appropriate, and attainable costs that plans are anticipated to incur under the managed care contract, a standard that is unique to managed care programs. In addition to incorporating the anticipated costs under the managed care contract, capitation rates can also incorporate the anticipated savings that managed care plans can reasonably be expected to achieve through the implementation of cost containment strategies that are not available under fee-for-service arrangements (discussed below).

Delivery Systems

State Medicaid programs—like many other payers—have responded to cost growth by implementing policies intended to counteract the inherent inflationary incentives of an unmanaged fee-for-service payment system. Chief among these is managed care, in which states contract with private health plans on a fixed (capitated) payment basis to provide Medicaid benefits to defined groups of enrollees. This approach can moderate cost growth through two mechanisms. First, federal rules allow managed care plans to use certain tools to limit the growth of per-person spending, including selective provider contracting, the use of drug formularies, and the option to offer alternative services in lieu of covered Medicaid services if the alternative services are more cost-effective. Second, by transferring insurance risk to private plans, states can gain greater predictability in their costs, limiting the state's own risk to costs associated with increases in enrollment (within

the limits of the actuarial soundness rules). In these ways, state Medicaid programs can not only achieve greater cost predictability, but can also require and enforce full adherence to standards for access and improvements in the quality of care, goals that are difficult to achieve under fee for service.¹¹

While enrollment in comprehensive managed care was low compared to fee-for-service Medicaid for many years, by 2011 the share of Medicaid beneficiaries enrolled in managed care exceeded 50 percent and has continued to grow, particularly because most states that expanded coverage to previously ineligible adults have chosen to enroll the majority of these new beneficiaries in managed care (Avalere Health 2014). States are also increasingly turning to managed care to help contain costs among populations with above-average needs, including people with disabilities and those in need of LTSS. From 2005 to 2013, the number of states offering managed long-term services and supports (MLTSS) more than doubled, from 6 to 14 states, and additional states plan to implement new MLTSS arrangements in future years (Mathematica 2016, Smith et al. 2015).

States can implement managed care in their Medicaid programs under multiple federal authorities. In the program's early years, mandated enrollment in managed care was possible only under Section 1115 demonstration or Section 1915(b) freedom-of-choice waivers, but the enactment of the 1997 Balanced Budget Act (BBA, P.L. 105-33) gave states a state plan option allowing mandated managed care enrollment (except for certain children with special needs, Medicare beneficiaries, and American Indians). Many states continue to seek waivers to implement managed care because these waivers allow states to mandatorily enroll a more comprehensive group of enrollees and can be coupled with other program reforms, such as alternate financing approaches (CMS 2015a). However, in exchange for the flexibility offered by waivers, states must meet budgetary criteria and provide regular reports and

evaluations to CMS to show that the requirements of the waiver are being met. Evidence of the effectiveness of state initiatives in this area is mixed (AcademyHealth 2015).

More recently, many states have complemented these efforts with other initiatives that aim to strengthen incentives for value-based delivery of health care. Many states have implemented delivery system reforms that offer financial incentives to providers to affect the volume and intensity of services delivered and shift the focus of the payment system from volume to value (Smith et al. 2015). Value-based purchasing approaches in Medicaid include accountable care organizations, bundled payments, and patient-centered medical homes, which can be implemented under existing state plan authority. Some states have pursued broader reforms using demonstration waiver authority to address the total cost of care. A number of states have also engaged in multipayer efforts to design new payment- and service-delivery models to improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid, and all residents of participating states (Takach et al 2015).

States have found that, regardless of the type of value-based model pursued, substantial resources are needed to implement new payment models (NAM 2016). CMS has provided start-up funding to some states through State Innovation Model grants, and states are increasingly using Delivery System Reform Incentive Payment (DSRIP) demonstration waivers to support hospitals and other providers as they try to transform their delivery systems (MACPAC 2015b). Although some of these models have already generated positive results, most of them are still in their infancy and have not yet led to measurable savings. Early results from several demonstrations have yielded only inconclusive or mixed results on quality and utilization (Wholey et al. 2016, RTI 2014).

Program Integrity

The U.S. Government Accountability Office (GAO) designated Medicaid as a high-risk program in 2003 due to its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight (GAO 2015). In 2014, CMS estimated that the Medicaid program had an overall improper payment rate of 6.7 percent, lower than the Medicare improper payment rate for that year (CMS 2015b, 2015c). This includes improper payments made for all reasons, including claims processing errors, eligibility determination errors, and lack of medical record documentation to substantiate claims. Because fraud is particularly difficult to detect, its precise magnitude is unknown, though analysis has shown that the great majority of Medicaid providers do not engage in such actions (Rosenbaum et al. 2009).

States and the federal government conduct a variety of program integrity activities meant to ensure that federal and state taxpayer dollars are spent appropriately on delivering high quality, necessary care, and on preventing fraud, waste, and abuse. States must ensure that eligibility decisions are made correctly, that prospective and participating providers meet federal and state participation requirements, that services provided to enrollees are medically necessary and appropriate, and that provider payments are made in the correct amount and for the appropriate services. When an improper payment is identified, the state must return the federal share to CMS, but may use the retained state share for any approved purpose (42 CFR 433.300).

MACPAC has previously noted challenges in implementing effective and efficient Medicaid program integrity practices—these challenges include insufficient collaboration and information sharing among federal agencies and states; lack of information on the effectiveness of program integrity initiatives and appropriate performance measures; incomplete and outdated data; and insufficient program integrity resources

for delivery system models other than fee for service (MACPAC 2011b). Additional ongoing investments at the state and federal level are needed to enhance and improve both front-end program integrity controls to prevent fraud and postpayment reviews to identify waste, fraud, and abuse. These investments can reduce the amount of program dollars wasted on improper payments, but states cannot eliminate waste, fraud, and abuse entirely because the costs of identifying every potential improper payment would eventually outweigh the potential losses and unduly burden legitimate providers.

Conclusion

This chapter provides an overview of the policy levers available to states and the federal government under current program authorities to reduce spending and achieve other program efficiencies. We will conduct more in-depth analyses of options intended to provide states with flexibility to manage and design their programs to enhance efficiency, reduce costs, and improve health care quality. We will also examine areas where Congress has already provided states with alternatives and the reasons, such as the ability to achieve similar goals through alternate authority, why states have chosen not to implement certain options. Finally, we will assess the potential outcomes associated with different choices, including the effects on federal and state spending, beneficiaries, and providers, and we will explore the trade-offs associated with each. These additional analyses will help inform future debate on redesigning Medicaid's financing structure.

Endnotes

- ¹ The ACA also set a single income eligibility disregard equal to 5 percentage points of the FPL. For this reason, eligibility is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.
- ² Prior to the enactment of the ACA, adults not eligible on the basis of disability without dependent children were generally excluded from Medicaid unless the state covered them under a Section 1115 waiver.
- ³ At times, Congress has imposed limits on states' ability to terminate coverage of optional eligibility groups by enacting MOE provisions. The ACA included provisions requiring states to maintain the eligibility levels in place at the time the ACA was enacted—for adults in Medicaid until 2014 and for children in Medicaid and the State Children's Health Insurance Program (CHIP) until 2019.
- ⁴ Although low-income adults without dependent children is a mandatory group under the statute, the Supreme Court ruling in 2012 effectively made the ACA expansion of coverage to this group optional by removing the Secretary's enforcement mechanism.
- ⁵ States receive an enhanced 90 percent federal match for the first eight fiscal quarters of the health home benefit. Other optional services are matched at the state's regular federal medical assistance percentage (FMAP).
- ⁶ States have discretion to vary the amount, duration, or scope of the services that they cover as long as each service is "sufficient in amount, duration, and scope to reasonably achieve its purpose" and is not arbitrarily denied or reduced due to an individual beneficiary's diagnosis, type of illness, or condition (42 CFR 440.230). States are generally required to make Medicaid benefits available to all eligible individuals, regardless of their geographic location within the state.
- ⁷ Groups excluded from mandatory enrollment in benchmark coverage are individuals who are medically frail or have special medical needs, pregnant women, persons dually enrolled in Medicaid and Medicare, certain parents, and individuals who qualify for Medicaid on the basis of blindness or disability.

⁸ States must assure access to federally qualified health center (FQHC) services, rural health clinic (RHC) services, non-emergency medical transportation, family planning services and supplies, and EPSDT services for children under age 21 either through the alternative benefit packages or as additional benefits provided by the state. States must also meet the mental health parity requirements. The ACA added a requirement that benchmark coverage must include the 10 EHBs offered in the individual and small group insurance markets. The EHBs include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

⁹ The foundational statutory provision for Medicaid provider payment requires that states provide payment for all Medicaid-covered services to “safeguard against unnecessary utilization,” be “consistent with efficiency, economy, and quality of care,” and be “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area” (§ 1902(a)(30)(A) of the Social Security Act).

¹⁰ Medicaid providers have used this provision to sue state Medicaid agencies for inadequate Medicaid payment rates, but on March 31, 2015, the U.S. Supreme Court precluded future lawsuits when it decided in *Armstrong v. Exceptional Child Center, Inc.*, that Medicaid providers do not have the right to sue Medicaid agencies regarding payment rates under the Supremacy Clause of the Constitution or under Section 1902(a)(30)(A) of the Social Security Act.

¹¹ Cost containment is not the only reason states implement Medicaid managed care: this model also allows states to make improvements in the delivery of health services and obtain better value (even if spending is not reduced) through provider contracting and quality oversight.

References

AcademyHealth. 2015. *Evidence roadmap: Medicaid managed care*. Washington, DC: AcademyHealth. https://www.academyhealth.org/files/FileDownloads/AH_Evidence%20Roadmap11%20v3.pdf.

Avalere Health. 2014. Medicaid managed care enrollment set to grow by 13.5 million. October 23, 2014, press release. Washington, DC: Avalere Health. http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1414069964_20141023_Medicaid_Managed_Care_Press_Release_FINAL.pdf.

Brooks, T., S. Miskell, S. Artiga, et al. 2016. *Medicaid and CHIP eligibility, enrollment, renewal, and cost-sharing policies as of January 2016: Findings from a 50-state survey*. Washington, DC: Kaiser Family Foundation. <http://kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey>.

Centers for Disease Control (CDC), U.S. Department of Health and Human Services. 2016. National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Atlanta, GA: CDC. <http://www.cdc.gov/cancer/nbccedp/about.htm>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Cost sharing. Baltimore, MD: CMS. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/cost-sharing/cost-sharing.html>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015a. *Medicaid managed care enrollment and program characteristics, 2013*. Baltimore, MD: CMS. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2013-managed-care-enrollment-report.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015b. *Medicaid and CHIP 2014 improper payments report*. Baltimore, MD: CMS. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP->

[Compliance/PERM/Downloads/2014MedicaidandCHIPAnnualErrorRateReport1.pdf](#).

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015c. *Medicare fee-for-service 2014 improper payments report*. Baltimore, MD: CMS. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/MedicareFeeforService2014ImproperPaymentsReport.pdf>.

Dickson, V. 2015. Michigan Medicaid waiver appears to save eligibility for 600,000 residents. *Modern Healthcare*, December 17. <http://www.modernhealthcare.com/article/20151217/NEWS/151219876>.

Kaiser Family Foundation (KFF). 2014. Medicaid-to-Medicare fee index. Washington, DC: Kaiser Family Foundation. <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index>.

Kaiser Family Foundation (KFF). 2012. Medicaid benefits data collection. Washington, DC: Kaiser Family Foundation. <http://kff.org/data-collection/medicaid-benefits>.

Mathematica Policy Research (Mathematica). 2016. *Medicaid managed care trends and snapshots 2000–2013*. Baltimore, MD: Centers for Medicare & Medicaid Services. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2013-medicare-managed-care-trends-and-snapshots-2000-2013.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016a. Exhibit 36: Medically needy program thresholds as percent of FPL, 2014. In *MACStats: Medicaid and CHIP data book*. December 2015. Washington, DC: MACPAC. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-36.-Medicaid-Income-Eligibility-Levels-as-a-Percentage-of-the-FPL-for-Individuals-Age-65-and-Older-and-Persons-with-Disabilities-by-State-2015.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016b. *Expanding Medicaid to the new adult group through Section 1115 waivers*. February 2016. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2016/02/Waiver-Summaries-Overview.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015a. *Report to Congress on Medicaid and CHIP*. June 2015. Washington, DC: MACPAC. <https://www.macpac.gov/publication/june-2015-report-to-congress-on-medicare-and-chip>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015b. *Report to Congress on Medicaid and CHIP*. March 2015. Washington, DC: MACPAC. <https://www.macpac.gov/publication/march-2015-report-to-congress-on-medicare-and-chip>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2014. Table: State Medicaid payment policies for inpatient hospital services. Washington, DC: MACPAC. <https://www.macpac.gov/publication/macpac-inpatient-hospital-payment-landscapes>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2011a. *Report to the Congress on Medicaid and CHIP*. March 2011. Washington, DC: MACPAC. <https://www.macpac.gov/publication/report-to-the-congress-on-medicare-and-chip-311/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2011b. *Report to the Congress on Medicaid and CHIP*. June 2011. Washington, DC: MACPAC. <https://www.macpac.gov/publication/report-to-congress-the-evolution-of-managed-care-in-medicare/>.

Moses, K. 2014. Presentation before the Medicaid and CHIP Payment and Access Commission, April 10, 2014, Washington, DC. <https://www.macpac.gov/wp-content/uploads/2015/01/2014AprilSession1a.pdf>.

National Association of Medicaid Directors (NAMD) and Bailit Health. 2016. *The role of state Medicaid programs in improving the value of the health care system*. Washington, DC: NAMD. http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicare.pdf.

National Conference of State Legislatures (NCSL). 2016. Recent Medicaid prescription drug laws and strategies. Washington, DC: NCSL. <http://www.ncsl.org/research/health/medicaid-pharmaceutical-laws-and-policies.aspx>.

Rosenbaum, S., N. Lopez, and S. Stifler. 2009. *Health insurance fraud: An overview*. Washington, DC: Department of

Health Policy, School of Public Health and Health Services, The George Washington University. http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1227&context=sphhs_policy_facpubs.

RTI International (RTI). 2014. *State Innovation Models (SIM) initiative evaluation model test base year annual report*. Baltimore, MD: Centers for Medicare & Medicaid Services. http://downloads.cms.gov/files/cmml/SIM-Round1-ModelTest-FirstAnnualRpt_5_6_15.pdf.

Rudowitz, R., and M. Musumeci. 2015. *The ACA and Medicaid expansion waivers*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers>.

Scott, D. 2012. Medicaid Expansion & States: Will They or Won't They? *Governing*, December 2012. <http://www.governing.com/topics/health-human-services/gov-medicaid-expansion-and-states.html>.

Smith, V., K. Gifford, E. Ellis, et al. 2015. *Medicaid reforms to expand coverage, control costs and improve care: Results from a 50-state Medicaid budget survey for state fiscal years 2015 and 2016*. Washington, DC: Kaiser Family Foundation and National Association of Medicaid Directors. <http://kff.org/medicaid/report/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2015-and-2016/>.

Smith, V., K. Gifford, E. Ellis, et al. 2010. *Hoping for economic recovery, preparing for health reform: A look at Medicaid spending, coverage and policy trends—results from a 50-state Medicaid budget survey for state fiscal years 2010 and 2011*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8105.pdf>.

Smith, V., K. Gifford, E. Ellis, et al. 2007. *As tough times wane, states act to improve Medicaid coverage and quality: Results from a 50-state Medicaid budget survey for state fiscal years 2007 and 2008*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7699.pdf>.

Smith, V., R. Ramesh, K. Gifford, et al. 2003. *States respond to fiscal pressure: State Medicaid spending growth and cost containment in fiscal years 2003 and 2004*

results from a 50-state survey. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/states-respond-to-fiscal-pressure-state-medicaid-spending-growth-and-cost-containment.pdf>.

Takach, M., C. Townley, R. Yalowich et al. 2015. Making multipayer reform work: What can be learned from medical home initiatives. *Health Affairs* 34, no. 4: 662.72. <http://www.commonwealthfund.org/publications/in-brief/2015/apr/making-multipayer-reform-work>.

U.S. Government Accountability Office (GAO). 2015. *High risk series: An update*. Report no. GAO-15-290. Washington, DC: GAO. <http://www.gao.gov/assets/670/668415.pdf>.

U.S. Government Accountability Office (GAO). 2012. *Opportunities for financial savings and program improvements in Medicare and Medicaid remain*. Report no. GAO-12-719T. Washington, DC: GAO. <http://www.gao.gov/assets/600/590722.pdf>.

Wholey, D., M. Finch, N. Shippee, et al. 2016. *Evaluation of the State of Minnesota's Health Care Homes Initiative evaluation report for years 2010–2014*. Minneapolis, MN: Division of Health Policy and Management, School of Public Health, University of Minnesota. z.umn.edu/hch2016report.