MEDICAID COST CONTAINMENT: REPORT NO. 3

Prepared for:
The Washington State Legislature

Prepared by:
The Lewin Group, Inc.

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I. EXECUTIVE SUMMARY

This report provides an analysis of possible new cost containment and revenue enhancement strategies for Washington, based on research, practices in other states, and the unique environment in Washington. Prior to this report, The Lewin Group developed two other reports for this project. The first inventoried current cost containment efforts in Washington and the second analyzed these strategies, as well as some that have not been implemented. This is Lewin's final report.

In general, there are three primary tools to reduce net expenditures in Medicaid: working "smarter" and more efficiently, implementing program cuts, and enhancing revenue. In Report No. 2, which we delivered to Washington in December 2002 (with a supplemental report on pharmacy delivered in January 2003), we analyzed many of the "working smarter" initiatives Washington launched in an effort to stave off program cuts. The following two sections of this report focus on possible strategies for budget reductions and for enhancing revenues. Within each focus area, Lewin presents detailed examples from other states and a savings estimate (where possible) of the implementation of a similar initiative in Washington.

The goal of this report is to put several options on the table for Washington to consider as it moves forward with its Medicaid cost containment activities. Lewin was asked to present options rather than make recommendations; our options relate to areas in which Washington's Medicaid program varies the most from other states' programs.

Like Washington, almost all states are experiencing a fiscal crisis, and Medicaid is considered to be one of the largest causes of the budget problem. States have several policy tools to address these budget challenges. For varying reasons, all can be politically difficult, and all represent hard choices.

In the past, states approached Medicaid budget problems by rounding up some of the usual suspects: maximizing federal funding through techniques such as disproportionate share hospital (DSH) payments; imposing strict eligibility controls and means-testing to reduce the Medicaid caseload; implementing managed care to re-orient utilization; and cutting provider payment rates.

Those traditional tools remain the first and best option for many states to address their budget problems, but their effectiveness has been reduced by growing resistance from the federal government, advocates, and providers. Now, new variations on these themes are emerging: finding new non-tax matching funds in tobacco settlements or supplemental pharmacy rebate programs, or accepting the invitation from the federal Centers for Medicare and Medicaid Services (CMS) to create tiered Medicaid programs-within-the-program for higher-income Medicaid beneficiaries under the new Health Insurance Flexibility and Accountability (HIFA) waiver process. Washington is ahead of virtually all states in moving forward on these fronts.

Carefully selecting and tailoring a Medicaid budget strategy can enable a state to continue serving vulnerable Medicaid beneficiaries without compromising the quality of care. But injudicious selection from among these options can lead to major problems. Apart from the risks posed *within* the Medicaid program by crudely selecting a budget containment strategy –

including the creation of access problems, the threat of federal audits, and the diminished health status of Medicaid beneficiaries – a poor Medicaid cost containment plan might reverberate throughout a state's overall health care system.

These ripple effects could include increases in the rate of the uninsured in the State, the loss of crucial funding to keep safety-net providers afloat, and the general loss of federal funding into urban and rural areas where the financial support that Medicaid provides not only serves a health care objective but also serves an economic development and jobs creation objective. Therefore, it is clear to Lewin, as it is to policy-makers in Washington State, that there are no easy or "painless" solutions to the State's Medicaid budget problem.

Certainly, Washington's Medicaid program has already been successful in reducing and containing costs by working "smarter" and more efficiently than virtually all other states. As one of its efforts to contain costs, the State of Washington established the Medicaid Utilization and Cost Containment Initiative (UCCI), which is designed to find efficiencies and lower expenditures in the State's Medicaid program, without reducing benefits or eligibility. In addition to UCCI, the State is also exploring other avenues for potential savings in its Medicaid program. As described in more detail in Report No. 2, Lewin has estimated that between $25.4 million and $30.2 million in cost avoidance and recovery is attributable to UCCI (exclusive of additional administrative expenses associated with UCCI). The UCCI program savings were generated as a result of increasing coordination of benefits as well as provider audits and quality reviews. The savings generated from these initiatives is a substantial victory for the taxpayers of Washington State.

Many states' Medicaid programs have undertaken a variety of cost containment initiatives in recent years. Not many, however, have worked as diligently as Washington to carefully measure the success of these initiatives. As Washington moves forward in implementing its cost containment strategies, the State will need to continue this type of measurement to determine the success of each initiative.

What follows in this report would build on UCCI. Table 1 shows the potential cost containment or revenue enhancement benefits to Washington's budget that are attributable to the options described in this report.

Table 1. Summary Effects of Various Cost Containment/Revenue Enhancement Approaches*

Approach	Annual Cost Containment/ Revenue (in millions)
Hospital rate reduction to FY 00 profit levels	$87.2
Long term care (the following are not cumulative)	
- Raise level of care in COPES	$41.5
- Cap COPES enrollment	$25.9
- Eliminate Medicaid personal care (MPC), but move eligible people to COPES	$18.1
- Raise MPC functional requirement to COPES standard	$22.7
Six Month Reporting for Pregnant Women and Children	$56.4**
Capitation Rate Setting	$30.5
Dual Eligible Cost Shifting	***
Indian Health Services and Tribal 638 Facilities	***
Employer Premium Assistance Program	***
Supplemental Pharmacy Rebates (two drug classes only)	$1.4
Nursing Facility Tax	$1.8

* As detailed in the full report, these figures may not relate to the same state fiscal year.

** This is premised on a study Lewin performed regarding California's Medicaid program. Issues involved in applying these assumptions to Washington are discussed in the full report. Moreover, this reflects savings in the entire biennium, with the majority of the savings achieved in SFY 2005, after full ramp-up. MAA's estimate is lower for the biennium: $43.7 million. This is discussed in the full report.

*** Due to the unavailability of data from Washington and/or the state that is utilizing this concept, an estimate could not be developed. The approach is described in the report and we recommend that the Legislature and DSHS evaluate its applicability in Washington.

As noted in the Table 1, for some strategies outlined in the report, creating credible estimates was not possible within the time and scope of this project. However, we encourage the reader to explore each section in order to gain some sense of the order of magnitude of the savings associated with these approaches.

II. COST CONTAINMENT

The Kaiser Family Foundation (KFF) commissioned a survey of states to identify state Medicaid spending trends, how states are responding to these trends, and their overall fiscal conditions.[1] The survey found that states are facing significantly increased Medicaid costs and that the overwhelming majority of states are implementing Medicaid cost control strategies, as Washington has been doing in recent years. For the second year in a row, Medicaid spending has increased by more than 10 percent. States reported that in fiscal year (FY) 2002, total Medicaid spending increased 13 percent, while the state share of Medicaid spending increased 11 percent. As in Washington, many states cite increasing pharmacy costs and increased enrollment as the primary factors behind spending growth. States' focus on Medicaid cost containment activities has increased from FY 2002 to FY 2003.

The KFF report cites the top five strategies being deployed by states to achieve Medicaid cost containment: prescription drug cost controls, reducing/freezing provider payment rates, reducing/restricting Medicaid eligibility, reducing the scope of Medicaid benefits, and increasing beneficiary co-payments. As described below, Washington is deploying each and every one of these strategies:

- 40 states are planning to implement prescription drug cost controls in FY 2003; the most common activities are prior authorization, reductions in payments for drugs through application of greater discounts, or a Maximum Allowable Cost list for generics. Washington is ahead of its peers and has already moved forward with these pharmacy initiatives in its UCCI effort.
- 29 states are either reducing or freezing some of their provider payment rates in FY 2003; in this report we mention two Washington could consider (hospital rates and managed care rates).
- 15 states are reducing Medicaid benefits in FY 2003; in this report we mention one Washington could consider (long term care). Washington is including some possible benefit reductions in its HIFA application; details of other states' proposed benefit reductions are included in this section.
- 18 states are reducing or restricting Medicaid eligibility – more details on some states' proposed eligibility cuts are included below; in this report we describe one eligibility reduction Washington could consider (eliminate continuous eligibility).
- 15 states are increasing beneficiary co-payments, as Washington has proposed in its HIFA waiver.

Table 2, from the KFF report, includes cost containment activities undertaken in FY 2003. Almost every state has undertaken some form of Medicaid cost containment activities, some more drastic than others. States continue to add to this list to change their Medicaid programs to contain costs.

[1] Medicaid Spending Growth: Results from a 2002 Survey, Kaiser Family Foundation, September 2002.

Table 2. Cost Containment Actions Taken in Each of the 50 States and the District of Columbia for FY 2003

State	Provider Payments	Pharmacy Controls *	Benefit Reductions	Eligibilty Cuts	Copays **	Managed Care Expansions	DM/CM	Fraud and Abuse	LTC
Alabama									
Alaska	X	X						X	
Arizona		X	X	X	X				
Arkansas							X		
California	X	X	X	X	X		X	X	
Colorado	X	X		X			X	X	
Connecticut		X	X	X				X	X
Delaware	X	X	X	X	X	X	X	X	X
District of Columbia								X	X
Florida		X	X			X		X	
Georgia		X		X			X	X	X
Hawaii	X	X							
Idaho									
Illinois	X	X		X	X		X	X	X
Indiana	X	X	X	X		X	X	X	
Iowa	X	X					X		X
Kansas	X	X	X	X		X	X		
Kentucky	X	X			X			X	
Louisiana		X				X	X		
Maine									
Maryland	X	X							
Massachusetts		X		X	X		X	X	
Michigan	X	X		X	X				X
Minnesota									
Mississippi	X	X	X		X		X	X	X
Missouri	X	X	X	X					
Montana	X	X	X						
Nebraska	X	X		X					
Nevada	X	X				X	X		
New Hampshire		X		X	X		X		
New Jersey	X	X							
New Mexico		X						X	X
New York	X	X				X		X	
North Carolina		X	X	X		X	X		X
North Dakota				X					
Ohio	X	X			X	X	X	X	X
Oklahoma		X							
Oregon	X	X			X		X		
Pennsylvania				X		X		X	X
Rhode Island	X		X		X	X			
South Carolina									
South Dakota	X	X							
Tennessee									
Texas	X	X	X		X			X	
Utah	X	X	X		X				
Vermont		X							
Virginia	X	X					X		
Washington						X	X		
West Virginia	X	X	X	X	X		X	X	
Wisconsin	X	X							X
Wyoming	X	X					X	X	
Total	**29**	**40**	**15**	**18**	**15**	**12**	**21**	**19**	**13**

* Pharmacy controls include states that began or increased beneficiary co-payments for prescription drugs.
** Co-payments category includes states that began or increased beneficiary co-payments for health care services other than prescription drugs.

There has been considerable press dedicated to state budget problems recently, particularly in states where eligibility and benefit cuts are on the table. California Governor Gray Davis proposed $10.2 billion in cuts on December 6, 2002, including cuts in health care programs. Davis' proposed cuts to health care include several changes to the State's Medi-Cal (Medicaid) program. Income eligibility limits would be reduced to 61 percent of the federal poverty level (FPL) for low-income individuals. In actual dollars, the level would be reduced from $18,000 a year for a family of four to $12,000. The State projects savings of $62 million in the fourth quarter and $118 million next year. More than 200,000 beneficiaries would lose their coverage. Medi-Cal beneficiaries would be required to re-verify their eligibility quarterly rather than every year, for an expected savings of $5 million in the current fiscal year and $85 million in the next fiscal year. Optional Medi-Cal benefits, including dental care and medical supplies, would be eliminated. Medi-Cal payment to physicians and other providers would be cut by 10 percent. Hospitals and federally qualified health centers would not be affected.

Similarly, in November 2002, Colorado Governor Bill Owens ordered Medicaid cuts, expected to total three percent from a $1.7 billion budget for 2002/2003. Due to these cuts, nursing home residents and people with severe disabilities or mental illnesses are likely to lose coverage for some medical services. Colorado may also decide to limit eligibility for Medicaid disability benefits and reduce the services such beneficiaries can receive.

Massachusetts temporarily ceased accepting patients in the Children's Medical Security Plan, citing higher-than-expected enrollment. Children in families that have incomes too high to qualify for Medicaid but cannot afford private insurance are eligible for the program, which covers primary and preventive care. The State has budgeted for the plan to cover 26,000 children, and it assumed a growth rate between 200 and 300 new beneficiaries per month. However, enrollment recently grew to between 500 and 600 new beneficiaries per month, and by the end of September, enrollment had reached 27,679. Enrollment will not resume until participation drops to below 26,000, which is expected in early 2003.

Missouri attempted to contain its Medicaid costs but has encountered several problems, including litigation, rule and contract challenges, provider distress, and extremely active lobbying groups. Missouri's Medicaid cost containment activities reduced custodial parents' eligibility from 100 percent of FPL to 77 percent of FPL, resulting in a reduction of 33,000 people. Non-custodial parents and a category called "Parents Fair Share" participants also were eliminated, a reduction of 1,400 people. Temporary Assistance for Needy Families (TANF) transitional coverage was reduced to one year from two years and income eligibility moved from 100 percent of FPL to 33 percent of FPL, a reduction of another 3,200 people. Women's Health Services were reduced from two years 60 days to one year 60 days, affecting about 15,250 post-delivery women. The total budgeted savings for FY 2003 are $29.1 million. Other program reductions, including reducing payments to providers, eliminating dental services for adults, eliminating eyeglass coverage for adults, and eliminating male circumcisions are expect to result in a total of $32.5 million.

Texas recently attempted to implement beneficiary co-payments for pharmaceuticals, but on December 16, 2002 the State's pharmacy association obtained a restraining order preventing the State's co-payment rule from taking effect. The association convinced the court that the

co-payments would not be collectible by the pharmacies, effectively resulting in a fee decrease to them that would therefore jeopardize access to care.

In 2002, Tennessee obtained CMS' approval for substantial changes to its landmark TennCare program. These changes are intended to ensure TennCare's financial viability by eliminating some 200,000 enrollees (of the program's 1.46 million membership). However, on December 19, 2002 a judge barred TennCare from eliminating these people, citing a "flawed" re-verification process. In early January 2003, a federal appeals court reversed this decision. Lawyers for affected beneficiaries have appealed. If the injunction is re-instated, Tennessee will not be able to save $300 million per year associated with this group of people.

When faced with the difficult decision of deciding which eligibility groups to cut or which benefits to reduce, states must consider that there may be lawsuits, often from the advocate or provider communities. The examples included above from California, Colorado, and Massachusetts are more recent and no attempts have been made yet to implement these programs; when programs are implemented, these states may also face litigation like Texas, Tennessee, and Missouri did, which can delay or change the program implementation. Moreover, stalled cost containment efforts fail to help solve the growing budget crisis.

As detailed in our first two reports, Washington already has taken steps to contain costs in its Medicaid program, and has other initiatives planned for the future. For example, UCCI aims to reduce expenditures and increase revenues through "working smarter" approaches. Many of Washington's efforts to use resources more efficiently and to identify areas for fiscal improvement – such as increased audit and quality review efforts – were made possible and more fruitful by the introduction of new technology. Specifically, Washington's new Payment Review Program allowed staff throughout the Medical Assistance Administration (MAA) and the Department of Social and Health Services (DSHS) to harness the power of their data for purposes of containing costs and increasing revenues.

As MAA and DSHS look forward and continue their efforts to contain costs and more efficiently manage their resources, having a functional and comprehensive information technology (IT) system will be the backbone of the State's success. It will allow the State to improve and actively monitor its current cost containment initiatives, while more effectively implementing future activities, such as those outlined in the following report. We encourage DSHS to stay vigilant in its efforts to implement a strong IT infrastructure to support its ongoing and future cost containment efforts.

A. Hospital Reimbursement

Several states have considered or implemented changes in Medicaid payments to hospitals as one approach to cost containment. These initiatives consider a number of factors to guide decision making, including:

- The overall financial performance of hospitals in the State, and the extent to which reducing or adjusting Medicaid payments would lead to financial distress – particularly for hospitals that serve a large number of Medicaid beneficiaries;
- The extent to which current hospital payment rates already are at or below the cost of delivering hospital care;

- Whether current methodologies for establishing fee-for-service (FFS) payment rates are more (or less) generous than approaches in other states or the federal Medicare program;
- The extent to which beneficiaries are enrolled in managed care organizations (MCOs), thus moderating the impact of FFS rate adjustment (unless MCOs have adopted FFS payment approaches or capitation rates paid to MCOs also are reduced); and
- Whether rate reductions can be implemented equitably and thus assure continued access to care for beneficiaries.

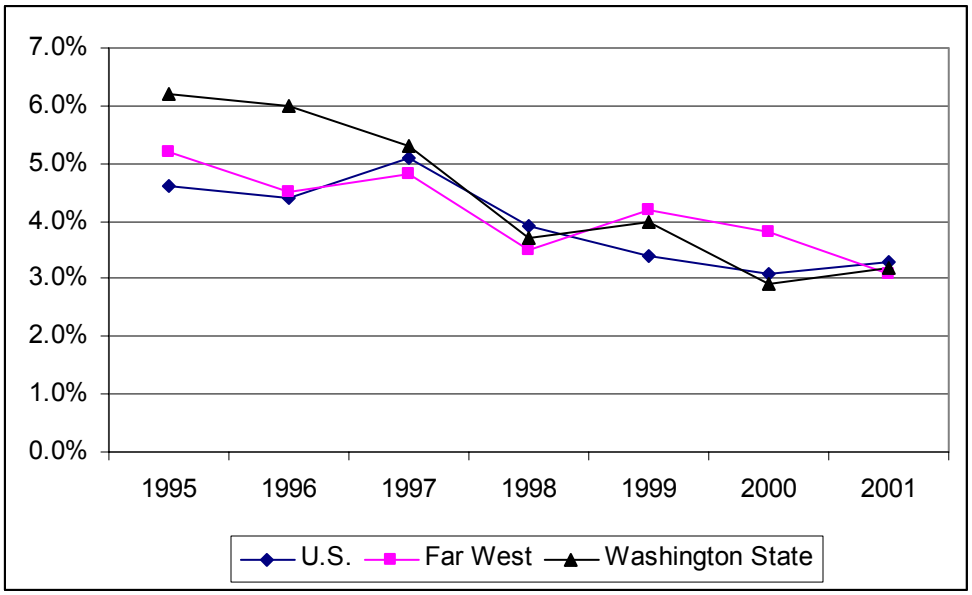
As discussed below, Washington could save approximately $87.2 million by reducing Medicaid payments by an average of 11.2 percent. This would reduce hospitals' operating margins to approximately 1.5 percent, which is slightly above the average operating margins hospitals were at in FY 2000. In our judgment, an expenditure cut at this level may be survived by hospitals in the short term, but is not sustainable in the long term; moreover, such a reduction would need to be distributed carefully across hospitals (since many already are losing money).

In addition to considering the potential effects of reducing hospital payments, Washington will need to take into account other cost containment strategies that may overlap or have essentially the same effect as reducing reimbursement levels. Specifically, the Governor's recent budget proposal calls for several cost saving measures -- including the elimination of the medically indigent program, the reduction in the vendor rate increase, and the reduction in Basic Health Plan enrollment -- that could greatly affect the reimbursement levels realized by Washington's hospitals. The options for cost savings contained in this chapter were developed exclusive of any of the Governor's proposals, and we recommend that Washington carefully consider the effect these proposals will have on both Medicaid and the larger health care system before implementing any changes to hospital reimbursement.

1. Washington State Hospital Financial Performance

Data available from Medicare Cost Report filings and the Washington State Hospital Association indicate that hospitals in Washington State have been profitable in recent years, and that margins are consistent with the U.S. average (Table 3). Total margins, which include investment profit from income earned on hospital reserves, have fallen, but remain above three percent.

Table 3. Median Hospital Total Margins, 1995 to 2001

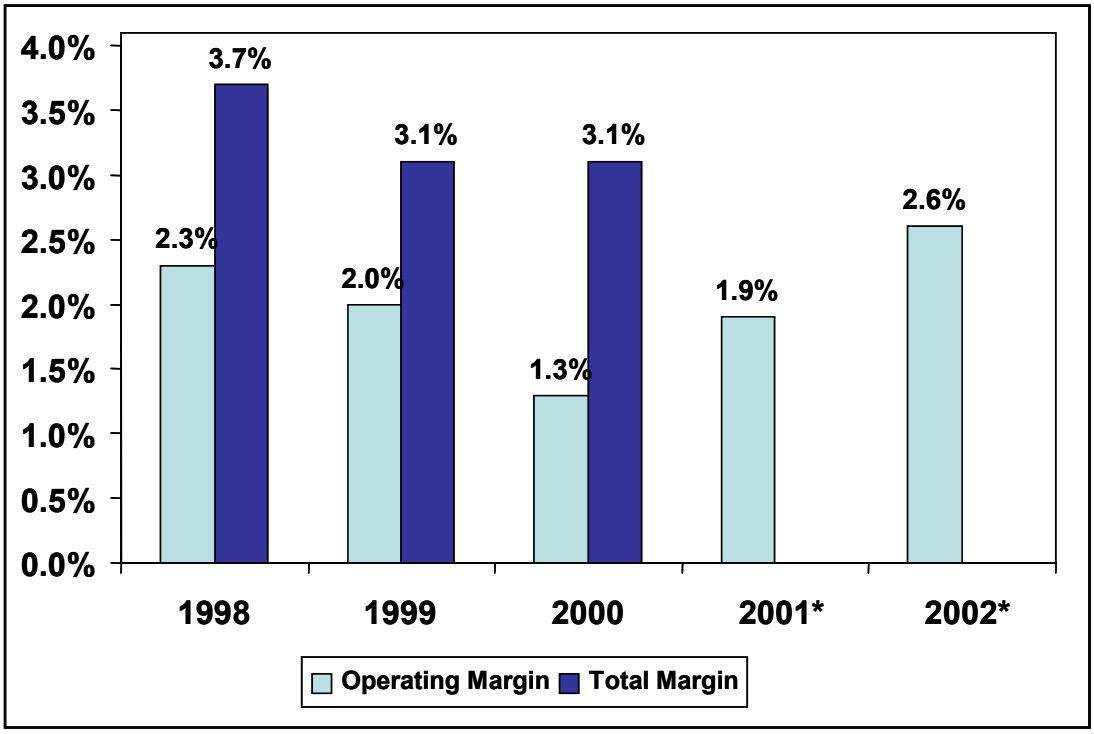


Source: 2001 Almanac of Hospital Financial and Operating Indicators.

According to data published by the Washington Hospital Association, in 2000 hospital operating margins fell to a low of 1.3 percent (i.e., profit on operations equaled 1.3 percent of total operating revenues).[2] In that same year, hospital total margins fell to 3.1 percent (Table 4). In 2002, hospital operating margins improved to 2.6 percent.

[2] Operating margins are based on income and expenses on operations, and excludes profit on hospital investments of reserve funds.

Table 4. Operating and Total Margins for Washington State Hospitals



* Data on total margin not available. Source: Washington State Hospital Association.

Hospitals are capital-intensive organizations that use net income (generated by positive margins) to replenish fixed assets (buildings and equipment) and to qualify for and re-pay borrowings. Most analysts believe that positive operating margins are necessary over the longer run to provide resources for these needs, which typically are greater than those of other groups of providers (e.g., physicians and nursing homes).

2. Medicaid Payments Compared to Cost

Data from the American Hospital Association indicate that Medicaid payments to Washington hospitals covered about 95.0 percent of the costs of treating Medicaid patients in 1999 (Table 5). This percentage is slightly below the national average of 95.5 percent, but is above the ratios found in most other western states.

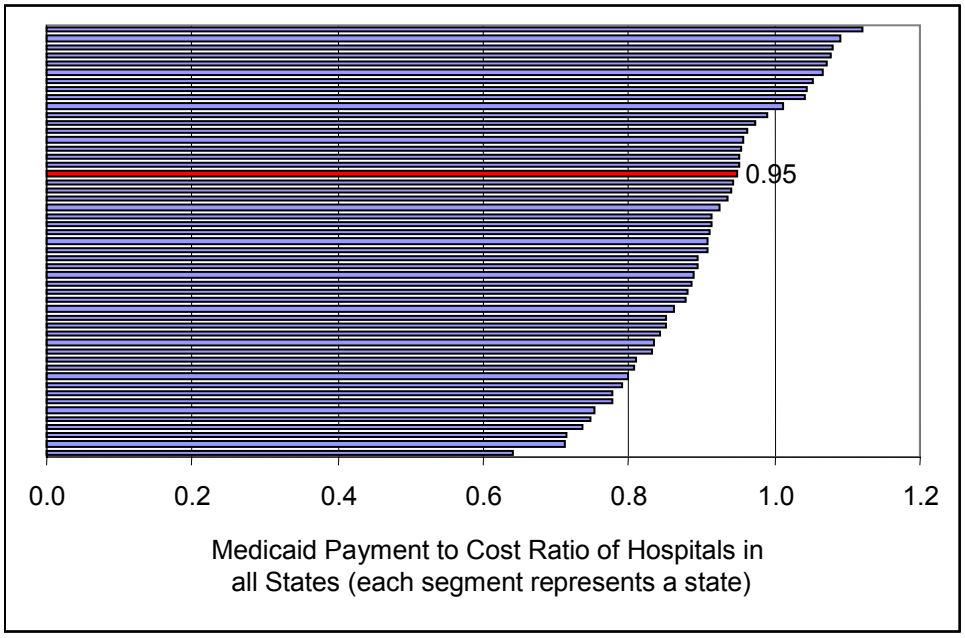
Table 5. Medicaid Revenues as a Percentage of Hospital Costs in 1999*

State	Medicaid Revenues as a Percentage of Costs
Arizona	80.6%
Idaho	94.3%
Oregon	87.9%
California	91.1%
Washington	**95.0%**
Nevada	95.6%
US Average	**95.5%**

* Includes payments and costs for all inpatient and outpatient services and DSH
Source: American Hospital Association Trendwatch Chartbook, 2001.

Across the United States, Washington ranked 18th highest in its Medicaid payment to cost ratio, as shown in Table 6.

Table 6. Medicaid Revenues as a Percentage of Costs in 1999



Source: American Hospital Association Trendwatch Chartbook, 2001.

Based on data from the Washington State Hospital Association for 2002, Medicare and Medicaid payments to hospitals in the State were below the cost of treating these patients. Profits for all other payers equaled 6.5 percent of revenues from these patients. In other words, in Washington both Medicaid and Medicare cost shift to private payers, so that on balance hospitals are able to generate a positive margin (Table 7).

Table 7. Hospital Margins by Payer Type in 2002

Payer	Weighted Patient Care Total Margin	Percentage of Net Patient Revenues by Payer
Medicare	-2.0%*	33.4%
Medicaid	-1.1%*	14.7%
All Other Payers	6.5%	51.8%

* For further context, please see Footnote 3 on Page 16.
Source: Lewin Group analysis of Washington State Hospital Association data.

Based on these data, we conclude that Medicaid payments for Washington hospitals have been approximately five percent below the cost of care. Because Medicaid services comprise approximately 15 percent of all hospital care in the State, the below-cost payments have reduced overall hospital margins in the State by approximately 0.8 percentage points on a weighted basis. Washington's Medicaid payments to hospitals have been comparable to the national average, and the State's payment-to-cost ratio has been higher than the U.S. median.

3. Description of Washington Medicaid's Hospital Fee-for-Service Payment Methods

Washington Medicaid reimburses hospitals in Washington State based in large part on the type of hospital, service provided, and setting of care. Table 8 briefly describes these methods and compares them to Medicare payment methods.

Table 8. Description of Medicaid and Medicare Payment Methods

Hospital Group	Medicaid Payment Method	Medicare Payment Method
Payment Method for Inpatient Services		
Critical Access Hospitals (CAH) *	Retrospective cost reimbursement	Retrospective cost reimbursement
Rural Hospitals (Type A) **	Cost based reimbursement (allowed charges * RCC ***)	DRG prospective payment except for Sole Community Hospitals and Medicare Dependant Rural Hospitals
Hospitals Participating in the Selective Contract Program	DRG prospective payment using negotiated conversion factor ****	DRG prospective payment
Other Acute Care Hospitals	DRG prospective payment using cost based conversion factor ****	DRG prospective payment
Specialty Hospitals *****	Cost based reimbursement (allowed charges * RCC) or fixed per diem rates.	Various methods depending on type of hospital
Payment Method for Outpatient Services		
Critical Access Hospitals (CAH)	Retrospective cost reimbursement	Retrospective cost reimbursement
Other Acute Care Hospitals	Percentage of Allowable Charges (allowed charges * RCC * outpatient adjustment) ******	Outpatient Prospective Payment

* Critical Access Hospitals are small rural hospitals certified by the Centers for Medicare and Medicaid Services (CMS) under the Critical Access Hospital Program Established in the Balanced Budget Act.

** Rural hospitals are defined as hospitals located outside of a metropolitan statistical area.

*** Ratio of costs to charges (RCC) for Medicaid allowable inpatient costs.

**** Certain services are exempt from prospective payment including: neonatal care, AIDS related services, alcohol and drugs detoxification, acute physical medicine and rehabilitation, psychiatric services, chronic pain management, organ transplants and administrative days. These services are paid under the RCC methodology.

***** Specialty hospitals include Children's hospitals, psychiatric hospitals, rehabilitation hospitals, and long term care hospitals.

****** Reimbursement for outpatient services are computed as allowed charges multiplied by an adjusted inpatient RCC (for 2003 the inpatient RCCs are reduced by about 28%). Outpatient prospective payment is scheduled for 2004.

Nearly half of hospitals that treat Washington's Medicaid recipients are paid under cost-based reimbursement methods (CAH and rural hospitals). However, these facilities account for only about 10 percent of total Medicaid inpatient discharges (Table 9). Thus, the vast majority of inpatient care is reimbursed under the DRG prospective payment methodologies.

Table 9. Distribution of Hospitals and Medicaid Discharges by Payment Method*

Hospital Group	Number of Hospitals	Hospitals	Medicaid Discharges in 2001
Critical Access Hospitals (CAH)	25 Hospitals	23%	4%
Rural Hospitals (Type A)	14 in Washington/6 in border States	19%	7%
Hospitals Participating in the Selective Contracting Program	28 in Washington/ 5 in border States	31%	59%
Other Short Term General Hospitals	19 in Washington/ 5 in border States	22%	26%
Specialty Hospitals	5 hospitals	5%	5%
Total Short Term Hospitals	107 Hospitals	100%	100%

* Includes Medicaid fee-for-service discharges in 2001.

Source: Lewin's analysis of Medicaid program data for 2002.

Washington's inpatient DRG prospective payment system is comprised of a hospital specific conversion factor multiplied by a DRG relative payment weight that yields a prospective payment for each Medicaid patient discharge. Hospital specific conversion factors are computed using the hospital's historical Medicaid allowable costs per discharge, adjusted for efficiency and inflated to the current payment year. A negotiated conversion factor is used for hospitals that participate in the Selective Contracting Program, which incorporates a negotiated discount from the hospital's cost-based conversion factor. Table 10 shows the features of Washington States' Medicaid DRG payment system compared to the Medicare system.

Table 10. Comparison of Medicare and Medicaid Inpatient DRG Systems

Payment Type	Medicaid	Medicare
Payment for Operating and Capital Expenses	Hospital specific rates based on 1998 costs. Rates capped at the 70th percentile within peer group. Inflated to current year. Negotiated rates for hospitals in selective contracting areas.	Separate National Rates for operating and capital payments, adjusted for area wage differences and whether hospitals are in large urban areas. Initial rates set in 1983 and inflated to current year.
Indirect Medical Education	Included in base conversion factor rates **(not subject to 70th percentile cap).**	Add on to operating and capital payments based on hospitals resident to bed ratio.
Direct Medical Education	Included in base conversion factor rates **(not subject to 70th percentile cap).**	Prospective amount based on number of residents, an updated per-resident amount, and hospital's Medicare utilization rate.
High Cost Outlier Payments	Additional payments made for extraordinarily high cost cases. Additional payments to some hospitals for long stay outiers.	Additional payments made for extraordinarily high cost cases.
Low Cost Outlier Payments	Payment made using RCC methodology for low cost cases.	N/A (Transfer cases paid a percentage of the total DRG rate).
Patient Classification System	AP-DRGs, relative payment weights based on relative charges across DRGs using historical Medicaid claims data.	CMS DRGs, relative payment weights based on relative charges across DRGs using historical Medicare claims data.
PPS Excluded Services	Neonatal care, AIDS related services, alcohol and drugs detoxification, acute physical medicine and rehabilitation, psychiatric services, chronic pain management, organ transplants and administrative days.	Rehabilitation and psychiatric services, if hospital establishes distinct part units.

A hospital's conversion factor includes the hospital's operating costs, capital costs, and direct and indirect medical education costs. The cost-based conversion factors are periodically "rebased" using hospitals' actual costs from their Medicare cost reports. The current hospital conversion factors are based on 1998 hospital cost reports trended to the current payment year, whereas Medicare rates are based on 1983 hospital costs trended forward. Periodic rebasing of the cost-based conversion factors accounts for changes in hospital operations, medical practice patterns, capital expenditures, technological advances, and labor costs over time and helps to maintain equity in payments across providers.

The calculation of the cost-based conversion factors places caps on the maximum rate that a hospital can receive. Conversion factors are capped at the 70th percentile within hospital peer groups (e.g., teaching hospitals are one peer group, non-teaching hospitals another). These caps limit payments to high cost providers which helps add efficiencies to the system. The DRG payment system also includes cost containment features which include reduced payments for very low cost cases and per-diem rates for administrative days.

Under the DRG specific payment system, hospital payment rates are appropriate to the specific patient to avoid adverse selection across patients of varying degrees of severity, to avoid under-provision of care for the severely ill. In addition, payment exceptions are made for cases that are not adequately reimbursed under the DRG system. Additional payments are made for extraordinarily high-cost cases and cost based reimbursement is used for specific types of cases, such as neonatal care and AIDS related services.

4. Comparison of Medicare and Medicaid Payment Rates for Acute Care Hospitals

To assess Medicaid inpatient payment rates, we compared each hospital's Medicaid conversion factor payment rate in effect as of November 2002 to its corresponding Medicare payment rate for the same period. These rates included additional payments for indirect medical education costs but do not include payments for DSH. We did not adjust the payment rates for case mix because the level of services provided to Medicare patients are very different from those provided to Medicaid patients. We also included payment rates for direct medical education (DME) because these costs are included in the Medicaid cost-based conversion factor. However, Medicare reimburses hospitals prospectively for DME on a per-resident basis whereas Medicaid payments are made on a per-discharge basis. Therefore, we estimated Medicare DME payments on a Medicare per discharge basis and added them to the Medicare base payment rates. Additional payments for outlier cases were also excluded from this analysis.[3]

Due to the variety of different Medicare payment systems for specialty hospitals, we did not attempt to compare Medicaid and Medicare payment rates for these hospitals.

CAH Hospitals: CAH hospitals are reimbursed retrospectively for their allowable costs by both Medicare and Medicaid, and the same payment method is used by both. Thus, CAH hospitals receive 100 percent of their costs for inpatient and outpatient services for treating both Medicare and Medicaid patients.

Rural Hospitals (Type A): As described above, rural hospitals are paid by Medicaid under the RCC methodology. Under this payment system, we assume that these hospitals are reimbursed for 100 percent of their Medicaid allowable inpatient costs (Table 11). Medicare reimburses most of these hospitals under the DRG prospective payment methodology except for Sole Community Hospitals and Small Rural Medicare Dependant Hospitals, which are paid at a higher rate. We estimate that Medicare payments equal about 108 percent of the hospitals costs for treating Medicare patients, which is slightly above the Medicaid payment levels.

[3] Please note that information in Tables 11 through 14, following, demonstrate that Medicare pays a higher percentage of costs than does Medicaid; however, Table 7 indicates that hospital margins for Medicare are lower than those for Medicaid. Information presented in Tables 11 through 14 compare Medicare payment rates for inpatient acute care services to Medicaid payment rates. These Medicare and Medicaid payment rates do not include payments for direct medical education and DSH. Thus, larger Medicaid "supplemental" payments in the form of DSH and medical education can soften the overall losses attributable to Medicaid, which explains the results in Table 7. In other words, unlike Tables 11 through 14, the information presented in Tables 5 through 7 include all payments made by Medicare and Medicaid, including DSH and medical education payments and include all hospitals services (i.e., acute inpatient, outpatient, inpatient rehabilitation and psychiatric services, home health, skilled nursing, etc.).

Table 11. Comparison of Medicaid and Medicare Inpatient Payment As a Percentage of Costs for Type A Hospitals

	Medicaid Payment as a Percent of Medicaid Allowable Costs	Medicare Payment as a Percent of Medicare Allowable Costs *,**
In-state Hospitals	100%	109%
Border Area Hospitals	100%	96%
Total	100%	108%

* Based on 1999 Medicare Hospital Cost reports, excludes DSH payments.

** Average Medicare payments as a percent of costs are weighted across hospitals based on Medicaid discharges.

Source: Lewin Group analysis of Medicare Hospital Cost Reports.

Acute Care Hospitals Participating in the Selective Contracting Program are paid prospectively using a contracted conversion factor for inpatient services that are subject to the DRG payment method. We estimate that the contracted conversion factor rates are about 76 percent of the equivalent Medicare payment rates for these hospitals on average (Table 12). However, Medicare payment rates are well above the cost of treating Medicare patients at about 108 percent of the cost. *It should be noted that Washington's hospital selective contracting program is very unique in the country, and we believe it is working quite effectively to hold down hospital costs.*

Table 12. Comparison of Medicaid and Medicare Inpatient Payment Rates for Hospitals Participating in Selective Contracting Program in 2002

Hospital Group	Number of Medicare Discharges	Average Medicaid Payment Rate*	Average Medicare Payment Rate**	Medicaid Payment as a Percent of Medicare	Medicare Payment as a Percent of Allowable Costs***
In-state Hospitals	36,231	$4,283	$5,569	77%	108%
Border Area Hospitals	961	$4,247	$6,301	68%	110%
Total	37,192	$4,282	$5,588	76%	108%

* Contracted conversion factors in effect as of August 31, 2002. Excludes payments for high cost outlier cases and DSH.

** Medicare base payment rates include operating and capital payment rates, indirect medical education, direct medical education. Excludes payments for high cost outlier cases and DSH.

*** Based on Medicare Hospital Cost Reports for 1999 and 2000. Payments and costs include operating, capital, indirect medical education and outlier payments. Excludes payments and costs for direct medical education and excludes DSH payments.

Source: Lewin Group analysis of Medicaid program data, Medicare Impact file for FY 2003, and Medicare Hospital Cost Report data.

Acute Care Hospitals that do not Participate in the Selective Contracting Program are paid prospectively using a cost-based conversion factor for inpatient services that are subject to the DRG payment method. We estimate that the conversion factor rates are about 82 percent of the equivalent Medicare payment rates for these hospitals on average (Table 13). However, Medicare payment rates are well above the cost of treating Medicare patients at about 115 percent of the cost.

Table 13. Comparison of Medicaid and Medicare Inpatient Payment Rates for Acute Care Hospitals Not Participating in Selective Contracting Program in 2002 *,**

Hospital Group	Number of Medicare Discharges	Average Medicaid Payment Rate*	Average Medicare Payment Rate**	Medicaid Payment as a Percent of Medicare	Medicare Payment as a Percent of Allowable Costs***
In-state Hospitals	15,852	$4,132	$5,056	80%	116%
Border Area Hospitals	459	$4,500	$4,857	93%	96%
Total	16,311	$4,142	$5,050	82%	115%

* Contracted conversion factors in effect as of August 31, 2002. Excludes payments for high cost outlier cases and DSH.
** Medicare base payment rates include operating and capital payment rates, indirect medical education, direct medical education. Excludes payments for high cost outlier cases and DSH.
*** Based on Medicare Hospital Cost Reports for 1999 and 2000. Payments and costs include operating, capital, indirect medical education and outlier payments. Excludes payments and costs for direct medical education and excludes DSH payments.

Source: Lewin Group analysis of Medicaid program data, Medicare Impact file for fiscal year 2003, and Medicare Hospital Cost Report data.

Hospital Outpatient Payments: Currently, Medicaid payments for hospital outpatient services are based on a percentage of allowed charges. Reimbursement for outpatient services is computed as allowed charges multiplied by 72.4 percent of the hospitals' inpatient RCC. On average, hospitals' outpatient RCCs are lower than their inpatient RCCs. This is due to higher hospital markups for ancillary services and supplies than for accommodation services, which produces lower RCC values. We estimate that outpatient RCCs are about 15 percent lower than inpatient RCCs for Washington hospitals. Thus, payment for outpatient services would equal about 85 percent of hospital costs for performing these services (Table 14). This is slightly below Medicare payment for outpatient services, which is about 92 percent of costs on average.

Table 14. Estimated Medicaid Outpatient Payment as a Percentage of Allowable Cost

Medicaid Outpatient Adjustment	Outpatient to Inpatient RCC Ratio*	Estimated Medicaid Outpatient Payment as a Ratio of Allowable Cost**	Medicare Outpatient Payment as a Ratio of Allowable Cost***
0.724	0.851	0.851	0.915

* Based on Medicare inpatient and outpatient RCCs computed by CMS using 1996 Hospital Cost Report data.
** Equal to Medicaid outpatient adjustment divided by the outpatient-to-inpatient RCC ratio.
*** Based on Medicare Hospital Cost Reports for Washington hospitals for 1999. Medicare payments are prior to implementation of outpatient PPS.

Source: Lewin Group analyses.

We estimate that payment for outpatient services equals about 85 percent of the hospitals' cost for providing the service. This is somewhat lower than the portion of costs covered by Medicare (91 percent for Washington hospitals).

Washington State Medicaid hospital payment rates to acute-care DRG hospitals are below Medicare payment rates for both inpatient and outpatient services. On average, Medicaid inpatient payments rates equal about 76 percent of Medicare payment rates for hospitals that

participate in the Selective Contracting Program. Medicaid rates are about 82 percent of Medicare rates for other acute care DRG hospitals.

5. Graduate Medical Education

States spend $2.3 billion of their Medicaid budgets to finance graduate medical education (GME) activities. GME financing covers the direct (hospital overhead, teaching and salaries) and indirect (lost productivity related to the extra time and resources for teaching) costs associated with the training of residents. GME has multiple sources of funding, including Medicare and Medicaid, the US Department of Defense, the US Department of Veterans Affairs, university and hospital practice plans, state and local government, and third-party payers. In recent years, many states have begun to rethink how they pay for GME due to several factors, including:

- The growth of Medicaid managed care, which in general has diminished the flow of GME funds to teaching hospitals;
- A shortage of primary care doctors and other providers in underserved areas;
- The decline of Medicare GME support; and
- The need to contain the general increase in health care costs and Medicaid spending.

According to a survey from the National Conference of State Legislatures in 1999, 45 states and the District of Columbia made some level of payment for GME under their Medicaid program. Medicaid agencies in five states (Alaska, Idaho, Illinois, Montana, South Dakota) and Puerto Rico do not pay for GME. Alaska, Idaho, and Montana do not have a medical school, but each houses at least one graduate training program in family medicine affiliated with the University of Washington. Delaware and Wyoming, which pay GME, do not have medical schools within their states, but each state contains residency training programs that Medicaid supports that are affiliated with out-of-state medical schools.

Like Washington, a growing number of states are "carving out" their GME payments from their state-set Medicaid managed care rates. By separating the GME component of the capitation rate, states can be sure that the GME funding is going directly to the teaching hospitals that rely on GME funding. Many states also use this funding to encourage hospitals to meet certain public policy goals. For example, in Michigan, carving out GME dollars from their managed care rates has enabled them to manage their costs. In 1997, Michigan decided to carve out its $196 million GME contribution from Medicaid hospital payment rates. The State was concerned that Medicaid GME costs were escalating and that institutions were not spending GME dollars to better meet the health needs of Medicaid beneficiaries. Carving out rates also gave the State an opportunity to move away from a cost-based system of hospital payment to a predetermined rate system. Using predetermined rates enables the State to limit escalating costs and achieve expenditure predictability.

Another issue associated with GME funding is the fact that there is no consensus on a "reasonable" cost to train physicians. Many states have experienced difficulty in trying to quantify these costs. In Michigan, the State has attempted to assess its GME costs by basing them on what it paid hospitals on a historical cost basis.

The State of Illinois does not pay for GME in its Medicaid program. In the 1980s, Illinois, under its ICare program, moved from paying a capitation rate to paying hospitals negotiated fees based on the number of bed days. This payment system operated under a federal waiver until the hospitals became unhappy with the system and successfully lobbied for a change. Illinois decided not to renew the waiver and began paying hospitals under a DRG system, which included GME payments. This lasted about one year until Illinois faced a very large recession. The State implemented a hospital tax in an attempt to balance their budget, resulting in revenue of $325 million from the hospitals, totaling $623 million with the federal matching funds. In the mid-1990s, the hospitals began to actively oppose the tax. As a result of the opposition, Illinois repealed the hospital tax. However, without the income from the hospital tax, the State was not able to pay for GME. By eliminating the GME payments, the State saved approximately $250 million of the $1.5 billion hospital budget. Since then, there have been gradual "add-backs." Under the Academic Excellence Program, the three major teaching hospital systems share approximately $20 million for education.

For the first few years after the elimination of GME payments in Illinois, there did not seem to be issues with the removal of the hospital tax. Eventually, however, there have been some concerns, particularly in hospitals with significant Medicaid budgets, because of the lack of GME payments. Individuals at the State have indicated that things have continued to go smoothly because the hospital rates are high enough even without the GME payments.

In determining whether or not to eliminate GME funding from hospital payments, there are issues that need to be considered. The first is the adverse effect on hospitals that are predominantly Medicaid, who also receive and rely on a large amount of GME funding. The second issue is the relationship between GME and other hospital funding. Hospitals may be hit too hard if both the overall rates and GME funding are cut. The options presented below provide more equitable strategies for cutting rates rather than simply eliminating GME.

6. Overall Findings

The foregoing discussion indicates the following:

- In recent years hospital operating margins bottomed out at 1.3 percent in 2000, and have risen steadily since then to 1.9 percent in 2001 and 2.6 percent in 2002.
- Hospitals in Washington State have been profitable, with margins consistent with the national average.
- Washington State's Medicaid payments have approximated 95 percent of cost, consistent with the U.S. average but higher than the payment-to-cost ratios in Oregon, California, Idaho and Arizona.
- Because Medicaid services represent 15 percent of all hospital care, the overall impact of below-cost payment is to reduce hospital margins by 0.8 percentage points.
- The FFS payment methodology has been thoughtfully designed by MAA, and it incorporates explicit policies for critical access and rural hospitals and flexibility through the selective contracting approach.

- The methodology by which FFS rates are determined is similar to that of the Medicare program, with the following key differences:
  - Both programs provide cost-based reimbursement to critical access hospitals, but Washington's Medicaid program also reimburses rural hospitals based on their cost of providing inpatient services.
  - Base payment rates for 33 hospitals (representing 59 percent of discharges) are determined based on negotiated rates (selective contracting); the Medicare program does not engage in selective contracting for hospital rates.
  - Base payment rates for DRG hospitals not participating in selective contracting incorporate efficiency adjustments determined within hospital peer-group categories (e.g., base rates for teaching hospitals above the 70th percentile cost per case are capped at the 70th percentile hospital).
  - Both programs provide reimbursement for medical education costs; Washington Medicaid incorporates these costs into base conversion factor rates, while the Medicare program has alternative formulae for these payments.
  - Specialty hospitals (children's, psychiatric, rehabilitation, and long-term hospitals) receive cost-based reimbursement or per-diem payment rates from Medicaid, while the Medicare program is implementing prospective payment approaches for these providers (except for children's hospitals).
  - Outpatient payments are based on a percentage of charges approach, with a prospective payment system (comparable to Medicare's) scheduled to be implemented in 2004.
- Most Medicaid managed care organizations in Washington reportedly have adopted the State Medicaid program's FFS rates for purposes of reimbursing hospitals for care provided to Medicaid managed care enrollees.

7. Options

These findings suggest certain options for Washington State's Medicaid program. As indicated below, Washington could reduce its overall hospital expenditures in Medicaid and, on average, hospitals still would generate positive operating margins based on their ability to cost shift to private payers. An average reduction of 11.2 percent, for example, would generate $87.2 million in Medicaid savings and would leave hospitals on average with an operating margin of 1.5 percent, which is a slightly better financial situation than they faced in 2000, when their operating margins averaged 1.3 percent. The 11.2 percent rate reduction, however, does not account for other changes that have been proposed for Washington's Medicaid program, which may limit the hospitals' ability to absorb such a reduction in rates. Other structural reforms to the hospital rate-setting process could include:

- *Accelerating implementation of outpatient prospective payment, depending on the design of the prospective payment system*. If modeled after the Medicare system, outpatient payments could actually increase. However, a conversion factor that is budget neutral to current aggregate payment levels could be implemented. The level of future increases to the conversion factor can be used as a mechanism to control costs. Care should be taken to maintain payment levels for outpatient services at sufficient levels to encourage providers to select the most appropriate setting of care for the patient.

- *Developing prospective payment rates for specialty hospital services rather than cost-based reimbursement*. Medicare has recently implemented prospective payment systems for rehabilitation hospitals and long-term acute care hospitals and can be used as a model for Washington State.
- *Migrating rural hospitals from cost-based reimbursement to prospective payment.* This would reduce payment to rural hospitals relative to their costs similar to that of urban hospitals. There are several difficulties with this option, however. Many rural hospitals are becoming designated as Critical Access Hospitals, which receive cost-based reimbursement. Also, these hospitals account for a relatively small portion of Medicare payments. Finally, adequate reimbursement for these hospitals is necessary in order to maintain access to these services for Medicaid beneficiaries in these areas.
- *Determining the 70th percentile rate cap not within peer groups but across all hospitals providing Medicaid services*. In developing hospital specific conversion factors, hospitals are separated into peer groups (rural, urban teaching hospitals, other urban hospitals and specialty hospitals) and conversion factor rates are capped at the 70th percentile within peer groups for hospitals in the two urban peer groups. If the 70th percentile cap is established across all hospitals and not within peer group then payment rates would be reduced for the most expensive 30 percent of hospitals without regard to hospital type, which should reduce overall payments. However, we believe that the current method of establishing the caps within peer group is appropriate because wages, capital related costs and other direct costs are higher for urban hospitals than for rural hospitals. Thus, separating hospitals into peer groups for purposes of establishing payment rate limits produces a more equitable payment system.
- *Reducing conversion factors by a specified percentage.* This would require renegotiating rates for hospitals participating in selective contracting.

The above options are some of the different pathways Washington may take to realize reduced hospital reimbursements. The implementation of any of these options must be considered in light of additional proposed changes to the Medicaid program, as well as other factors that may affect the overall level of hospital reimbursement. Additionally, the implementation of several of these options may have a synergistic effect, compounding the magnitude of the individual reductions. Washington must carefully consider the individual and collective effects of these options so as not to inadvertently lower hospital reimbursement levels to an unsustainable level.

In addition, regardless of the approach taken, if hospital payments are reduced, it will be critical to distribute the effects of the reduction with some degree of precision (i.e., we strongly urge against an across-the-board rate cut). To more equitably distribute a reduction in reimbursement, the State could estimate the "margin impact" of proposals.

For example, a five percent reduction for a hospital with 20 percent of its services provided for Medicaid patients would reduce that hospital's margins by 1.0 percent; the same reduction for a hospital with a payer mix of 10 percent for Medicaid would reduce the hospital's margin by 0.5 percent. By equalizing the "margin impact" of the initiatives (i.e., higher rate cuts to hospitals that serve proportionately fewer Medicaid patients and therefore have a stronger

private pay base against which to cost shift the larger percentage rate cut), the impact of below-cost Medicaid payment can be more equitably distributed.

In order to estimate the impact that reductions in Medicaid FFS hospital payments would have on hospitals in the State, we estimated overall hospital operating margins at certain levels of payment reduction (Table 15). On average, hospitals would have a 2.0 percent operating margin if payment rates were reduced by $43.6 million, which would require a reduction in fee-for-service hospital payments (inpatient, outpatient, and DSH payments) of 5.6 percent.

Table 15. Estimated Hospital Operating Margins Assuming Various Levels of Medicaid Fee-For-Service Payment Reductions

Hospital Operating Margin*	Payment Reduction in Millions	Estimated Rate Reduction Percentage**
Current 2.6%	n/a	n/a
2.0%	$43.6	5.6%
1.5% (just above 2000 level)	$87.2	11.2%
1.0%	$124.3	16.0%
0.5%	$163.5	21.0%
0.0%	$200.6	25.8%

* Includes net patient revenues for all payers and other operating revenues.

** Estimated Percentage Reduction in fee for service hospital payments including inpatient, outpatient, and DSH payments. Assumes a base of $777.2 million in hospital payments from 2001 CMS-64 reports.

As described above, a payment reduction of $87.2 million (exclusive of any other changes to the Medicaid program) would reduce hospitals operating margins to 1.5 percent, which is slightly above the level hospitals experienced in 2000. In that year, the Washington State Hospital Association estimates that 28 percent of the State's hospitals experienced negative total margins.

B. Long Term Care

1. Summary

Quietly, Medicaid has emerged as the nation's primary purchaser of long term care services, including payments both for nursing facility residents and for individuals in home and community-based services (HCBS). On a national basis Medicaid programs sponsor the care of nearly 70 percent of all nursing facility residents, and comprise over 50 percent of the revenue base of the nursing home industry.

In Washington's Medicaid program, the State now sponsors over 13,000 residents in 253 nursing facilities. On average, Washington nursing facilities receive 52 percent of their revenue from Medicaid, which paid for 4,794,033 bed-days in SFY 2001. At any given point in time, over 55 percent of the State's 23,665 licensed nursing home beds are filled by Washington citizens whose care is sponsored by the State's Medicaid program.

The past 20 years have seen a dramatic shift in the philosophical direction of Medicaid long term care programs. Most states no longer solely emphasize institutional care; a strong consumer movement in favor of home-based services, coupled with the U.S. Supreme Court's 1999 Olmstead decision, has led states to try and develop non-institutional long term care services.

The State of Washington long has been one of the leaders in this movement, innovating its programs a full decade before most other states, and well before the Olmstead decision. Washington moved aggressively, and early, to develop HCBS as an alternative to nursing facility services, in order to:

- Honor client choice and self-determination;
- Pursue services that, on a per capita basis, are less costly; and
- Level the playing field between nursing facility and HCBS settings by operating the programs in a completely coordinated fashion.

Table 16 shows, for example, that in federal fiscal year 2000, Washington ranked 5th among the states in the percentage of overall[4] Medicaid long term care expenditures that it devoted to HCBS.

Table 16. Distribution of Medicaid Long-Term Care Expenditures, FFY 2000 Comparison of Top 10 States

Rank	State	Community-Based Expenditures	% FY of 2000 LTC Expenditures	Institutional Care Expenditures	% of FY 2000 LTC Expenditures
1	Oregon	$430,299,161	62%	264,821,955	38%
2	Vermont	$92,653,301	54%	80,236,843	46%
3	Alaska	$60,091,523	50%	60,094,531	50%
4	Colorado	$360,685,381	49%	381,586,060	51%
5	**Washington**	**$609,926,980**	**45%**	**748,311,527**	**55%**
6	Kansas	$304,698,588	42%	415,740,846	58%
7	New Mexico	$139,010,812	42%	192,115,581	58%
8	Maine	$155,272,608	40%	234,895,732	60%
9	New-Hampshire	$142,483,827	40%	215,923,161	60%
10	Rhode-Island	$163,323,373	39%	253,996,189	61%
	National	**18,097,849,594**	**27%**	**49,533,016,243**	**73%**

Washington's relative spending on community-based care exceeds the national percentage and ranks 5th overall

Source: Lewin's analysis of HCFA 64 Reports

[4] Table 16 combines services for the aged, disabled and developmentally disabled populations. "Community-based" expenditures include HCBS waiver services and state-plan long term care services; "institutional care" includes nursing facilities and ICFs/MR.

Once services to people with developmental disabilities are set to the side, and the focus is directed to services to the aged and physically disabled -- which is the subject of the remainder of this section -- Washington devotes an even larger percentage of funding to community-based services. For example, in SFY 2002, Washington spent $414.4 million on HCBS (47.8 percent) and $489.4 million on nursing facilities (52.2 percent). Although the spending was fairly evenly split between these services, nearly three times as many aged and physically disabled clients were served in home and community-based settings (a caseload of about 32,200 clients) as were served in nursing facilities (13,140 clients).

Washington's progressive long term care policies have not necessarily come cheaply, however:

- The functional eligibility criteria under Washington's Medicaid policies (i.e., the disability threshold necessary to qualify) is among the easiest to meet in the country;
- Unlike many other states, Washington imposes no cap on the number of people it accepts into its Medicaid HCBS waiver known as the "Community Options Program Entry System" (COPES); and
- Apart from COPES, Washington's Medicaid program offers a personal care benefit within the standard Medicaid program that is quickly accelerating in terms of both participants and expenditures.

The State of Washington likely would save money if it chose to move in the direction of the majority of states in the country by raising the entry criteria (functional eligibility), capping entrants in COPES, or by modifying its personal care benefit. Needless to say, any such change might jeopardize the State's progress toward expansive home and community-based services.

2. Background Information

As Lewin noted in a report prepared for the federal government in 2001, "Washington has a national reputation as a leader in innovative home and community services and relies heavily on consumer-directed home care and nonmedical residential services . . .[i]n fiscal year 1999, almost twice as many people received home and community-based services as received Medicaid-funded nursing home care, making Washington one of the most balanced long-term care delivery systems in the country."[5]

Indeed, unlike many other states, Washington successfully has reduced the number of people receiving Medicaid funding in nursing facilities, while dramatically increasing the people served in home and community-based settings through programs such as COPES and Medicaid personal care (Table 17).

[5] Lutzky, Steven, et al., The Lewin Group, "Home and Community-Based Services for Older People and Younger Persons with Physical Disabilities in Washington", June 5, 2001.

Table 17. Changes in Components of Long-Term Care Caseloads from FY 92 through FY01

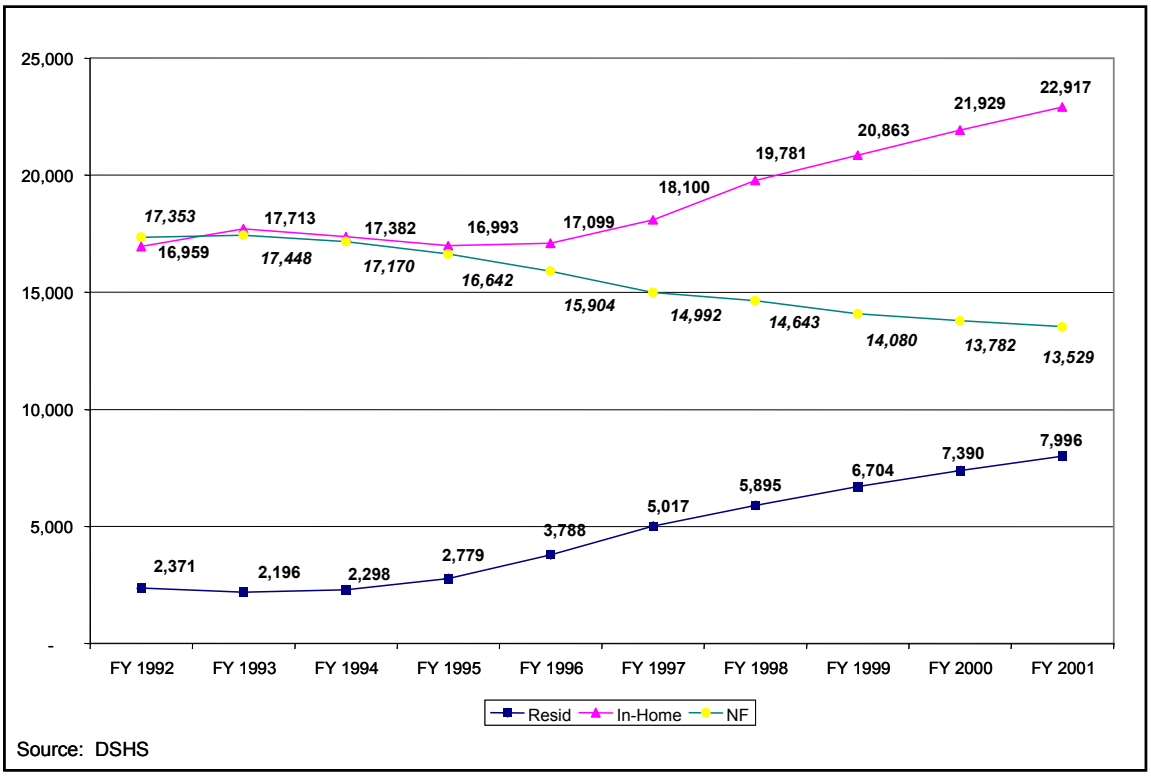


Table 18 was produced by Lewin in conjunction with that report and documents the early, and extensive, development of HCBS options in Washington.

Table 18. Selected Home and Community Services in Washington

	Community Options Entry System (COPES)	Medicaid Personal Care
Year Program Started	1983	1989
Administrative Responsibility	Aging and Disability Services Administration (ADSA) of the Department of Social and Health Services (DSHS) has broad overall policy and administrative responsibility for long-term care programs. Initial functional and financial eligibility determinations done by ADSA caseworkers in a single-point-of-entry to publicly-funded services. If the client enters residential settings, ADSA staff continues case management responsibilities. If client receives in-home services, ongoing case management is transferred to 13 Area Agencies on Aging.	Same as COPES.
Functional Eligibility	Individuals must meet nursing facility level of care: individuals must need substantial or total assistance with two or more self-care tasks (eating, toileting, ambulation, self-medication, transfer, positioning, or bathing) or have cognitive supervision needs, or require minimal, substantial or total assistance in three or more ADL tasks.	Requires help with at least one of the following direct personal care tasks—eating, toileting, ambulation, self-medication, transfer, positioning, specialized body care, personal hygiene, bathing or dressing.
Financial Eligibility	Up to 300 percent of SSI.	Categorically needy. For a single individual, SSI/SSP level was $539 a month in 2000. No medically needy coverage.
Number of Beneficiaries	Average monthly caseload in 2002: 22,666 clients.	FY 2002 average monthly caseload: 9,269.
Funding Source	Medicaid	Medicaid
Expenditures	$289.9 million in FY 2002	$83.5 million in FY 2002
Covered Services	Assistance with personal care and household tasks in the home, adult day care, environmental modifications, home delivered meals (limited to one per day), home health aide services (beyond the amount duration and scope of regular Medicaid home health), personal emergency response systems, skilled nursing (beyond the amount, duration, and scope of regular home health), specialized medical equipment and supplies, training to meet a therapeutic goal, and transportation services to meet a therapeutic goal and beyond regular Medicaid transportation, and services in adult family homes and assisted living facilities. Services are to be provided in the home and are not designed to be provided at the workplace or other settings in the community.	Personal care, including help with household tasks.
Consumer Direction	Used by majority of persons receiving in-home services. Required of all clients needing more than 112 hours of service a month.	Same as COPES.
Cost Containment Mechanisms	Aggressive effort to limit and reduce nursing home use in order to reallocate resources to home and community services. Individual expenditures must be below 90 percent of average cost of nursing home care. Heavy use of low-cost independent providers. Payment rates considered low by many stakeholders. No waiting list.	Same as COPES.
Quality Assurance Mechanisms	Agency-directed and independent provider home care workers must have 22 hours of training and pass a written and hands-on test and receive 10 hours of continuing education annually. Workers must pass a criminal background check that is limited to Washington crimes. Home care agencies are licensed and supervisors must visit client twice a year. Case managers must conduct annual face-to-face assessment with clients. Adult family homes and assisted living facilities are licensed and surveyed annually. Medicaid standards exceed licensure standards.	Same as COPES.

Source: Lutzky et, al., June 5, 2001, as updated.

Table 19 shows that Washington's emphasis on progressive HCBS policies has led to a rapid expansion in services in those areas at the same time that the State has slightly reduced overall nursing home residents supported by Medicaid.

Table 19. Changes in Various Long Term Care Programs: FY2000 to FY2002

	Avg. Monthly Caseloads (FY)			Percent Change '00-'02
	2000	2001	2002	
COPES	22,213	23,264	22,666	2.04
Personal Care	6,514	7,208	9,269	42.29
Nursing Facility	13,782	13,529	13,144	(4.63)
	Avg. Monthly Cost Per Case (FY)			Percent Change '00-'02
	2000	2001	2002	
COPES	$958	$1,015	$1,066	11.27
Personal Care	$505	$597	$751	48.71
Nursing Facility	$2,913	$2,996	$3,103	6.52
	Total FY Spending (in millions)			Percent Change '00-'02
	2000	2001	2002	
COPES	$255.4	$283.4	$289.9	13.54
Personal Care	$39.5	$51.6	$83.5	111.61
Nursing Facility	$481.8	$486.4	$489.4	1.59

Source: Lewin's analysis of DSHS reports.

In addition, Table 19 strikingly shows that the most significant growth in recent years, both in participants and in cost per participant, is in Medicaid's personal care benefit. The number of participants in that benefit grew by more than 42 percent over two years (FY 2000 to FY 2002) and more than 48 percent in cost per person over that same period, more than doubling the expenditures in personal care over a two year period.

In reviewing a draft of this report DSHS noted that a significant portion of the growth in personal care relates to serving about 1,500 people who were moved into the Medicaid personal care benefit from COPES. Table 20 shows that had these 1,500 people not been moved, the two-year growth in personal care still would have been rapid at about 20 percent (or 10 percent a year) and in COPES it would have been about 8.8 percent (or about 4.4 percent a year).

Table 20. Adjusted Changes in Average Monthly Caseloads between FY 2000 to FY 2002

	Avg. Monthly Caseloads (FY)		Percent Change '00-'02
	2000	2002	
COPES	22,213	24,166	8.79
Personal Care	6,514	7,769	19.27

Source: Lewin's analysis of DSHS reports.

According to the most recent data available, Washington's payment rates for nursing facilities exceed the national average,[6] and are substantially above the per person costs under COPES ($3,103 per month in nursing facilities compared to $1,066 per month in COPES in FY 2002).

In reviewing a draft of this report, DSHS commented that policy changes that would interfere with early access to COPES or personal care services might result in a higher acuity level for nursing facility residents (and in more Medicaid-sponsored residents). This may be true, but it is hard to square with the nursing facility reimbursement rate: an above-average nursing facility rate suggests a higher than average Medicaid acuity level in Washington's nursing facilities, when compared to other states. Given Washington's relatively low nursing facility level of care (LOC) criteria (discussed below), the existing rate might be too high (for a lower acuity population) or it might be reasonable (for a population that on average could meet a higher LOC criteria).

3. Change Functional Eligibility Criteria

States vary widely in the functional eligibility criteria utilized to determine whether someone needs a nursing facility LOC. Because of a federal waiver requirement that links nursing facility LOC criteria to eligibility for an HCBS waiver program such as COPES, any change in nursing facility LOC criteria also affects COPES eligibility.

The National Academy of State Health Policy (NASHP) recently conducted a 50 state comparison of nursing facility LOC criteria.[7] They found that states use different methodologies to determine when an individual is sufficiently compromised so as to require Medicaid-funded support in a nursing facility or HCBS waiver, based on meeting one or more of the following:

- Medical conditions or needs;
- Functional impairment ; and/or
- Scores from an assessment instrument.

Washington State's criteria permits a person to meet a nursing facility LOC if he/she:

- Requires daily nursing care (a medical need criteria);
- Has an unmet need requiring substantial or total assistance with at least two of the seven activities of daily living (ADL) (eating, toileting, ambulation, transfer, positioning, bathing, and self-medication);
- Has an unmet need requiring at least minimal assistance with at least three of those ADLs; or
- Has a cognitive impairment and requires certain assistance.

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6 Charlene Harrington, James H. Swan, Valerie Wellin, Wendy Clemena and Helen M. Carrillo, "1998 State Data Book on Long Term Care Program and Market Characteristics," UC San Francisco, 2000.

7 Mollica, Robert, National Academy for State Health Policy, "State Assisted Living Policy: 2002."

Washington State therefore allows a person to meet nursing facility LOC with either a medical need/condition or a functional need of as little as two "substantial" ADLs or three "minimal" ADLs.

Washington State's nursing facility and COPES LOC criteria were characterized by NASHP as being one of nine states in the "low" (relatively easy LOC to meet) group. At the other extreme, among the "high" (difficult LOC to meet) states, are other states considered to have progressive health policies, such as Maine (which requires nursing care at least three times a week plus substantial assistance with three ADLs) and Maryland (which requires fulltime care under the supervision of a licensed nurse).

In reviewing a draft of this report, DSHS correctly noted that Maryland's LOC has always been relatively difficult to meet, in contrast to its more progressive health policies in other areas. Maine is slightly different; it deliberately raised its LOC criteria only a few years ago in an attempt to save money. To our knowledge, the implications of this action on other aspects of Maine's health care spending – such as in hospitals or in pharmacies – has never been studied to determine the actual effect of the decision on the overall expenditures in Maine's Medicaid program.

DSHS also noted in its comments that:

> "Washington has made the decision to provide services at an earlier stage of individuals' functional decline in order to avoid the high costs associated with clients who are in crisis in regard to their medical and functional needs. Serving clients earlier can help stabilize the situation in their home and possible prevent hospitalization and/or nursing facility placement altogether…"

As we have noted throughout this section, Washington has been a proactive leader among the states in serving citizens' long term care needs in the settings, and at the times, most desired by clients. Certainly, to its credit, Washington serves them earlier.

In this report, however, Lewin was asked to note those areas where Washington's Medicaid policies exceed the majority of other states, as the Governor and Legislative grapple with difficult budget decisions. As a result, we do not disagree with DSHS that its policies help clients. Nevertheless, as indicated in Table 21, Washington's LOC is low and the savings associated with "prevent[ing] hospitalization and/or nursing faculty placement" may not exceed the costs associated with delivering those services early to the other clients. Maine viewed this as a laudable but expensive choice, and in the late 1990s raised its LOC as a result.

Table 21. Array of Selected States Along Continuum of Nursing Home Admission Criteria

1 (low)	2	3 (moderate)	4	5 (high)
DE	AR	AK	AZ	AL
KS	IL	MO	NC	HI
NH	IA	CO	UT	ME
OH	IN	MT		MD
OR	LA	CT		TN
RI	MI	NJ		VA
WA	MN	FL		
WY	MS	NM		
	NE	GA		
	OK	ND		
	TX	ID		
	VT	PA		
	WI	MA		
		SC		

Source: NASHP: "State Assisted Living Policy: 2002."

In the 2002-2003 Supplemental Budget cycle, DSHS estimated that, if it merely eliminated from its functional eligibility criteria the feature that allows eligibility based on needing "minimal assistance" with three ADLs, the effect would be to reduce the COPES caseload by 15.1 percent. *It should be noted that, even if made, this change would not alter Washington's placement by NASHP in the "low" category.* That is, Washington State would need to raise the functional eligibility standard even farther merely to move toward the median of states (by, for example, requiring both a medical need and a functional impairment, or by requiring a deficit in at least three ADLs that requires "substantial assistance").

Applied to the average caseload in FY 2002, and using the assumptions that 15.1 percent of the caseload would be eliminated, and that these people have monthly costs at 94.7 percent of the average case, this change would generate estimated savings to Washington of $41.5 million per year by eliminating 3,423 people from the COPES caseload, as indicated in Table 22.[8]

[8] In all likelihood altering the LOC also would reduce nursing facility expenditures, but we were unable to calculate the magnitude of this effect for this report.

Table 22. Potential Savings Achieved in COPES by Raising the Nursing Facility LOC: FY 2002

	FY 2002
Average Monthly Cost Per Case	$1,066
Monthly Cost Per Case for Reduced Cases (at 94.7%)	$1,010
Projected Caseload Reduction	3,423
Savings Per Month (in millions)	$3.46
Annual Savings (in millions)	$41.5

Source: Lewin's analysis of DSHS data.

The extent to which these savings may be realized depends on whether other areas in Washington's Medicaid program would experience increased costs as a result of the higher LOC criteria (e.g., emergency room, inpatient hospital, institutional long term care). The magnitude of this potential increase, in relation to the potential savings, could not be analyzed within the time and scope of his project. In commenting on an earlier draft of this report, DSHS correctly notes that the estimated savings in Table 22 may be overstated if other service-lines in Medicaid simultaneously experience increased costs. We agree, but we were not able to model these effects.

4. Impose Cap on Enrollment in COPES

Prior to 1981, long term care services were primarily offered in institutional settings. In 1981, Congress gave the Secretary of the Department of Health and Human Services (HHS) the power to "waive" the requirements of Medicaid law (Title XIX of the Social Security Act), allowing states to offer a broad range of HCBS to individuals who otherwise would be institutionalized.

The George Washington University, Center for Health Policy Research explained the differences between Medicaid state plan services and HCBS waivers in its HHS funded publication *Understanding Medicaid Home and Community Services: A Primer.*"[9] Federal law distinguishes between services offered under a Medicaid state plan and services that can be offered when the Secretary of Health and Human Services, operating through CMS, grants waivers for a state to operate a home and community-based waiver program.

The services that can be offered without a waiver are called Medicaid state plan services. Some of these (e.g., home health) must be provided by every state that operates a Medicaid program. These are called mandatory services. Others can be offered at state option. These are called optional services. With a minor exception (targeted case management), a state's decision to offer an optional service under its Medicaid state plan amounts to a decision to make the service available to all who require it. This is why Medicaid beneficiaries are said to be "entitled" to state plan services.

[9] Smith, Gary, et.al., George Washington University, Center for Health Policy, "Understanding Medicaid Home and Community Services: A Primer," October 2000.

HCBS waivers such as COPES are not entitlement programs. Every person with a disability who is eligible for Medicaid state plan services is not "entitled" to waiver services. Thus, states may restrict the number of individuals they serve in a waiver and/or the number of dollars they expend. While Washington's COPES waiver is only approved by the federal government up to a limited number of slots (as is the case for all HCBS waivers approved by CMS), the State does not take the further step employed by many states to limit the enrollment to a figure *below* the number of approved slots that the State believes it has the financial resources to support.

In many states, the enrollment in the HCBS waiver targeted for seniors and adults with disabilities is capped below the number of approved slots, and the enrollment cap is based on the available funds appropriated to the HCBS waiver divided by the estimated cost of an average plan of care.

Assume, for example, that a state has a waiver approved by CMS to serve up to 1,000 clients. If the average annual cost per client is $20,000, the number of clients who might occupy a slot in the waiver might be capped at 800, if the combined state and federal funds appropriated to be waiver only is $16 million. Should an additional 200 clients seek waiver services, and meet other eligibility criteria (functional and financial), they nonetheless would be placed on a waiting list, due to the lack of available funds. Moreover, because HCBS slots are not part of Medicaid's "entitlement program," these clients would not be entitled to HCBS services, in spite of the fact that the state has vacant slots approved by CMS.

Many states simultaneously manage their budgets, and their waivers, in this way. To its philosophical credit, but perhaps to its budget detriment, Washington has rejected this approach and has treated its HCBS waiver programs as entitlements, as Washington and other states are obligated to treat state plan services such as nursing facility services, thereby altogether avoiding waiting lists.

In states that take this approach, where applicant interest in the program might exceed the number of funded slots, a waiting list is generated. While the creation of such a waiting list is subject to unresolved litigation in some states, the prevailing view among states, federal officials and others (such as the researchers at The George Washington University, Center for Health Policy Research) is that a waiting list legally is permissible, since the waiver programs are not entitlement programs. Moreover, states then typically move people from the waiting list into services, as funds become available, based on wait list criteria adopted by the state: states do not necessarily move people on a first-to-apply-first-in-services basis.[10] Consequently, for states that emerge from a budget crisis the "base" appropriation for an HCBS waiver might expand from 800 funded slots to 1,000 funded slots, and individuals would be moved from the wait list into HCBS services pursuant to the state's prioritization criteria.

[10] New Hampshire was sued by a person on such a waiting list when the state moved a later-applicant into services first, based on the state's wait list prioritization system that placed a higher value on moving into service a person with severe needs or no family support system than a person who had been waiting a longer period of time. In that case, known as Hearst v. Morton, the federal court decided in 1999 that New Hampshire's approach was reasonable and should not be altered into a first-come-first-served approach as sought by the plaintiff.

There is no such budget-driven cap or waiting list in Washington, where all applicants who meet the financial and functional eligibility criteria for COPES are placed into services. Using the caseload forecasts produced by the State for state FYs 2003 and 2004, such a cap (at the SFY 2002 level of 22,666 people) would save the State an estimated $25.9 million in FY 2004, as shown on Table 23.

Table 23. Potential Savings Achieved by Capping COPES Enrollment at FY 2002 Levels

	FY 2002	FY 2003 (est.)	FY 2004 (est.)
Average Monthly Caseload	22,666	23,499	24,677
Capped at FY 02 Levels		22,666	22,666
Cost per case per month	$1,066	$1,064	$1,073
Annual Expenditure Without Cap (in millions)	$289.9	$300.0	$317.7
Annual Expenditure With Cap (in millions)		$289.4	$291.8
Savings (in millions)			$25.9

Source: Lewin's analysis of DSHS data.

Washington reported to us that, in recent conversations with CMS, the federal government would expect the State to ensure the health and safety of any individual who is made ineligible for waiver services. If CMS holds to this position – which it is not taking in states that are outright terminating the Medicaid eligibility of individuals as a cost containment initiative – it supports the notion that rather than eliminating people in COPES altogether, the most aggressive option the State should consider is imposing a cap with grandfathering provisions for all current COPES recipients.

5. Personal Care

On a separate note, Washington could modify its Medicaid state plan personal care benefit. It could do so in two fundamentally different ways. It could:

- Eliminate the personal care benefit but guarantee recipients of that service that if they meet the COPES eligibility criteria they may immediately begin receiving alternative services through COPES (this could be done even with a COPES wait list strategy, if current personal care recipients "move to the front of the line" and receive COPES' services) (Option 1), or
- Modify the personal care benefit by imposing unit or service caps on individuals and/or raising the functional need standard necessary to qualify for personal care (i.e., the medical necessity definition could be changed to bring the clinical eligibility for personal care services in line with the clinical eligibility for COPES) (Option 2).

As shown in Table 24, Option 1 would produce estimated savings in FY 2004 in the amount of between $16.5 million and $19.7 million.

Table 24. Potential Savings Achieved by Eliminating Personal Care and Moving Qualified Recipients into COPES

	FY 02 Cases	'03 (proj.)	'04 (proj.)
Monthly Cases in MPC (no change)	9,269	10,279	10,852
Monthly Cases moved to COPES (change)		8,943*	9,441*
COPES Monthly Cost Per Case (FY 02 base with trend factor)	$1,066	$1,126	$1,190
Personal Care Monthly Cost Per Case (FY 02 base with trend factor)	$751	$934	$1,161
Estimated Cost with No Change (at MPC monthly per capita cost)		$115,200,075	$151,248,959
Estimated Cost with Change (at COPES monthly per capita cost)		$120,847,303	$134,779,634
Estimated Cost with Change (at MPC monthly per capita cost)		$100,224,065	$131,586,595
Savings in MPC (in millions) (high end)		$14,976,010	$19,662,365
Savings in MPC (in millions) (low end)		-$5,647,228	$16,469,325

* DSHS estimates that 87% of personal care recipients would qualify for COPES
Source: Lewin's analysis of DSHS data.

The "high-end" savings in Table 24 estimate assumes that the cases moved from personal care to COPES will cost, on a per capita monthly basis, the same in COPES that they would have cost in personal care. This assumption is premised on the notion that the assessed client need for authorized hours would not change as the given client moves into COPES. The "low-end" estimate alternatively assumes that the cases would cost more in COPES than they have cost as a personal care benefit, in part because of access to non-personal care services in COPES. The average COPES monthly cost-per-case was utilized in this estimate. The midpoint of the range, in the projections for state FY 2004, is savings in the amount of $18.1 million.

Another option to consider is Option 2, which would retain personal care as a benefit, but alter: (a) the standards under which it is authorized and/or (b) the number of units a person is eligible to receive. Option 2 probably is a better option than Option 1, given the dependence placed on it by people with developmental disabilities. Because Washington cannot eliminate a state plan benefit for one population while leaving it in place for another, Option 2 would preserve personal care for people with developmental disabilities.

Option 2 was not amenable to independent estimation for purposes of this report, in that it would require sampling the current personal care cases, applying alternative medical necessity determinations to the cases, and then extrapolating the results across the entire caseload. DSHS estimates that raising the Medicaid personal care functional LOC requirement to the current LOC in COPES would "cut 15% of the current [personal care] caseload and it would also slow the rate of growth in [personal care]." Table 25 shows that, using DSHS's caseload reduction figure, Washington could save $1.9 million in state FY 2004 as a result.[11]

[11] Again, this does not take into account the effects on persons with developmental disabilities.

Table 25. Potential Savings Associated with Raising the Personal Care Functional Requirement: FY 2004

	FY 2004 Cases (proj.)
Monthly Cases in MPC (no change)	10,852
Monthly Cases Eliminated After Change in Functional Eligibility (15%)	1,628
Personal Care Monthly Cost Per Case (FY 02 base with trend factor)	$1,161
Annual Savings (in millions)	$22.7

Source: Lewin's analysis of DSHS data.

C. Six Month Reporting for Pregnant Women and Children

In 1997, the Balanced Budget Act gave states the option of providing up to 12 months of continuous eligibility for children up to and including age 18 enrolled in Medicaid and the State Children's Health Insurance Program (SCHIP). Many states implemented this option in hopes of improving stability and continuity of care and coverage. Now, with the recent fiscal pressure states have been facing as a result of growing Medicaid costs, many states have been forced to consider eliminating 12-month continuous eligibility.

In his proposed budget, Governor Locke calls for applying more controls to Medicaid eligibility. Specifically, eligibility for Medicaid would be reviewed every six months rather than every year for non-cash assistance children and pregnant women. Further, the enrollment process would be aligned more closely with the Basic Health Plan's requirements, including the need for verification of eligibility. Other states are considering similar measures. California Governor Gray Davis has proposed a change to the current eligibility renewal policy; Medi-Cal beneficiaries would be required to re-verify their eligibility quarterly rather every year, for an expected savings of $5 million in the current fiscal year and $85 million in the next fiscal year. Kentucky has implemented policy changes to increase control of eligibility, specifically a requirement for income verification. There has been no identifiable effect on Kentucky's enrollment as a result of this change, and therefore no associated savings.

According to the Governor Locke's budget, implementing both the six-month eligibility review and the increased income verification requirements would save $10 million for the State General Fund, $23 million in federal funds, and $13 million in the Health Services Account over the current biennium. Most of these savings are attributable to the six-month renewal process. In this section, we examine the estimated savings associated with implementing a change from 12 months continuous eligibility to a six-month renewal process.

1. MAA's Estimation Methodology

To estimate savings associated with the implementation of a six-month reporting process, MAA used the November 2002 fiscal forecast to determine baseline monthly eligibility and per capita cost for the categories affected by the policy change, assuming that no change in the eligibility process took place. To determine the reduction in eligibility due to the implementation of the six-month reporting process, MAA evaluated its own eligibility data regarding the patterns and duration of eligibility. MAA also quantified the degree to which persons were dropping out at

12 months by virtue of not providing recertification data. Using these data and an entry-exit model from the Office of Financial Management, MAA estimated that five percent of eligible persons would no longer be enrolled in Medicaid at the time of full implementation of the six-month reporting process.

MAA calculated savings estimates for both years of the biennium, with a majority of savings occurring in the second fiscal year (SFY 2005). MAA projects that the system changes needed to implement the six-month reporting process will be completed by January 2004, and their model assumes the first effects of the new policy change will occur in that month. However, the initial effect on eligibility is assumed to be considerably less than five percent. The MAA model assumes that the full impact of the policy change will be felt within a 24 month period, as eligibles move through the re-determination process based upon their specific renewal dates. The methodology also assumes that persons who may have received notice that their eligibility would continue for 12 months would be subject to the six-month reporting requirement, even if their 12-month eligibility period has yet to expire. (Please see the section on limitations, below, that further discusses this policy.)

2. Lewin's Estimation Methodology

Lewin reviewed the model used by MAA and found the basic methodology to be sound. However, we made two significant changes to the assumptions that resulted in different savings estimates. First, we assumed that the persons in the FFS program who would lose eligibility are, on average, less costly than those who would maintain eligibility. We made this assumption because people who have a health need and consistently use services are more likely to ensure that they maintain or re-acquire coverage.[12]

Secondly, we assumed a larger decrease in the number of covered lives as a result of this policy change. Our estimate in the reduction of covered months is based on a study Lewin performed in California related to continuous eligibility for California's Medi-Cal (Medicaid) program.[13] As a result of our California study, we estimated that 7.9 percent of non-cash assistance, TANF-like children would lose eligibility as a result of the six-month reporting policy. Table 26 outlines the results of our analysis, as well as comparing our results to MAA's estimate.

[12] While persons who leave the managed care program may also be less costly than those who remain, capitation rates may not change immediately as a result of this policy. Capitation rates are set prospectively, and unless Washington chooses to make a prospective adjustment to Year 2004 rates for the effect of this change, the per capita managed care cost will not change. In our analysis, we assumed the managed care rates would not change as a result of the policy change, and therefore did not reduce savings associated with this population.

[13] The Lewin Group, Inc. "Continuous Eligibility for Children Under Medi-Cal" Cost Estimates for Six-Month and Twelve-Month Coverage Extension Options." Medi-Cal Policy Institute, May 1999.

Table 26. Estimated Savings Associated with Six-month Reporting Process*

	MAA Estimate	Lewin Estimate	Difference
SFY 2004	$4.94	$6.37	$1.43
SFY 2005	$38.76	$50.00	$11.24
Total	$43.70	$56.37	$12.67

* Estimates do not included additional administrative costs associated with implementing the six-month reporting requirement. MAA estimates these costs to be $1.84 million in SFY 2004 and $3.53 million in SFY 2005.

Using our revised assumptions premised on our California study, we calculated an alternative savings estimate in Washington State of $56.37 million, which is $12.67 million more than the estimate calculated by MAA.

As stated above, Lewin's estimate is derived from a study we conducted in California. In creating our estimate of 7.9 percent for this report, we also looked to other possibly relevant studies that may inform our assumptions. We reviewed a simulation study conducted by Mathematica Policy Research, Inc. that suggested an increase of between 10 and 16 percent in Medicaid covered months with the institution of a 12-month continuous eligibility policy.[14] We chose not to use these estimates because the Mathematica study included children of a wider range of Medicaid eligibility categories in the analysis. Specifically, Mathematica's model included Medically Needy children, who tend to see more dramatic increases in covered months with the implementation of 12-month continuous eligibility policy than do TANF and TANF-like children. Because Washington's policy does not affect Medically Needy children, we are more confident in Lewin's estimate of 7.9 percent, which is specific to TANF and TANF-like children; our California study is a more appropriate estimate for modeling the effects of the policy change under discussion in Washington.[15]

Finally, please note that little or no cost savings were projected for pregnant women, given that delivery-related costs will likely be paid for by Medicaid even if the woman fails to recertify prior to her delivery date. Thus, the cost savings from this policy change occur predominantly by providing less coverage to children.

3. Limitations

There are several important factors to note in the savings estimates in Table 26. First, the five percent reduction in eligibility was based on discussions and analyses specific to Washington's

[14] Mathematica Policy Research, Inc. "Discontinuous Coverage in Medicaid and the Implications of 12-Month Continuous Coverage for Children." Health Resources and Services Administration, Maternal and Child Health Bureau. October, 2001.

[15] Please note that Lewin did estimate the effect of 12-month continuous eligibility for both TANF and Medically Needy children. The results of our analysis suggest a 7.9 percent increase in the number of covered months for TANF children and a 19.8 percent increase in covered month for Medically Needy children. We projected an overall increase of 10.4 percent (TANF and Medically Needy), which is very close to the 10.3 percent Mathematica projected for California's children (TANF and Medically Needy).

Medicaid population. The 7.9 percent reduction is based on Lewin's California study and is specific to the California Medicaid program. There are many differences between Washington and California's Medicaid programs, and caution should be taken in comparing the estimated effects of this policy change on these different programs.

There are also several intervening factors that may change the amount or the timing of the estimated savings amounts.

- The Medicaid health plans may make a more concerted effort to help persons recertify under a six-month reporting period, as the Medicaid managed care organizations would lose revenue due to the eligibility drop (and probably stand to lose months of coverage that entail lower-than-average claims costs). Washington may not realize as large a savings as is projected if health plan outreach efforts are initiated that succeed in helping people to maintain coverage.
- Additionally, the advocacy community may work hard to preserve continuity of coverage for children, including through litigation, as occurred in Tennessee. Such efforts could result in savings being smaller than the amounts projected herein.
- MAA is currently reviewing legal issues surrounding the effective date of the policy change, as it applies to persons who receive notice of 12 month eligibility before the official implementation date. If these persons are not subject to the six-month reporting requirements immediately, savings could be delayed.

D. Capitation Rate Setting

In response to budget pressures in Washington, Governor Locke's proposed budget calls for tying increases in Medicaid managed care rates to the State's cost of living index. In Washington, the annual rate increases the State has paid for managed health care coverage historically have typically been higher than the inflation rate. The most recent managed care rate increases averaged eight percent in 2003 and 2002, 3.5 percent in 2001, 13 percent in 2000, and five percent in 1999. The Governor proposes, in the coming biennium, to tie the rate increases to the Seattle Consumer Price Index, for an estimated savings of $28 million in State general funds, $53 million in federal funds, and $35 million in the Health Services Account.

1. Background On HMO Financial Performance

Lewin reviewed financial statements for the seven Washington State HMOs serving Medicaid enrollees.[16] These HMOs' current Medicaid enrollment levels and the proportion of their revenues represented by their Medicaid lines of business are shown in Table 27.

[16] For Tables 27 to 29, all data was taken from HMO financial statements submitted to Washington's Office of the Insurance Commissioner (OIC).

Table 27. Medicaid Enrollment and Medicaid Share of Total Revenue, By Health Plan

Health Plan	Medicaid Enrollment (Dec '02)*	% of Statewide Capitated Medicaid Enrollment	% of Revenue Derived From Medicaid Line of Business (CY2001)
Aetna/US Healthcare	0**	0%	71%
Columbia United Providers	32,696	8%	83%
Community Health Plan	112,372	28%	52%
Group Health Cooperative	30,079	7%	3%
Molina Healthcare	152,636	38%	98%
Premera Blue Cross	44,704	11%	3%
Regence Blue Shield	30,675	8%	< 10%***
Total	403,162	100%	13%****

* Enrollment data from Medical Assistance Administration's Health Options-Managed Care website

** Aetna participated in Washington's Medicaid program until mid-2002, at which point the Medicaid line of business was purchased by Molina.

*** While Regence serves Medicaid enrollees, Medicaid-specific information was not found on the organization's financial statements. Given that Regence's annual revenues exceed $1 billion, Medicaid clearly accounts for less than 10 percent of revenue.

**** This figure excludes Regence Blue Shield, for whom a precise figure is not known.

Washington's HMOs have been financially successful throughout recent years, both with their Medicaid lines of business and overall. Table 28 aggregates the financial performance of six HMOs serving Medicaid (all except Regence Blue Shield were available), which collectively comprise 92 percent of Washington's capitated Medicaid enrollment.

Across the most recent three years for which audited statements are available (calendar years 1999 to 2001) the six HMOs collectively achieved an operating surplus of $30 million on their Medicaid lines of business: a loss of $1.9 million in 1999 followed by gains of $15.4 million in 2000 and $17.0 million in 2001. This surplus represents 2.8 percent of Medicaid premium revenue. During the most recent two years (2000 to 2001), the plans achieved an operating surplus of $32 million (3.7 percent) on Medicaid. The health plans have been generating an operating surplus of approximately one percent throughout the past several years across all their lines of business; thus Medicaid has been a particularly profitable line of business in Washington in recent years.

Table 28. Operating Gains/Losses Aggregated Across Six Health Plans, Medicaid and All Lines of Business Combined

	Medicaid			All Lines of Business			Six HMOs, Jan-Jun 2002	Four Medicaid Focused HMOs, Jan-Jun 2002
	CY			CY				
Total Dollar Figures (in Millions)	**1999**	**2000**	**2001**	**1999**	**2000**	**2001**		
Total Revenues*	$209.0	$341.6	$543.0	$2,634.7	$3,431.1	$4,105.3	$2,183.7	$332.5
Medical Expense	$188.2	$286.1	$456.6	$2,331.3	$2,974.6	$3,503.8	$1,862.7	$269.3
Administrative Expense	$22.7	$40.2	$69.3	$289.4	$410.3	$551.3	$289.6	$37.4
Net Operating Gain (Loss)*	-$1.9	$15.4	$17.0	$14.0	$46.2	$50.2	$31.3	$25.8
Percentage of Revenue Figures								
Medical Expense	90.0%	83.7%	84.1%	88.5%	86.7%	85.3%	85.3%	81.0%
Administrative Expense	10.9%	11.8%	12.8%	11.0%	12.0%	13.5%	13.3%	11.3%
Operating Gain/Loss*	-0.9%	4.5%	3.1%	0.5%	1.3%	1.2%	1.4%	7.8%

* Revenues and operating gains/losses reflect operating income only, investment gains/losses are excluded. Administrative costs include payment of a 2percent premium tax. Federal income taxes are excluded from above figures. Data not available for Regence Blue Shield; Molina data were not available for CY 1999.

The Medicaid line of business appears to have become far more profitable for the health plans in 2002. Unaudited financial reports are available for the first six months of 2002 on a plan-wide basis for each HMO. These figures are also shown in Table 28 for those HMOs whose Medicaid line of business represents more than half of the HMO's annual revenue (and thus whose plan-wide figures may be a valid proxy for their Medicaid line of business performance). **These figures suggest that the HMOs achieved a large Medicaid surplus in calendar year 2002.** Through June, the four Medicaid-focused HMOs achieved a collective operating surplus of $26 million, a 7.8 percent operating margin. (This figure includes a one-time revenue write-up for Molina of $7.5 million that will not recur.) If the second half of 2002 matched the first half, the three Medicaid-focused health plans (Columbia United, Community Health Plan and Molina) collectively earned $44 million (if Molina's 2002 write-up is included; $37 million if this write-up is allocated to prior years). These figures represent an operating surplus of approximately 5.5 to 6.6 percent, which are fairly robust margins in the managed care industry. With an eight percent rate increase from 2002 to 2003, the health plans are likely to fare at least as well during 2003 as has seemingly occurred in 2002.

All these data suggest that Governor Locke appropriately is looking at managed Medicaid rates as a source of cost containment. **For example, had the State held just the three Medicaid-focused HMOs to the operating margin offered above for hospitals (1.5 percent) it would have generated savings during CY 2002 of $27 to $34 million, with a midpoint of $30.5 million**.

Table 29 summarizes the plan-specific Medicaid operating gains/losses by time period. There is substantial variation in the profitability of the Medicaid lines of business across the HMOs. While most of the HMOs lost money on Medicaid in 1999, every HMO except Group Health has been consistently profitable since CY 2000. (Group Health appears to be an anomaly largely because it is a staff model HMO – where the physicians are not network contractors, but rather

are employees of the HMO and work across customer lines such as Medicaid and commercial employers. Group Health therefore does not allocate costs differently for Medicaid than for its other lines of business. If Group Health were to reprice its Medicaid services using a Medicaid fee schedule as done by Group Health's non-staff model competitors, its Medicaid financial performance likely would improve considerably.)

Molina, the plan with the largest Medicaid membership, has generated particularly large operating surpluses. Regardless of which years Molina's 2002 write-up are allocated to (Table 29 shows this two ways), the health plan achieved a rather exceptional operating margin (averaging nine to 10 percent and more than $20 million per year) during 2001 and 2002. Nearly all of this surplus can be attributed to Medicaid given that Molina's Medicaid line of business represents 98 percent of its total revenues. MAA anticipates that its rate-setting policy change to eliminate retrospective disenrollment of SSI-eligible enrollees will reduce Molina's 2003 profitability by approximately $4 to $5 million from what it would otherwise be – although this policy change will be budget neutral across the entire program.

Table 29. Medicaid Line of Business Operating Gains/Losses (all figures exclude investment income and federal income taxes.)

Health Plan	Percent Gain (Loss), Medicaid Line of Business			
	CY 1999	CY 2000	CY 2001	Jan-Jun 2002*
Aetna	(2.2%)	4.4%	3.0%	3.9%
Columbia United Providers	8.8%	3.2%	1.1%	1.2%
Community Health Plan	3.1%	5.0%	4.7%	4.4%
Group Health	(8.5%)	(6.7%)	(20.0%)	
Molina (unadjusted)		5.7%	6.5%	14.5%
Molina (reallocating 2002 write-up)		7.3%	9.6%	8.2%
Premera	(2.9%)	11.4%	4.1%	
6 HMOs Combined	(0.9%)	4.5%	3.1%	7.8%**

* Figures for the first half of 2002 represent all HMO lines of business combined. Figures in this column are shown only for those health plans whose Medicaid business represents more than half of the HMO's total revenues.

** Figure represents aggregate performance of the four HMOs for whom Medicaid is the primary line of business.

2. Observations On Washington's Medicaid Capitation Rate-Setting Process

Within the scope of our study, Lewin was not able to conduct a detailed assessment of Washington's rate-setting approach. However, interviews with State staff and the data analysis described in the previous section led to the following observations.

a. Annual Rate-Increases do not Appear to be Well-Correlated with HMOs' Fiscal Performance and the State's Budget Situation

Collectively, Washington's health plans likely earned one of their largest Medicaid operating incomes during 2002. With an eight percent rate increase in 2003, the health plans may fare just

as well in 2003. Average Medicaid operating margins currently appear to be more than five percent – well above the average margins being earned by the State's HMOs on their other lines of business. While the large surpluses the health plans achieved on Medicaid during 2002 – a very difficult budget year for Washington's overall Medicaid program - are problematic, it is even more detrimental to the Medicaid budget that MAA is locked into paying the health plans at rates likely to preserve the health plans' strong Medicaid margins throughout 2003.

Note that a new policy is being implemented regarding treatment of HMO enrollees who become SSI eligible. Such persons previously were disenrolled from their HMO effective the date their SSI eligibility began, often many months in the distant past while the SSI application was being processed by the federal Social Security Administration. Thus, the previous policy entailed having the HMOs reimburse the state the capitation payments made by the State to the HMO, back to the SSI eligibility start date; the HMO would seek recoupment from the person's health care providers for this period; and the SSI-eligible person's providers then would have to resubmit the claims for the services during this period to MAA, which would pay them within the State's FFS program. Due to this policy, Washington's HMOs had an active incentive to pursue SSI eligibility for their enrollees, because the medical claims paid by the HMO often exceeded the capitation payments made by MAA during the pendency of the SSI eligibility determination process.

MAA has altered this policy. Now, once SSI eligibility is established, a person prospectively will be disenrolled from Healthy Options, but no retrospective adjustments will be made. On the whole, MAA will pay more in capitation and less in the FFS setting on behalf of enrollees who convert to the SSI category of eligibility, since retrospective adjustments will not be made. The new SSI disenrollment policy likely will cause some plans to realize a decrease in operating income, while others will experience an increase.[17] This is likely to be a budget neutral adjustment that should not lower overall plan margins.

b. MAA Possesses Substantial Rate-Setting Leverage

Roughly three-fourths of Washington's Medicaid HMO enrollees are served by the three health plans (Columbia United, Community Health Plan and Molina) for whom Medicaid is their dominant line of business. In establishing payment rates for these health plans, MAA needs to be cognizant of the quality and breadth of the provider network the health plans can maintain, and of the fact that MAA can literally drive these plans out of business by underpaying them. At the same time, MAA holds enormous bargaining leverage. It would be a poor business decision for the Medicaid-focused health plans to drop out of Healthy Options (and essentially go out of business altogether) because the State was paying a rate that yields an expected surplus of only one to two percent. It is important that MAA consider a more aggressive rate-setting posture, given its own fiscal situation (and the alternative types of cuts that may need to be made in Medicaid), as well as the fact that the health plans should have been able to amass

[17] For plans that did not actively seek to establish SSI eligibility, the policy change will functionally result in an increase in capitation payments for covering largely the same population. For those plans that aggressively disenrolled SSI members, the increase in capitation may not be as profitable as retrospectively disenrolling SSI members.

substantial reserves across the past few years due to the surpluses being achieved. The Medicaid-focused health plans seem well-positioned to ride out a few "lean" years in tandem with the State's fiscal situation.

c. *Important Data Are Not Being Accessed*

Two data concerns have emerged through this project. One is that it appears that MAA can track the health plans' financial performance more closely than has been occurring. The information collected by the OIC is invaluable in monitoring the financial health and performance of the health plans and should be considered by MAA when determining future rate increases.

Secondly, the quality of the encounter data available to and utilized by MAA probably warrants strengthening and greater reliance in future rate-setting efforts. Currently, MAA obtains no price information in the encounter data it is accessing, and inconsistencies and gaps in the encounter data prevent the tabulating of even fairly basic utilization measures (e.g., inpatient admission and bed day usage rates, prescription drug usage rates, generic fill rates, etc.). Many states, such as Oregon and Pennsylvania, have moved to capitation rate-setting processes that rely almost exclusively on health plan encounter and financial data. The use of these data sources allows these states to set plan-specific rates that reflect some of the particular characteristics of the plans, as well as to benchmark plans against one another on key utilization and cost measures. Thus, Oregon and Pennsylvania are able to develop very refined rates that do not depend on more crude tools such as consumer price indices. While collecting quality encounter data is challenging and may take the Healthy Options plans some time, the potential advantages of obtaining such data are great.

In addition, the CMS review process requires a heavy reliance on encounter data to demonstrate the "actuarial soundness" of the proposed rates. Also, the encounter data are needed to look underneath aggregate cost data; the OIC filings cannot discern whether or not a health plan has increased payments to providers to avoid showing a large Medicaid surplus, for example. With more than half a billion dollars of Medicaid payments going to the HMOs each year, it is important to assure that encounter data can be used to more fully accommodate MAA's need to provide financial monitoring and oversight of Healthy Options.

d. *The State's Rate-Setting Contractor Provides Actuarial Services to Some Participating Health Plans*

Milliman USA (Milliman) assists MAA in deriving annual capitation rates for the HMOs that participate in Healthy Options. Milliman is also a key actuarial consultant to two of the Medicaid-focused health plans (Columbia United and Molina) when those plans negotiate with other purchasers, such as employers. Steps have been taken to protect against conflicts of interest, such as through assuring that different Milliman staff are working for MAA than those working for the HMOs. We are not aware of any allegations or evidence of impropriety on Milliman's part, and certainly do not mean to imply that any impropriety has occurred. Nonetheless, Milliman's strong presence as a firm utilized by Washington's HMOs in their commercial lines of business, at the same time it assists MAA in negotiating Medicaid rates in arms-length relationships with two of those very HMOs, creates a potential perception problem. MAA and Milliman are in an awkward position, given that the Medicaid financial performance

of the HMOs (particularly Molina, which employs Milliman) appears to be reaching a high-water mark at the same time the State is facing a particularly severe fiscal crisis.

3. Options Regarding Cost-Savings Opportunities

Based on the analyses Lewin was able to conduct, the following options are offered.

a. Washington's Rate-Setting Methodology Should be Revisited

The central federal requirement in the rate-setting process is changing in 2003 from staying within what is known as an "upper payment limit" to assuring "actuarial soundness." This change alone warrants a revisiting of the rate-setting methodology employed by MAA. However, even without this change, it appears that some aspects of the rating methodology warrant reconsideration.

- The process may warrant a thorough, objective review by an independent third party who is given access to all information currently available.[18]
- The size of the system-wide annual percentage increase in capitation rates – as well as the increases awarded/negotiated at the HMO level, warrant particular attention, both in addressing the current budget crisis, and in minimizing the potential for HMOs to achieve large surpluses (or suffer very large losses).
- MAA may wish to take the stance, as occurs in several other states, that its actuarial contractor not be permitted to simultaneously provide actuarial consulting services to any of the Medicaid-participating HMOs.

b. Some HMOs' Medicaid Line Of Business Would Remain Viable at Lower Payment Rates

Currently, three HMOs are largely dependent on the adequacy of MAA's Medicaid payments in order to remain viable business entities. These are Columbia United Providers (Medicaid is 83 percent of annual revenues), Community Health Plan (52 percent Medicaid), and Molina (98 percent Medicaid). There clearly seems to be room for rate reductions to be implemented or, at a minimum, percentage rate increases that are far smaller than those typically paid during recent years.

A wide range of rate-setting methodologies can be employed, including the one currently in place, competitive bidding, individual negotiations with each health plan, and other options. For example, several states, including New Mexico and Missouri, have experienced tight fiscal conditions in the past several years and were able to negotiate with health plans to achieve targeted rate increases.

[18] It should be noted that Lewin provides actuarial rate-setting support to several states' Medicaid managed care programs, but if MAA pursues this recommendation, we would not seek the work. We are offering an unbiased recommendation.

Lewin is not taking a position on which approach to implement – all approaches have strengths and weaknesses that must be considered. Whatever the methodology, however, it seems appropriate that the rates be established for the immediately upcoming years such that MAA's target would be a very modest (if any) collective Medicaid operating gain for the participating plans. In the case of Molina, the operating margins have become so large in recent years as to perhaps warrant special attention. Moreover, as in the hospital rate discussion above, rate changes should be tailored, by HMO, to avoid the detrimental affects of an across-the-board approach.

During calendar year 2001, MAA capitation payments to the HMOs for Medicaid enrollees totaled approximately $600 million according to the HMOs' audited financial statements. During calendar year 2003, it is estimated that capitation payments will total approximately $700 million. On an aggregate basis, each percentage point reduction in calendar year 2004 capitation payments will save approximately $7 million in total Medicaid funds (State and Federal shares combined). One further data point is this: had the HMOs been held to a 1.5% operating margin in CY 2002, the State would have realized savings in the amount of approximately $30.5 million, as described at the beginning of this section of the report.

III. REVENUE ENHANCEMENT

When faced with a Medicaid budget crisis, states can implement initiatives to increase revenue by maximizing federal funding or by finding new sources of revenues, in addition to the cost containment strategies outlined in the previous section.

The first option is to seek a way to cost shift more of the Medicaid burden onto the federal government. The availability of federal financial participation (FFP), also known as federal "match," is a key element in state and local health care financing. The federal government pays half or more of each state's Medicaid costs, enabling states to purchase at least twice as much care as could be done with state and local dollars alone. Unlike cost cutting, not only does revenue enhancement potentially leave intact the eligibility, benefits, and other parameters of the State's Medicaid program, it continues to keep funds flowing to providers and communities.

This option, known in shorthand as "federal maximization," avoids many of the difficult policy and political debates at the state level. However, federal maximization does nothing to restructure the underlying program, nor does it slow down the growth in Medicaid expenditures, so this strategy often proves to merely defer the hard choices to a later date. Furthermore, in the current fiscal environment in most states, federal maximization strategies alone are not significant enough to solve budget problems. There is also a risk that as states might become overly reliant on federal maximization strategies, federal agency reinterpretations of matching provisions will expose states to greater financial risks.

Some maximization options might include incorporating services formerly funded with state-only dollars into the Medicaid benefit package, increasing provider reimbursement to state and local government-owned providers, or shifting Medicaid activities from low-match to high-match categories.

The second option to avoid the difficulties of cutting back in Medicaid is to find new sources of non-tax revenues to meet the State's matching obligations. As with federal maximization, this option does not change the underlying dynamics in the program, and it does not contain Medicaid costs. But it does protect Medicaid beneficiaries, providers, and local economies, all of which are important objectives. In today's environment, this can be a portion of a state's strategy, but other actions will likely need to be taken.

It is difficult, for many reasons, for states to find new sources of revenue. Most Medicaid beneficiaries receive coverage because they are poor, and are therefore unable to contribute much to the cost of their care. Many Medicaid providers are paid low rates, and are therefore unable or unwilling to provide permissible provider taxes.

Revenue options include applying tobacco taxes and settlement funds towards Medicaid, increasing federal matching funds, collecting revenue from Medicaid providers, or collecting revenue from program beneficiaries.

With recent fiscal crises, revenue enhancement continues to be a large focus for states. As explained in the cost containment section, 15 states are using beneficiary co-payments in FY 2003 and 19 states are focusing on fraud and abuse strategies, both of which can increase

revenues. Other states are experimenting with pharmacy supplemental rebate programs or increasing cost-sharing through HIFA waivers and Health Insurance Premium Payment (HIPP)-like programs. Specific revenue enhancement options for Washington to consider are included in the following sections.

A. Dual Eligible Cost Shifting

In an effort to ensure that Medicaid is the payer of last resort, many states have been focusing on Medicaid beneficiaries who are also eligible for Medicare. For these beneficiaries, Medicare should be billed first, with Medicaid covering services that are not provided under Medicare. Often, Medicaid pays claims that could have been covered by Medicare, leading to an unnecessary financial burden on the state Medicaid program. Many states have systems in place to help solve this problem, ranging from edits in the IT systems to staff dedicated to pursuing payment from Medicare.

Washington has been successful in the past with making sure that all persons who are dually eligible (i.e., eligible for both Medicaid and Medicare) are enrolled in Medicare. Washington can now move to the next step of making sure that claims are paid correctly. For example, the State of Connecticut contracts with the Center for Medicare Advocacy, Inc. to ensure that Medicare is paying for all appropriate charges for which it has primary responsibility. The Center for Medicare Advocacy has also contracted with Massachusetts and New York, although the majority of their work has been in Connecticut.

The State of Connecticut provides a list to the Center for Medicare Advocacy that includes nursing facilities claims that have been paid by Medicaid after being denied by Medicare, and all home health claims that have been paid by Medicaid. The Center for Medicare Advocacy pursues appeals of Medicare claim denials for nearly all the nursing home claims of dual eligibles. According to Connecticut, the nursing facilities have become better at billing Medicare for the proper services, so in recent years, the number of nursing facility claims to pursue has been decreased. In the case of home health claims, the Center for Medicare Advocacy uses an algorithm to determine the best cases for which to pursue Medicare determination.

In Connecticut, the total Medicaid home health budget is approximately $140 million, and about $20 to $30 million of that budget is returned to the State each year through this process. The majority of the cases that the Center for Medicare Advocacy pursues are related to nursing facilities, home health care, and for people with chronic conditions. Approximately 15 staff (consisting mostly of nurses and attorneys) devote at least half their time to pursuing claims for dual eligibles. The majority of beneficiaries that face problems with claims not being paid are those with chronic conditions, who require a lot of services, and are not going to get well (or die) soon. The Center for Medicare Advocacy is paid based on the number of claims that it pursues; the fee per home health claim is $300 and $200 for nursing facilities claims. The State of Connecticut feels that its investment in the contract has been very worthwhile and attributes the success to the Center for Medicare Advocacy's knowledge of the federal regulations and its good understanding of Medicare beneficiaries' rights.

While this revenue enhancement strategy has worked well for Connecticut, MAA expressed some reservations about its potential effectiveness in Washington. First, the home health

budget for Washington Medicaid is approximately $4 million per year, significantly less than that of Connecticut. Secondly, MAA already performs several activities related to the proper payment of home health services. From correspondence with MAA, we learned that clinicians review all home health claims on a quarterly basis and question providers if the claims were not billed to Medicare first for dually eligible clients. MAA investigates the appropriateness of services provided to dually eligible clients, as well.

There are several factors to consider when deciding whether to pursue a strategy in Washington such as the one underway in Connecticut. First, the cost of exploring this option is relatively low. Through a conference call with a vendor, MAA may be able to discover more precisely the specific advantages and disadvantages of this kind of program in Washington. Additionally, this strategy for revenue maximization is not limited to home health services. While Connecticut does not pursue many nursing facility claims today, they undertook this strategy for several years for their nursing facility claims. As a result, providers have improved their Medicare billing practices to the point where minimal follow-up activity is needed. Washington may consider whether this revenue maximization strategy may be fruitful in either or both its home health and nursing facility programs. Finally, while Washington may not be able to achieve the magnitude of savings that Connecticut claims, there may be an opportunity to make some increase in revenue through this strategy. In challenging budget times, any additional revenue can be helpful.

B. Indian Health Services and Tribal 638 Facilities

One area that Washington will want to evaluate for the possible maximization of federal dollars is services for American Indians and Alaskan Natives (AI/AN). The Indian Health Service (IHS) provides health care to AI/AN who are members of federally-recognized tribes through health facilities located on or near Indian reservations. Current funding is authorized under the Indian Health Care Improvement Act (P.L. 94-437.) The federal funding for all the IHS, tribally-operated, and urban Indian programs is appropriated in advance each year in fixed amounts. These programs are not entitlement programs, like Medicaid. However, they can receive funding from entitlement programs, including Medicaid

In addition to IHS facilities, AI/AN may access care at Tribal 638 clinics. Tribal 638 facilities are those owned and operated by AI/AN tribes and tribal organizations with funding authorized by Title I or Title III Of the Indian Self-Determination and Education Assistance Act (P.L. 93-63 8.) States can be provided 100 percent FFP for payments made by the State for services rendered through an IHS or a Tribal 638 facility.

Since IHS facilities provide services exclusively to AI/AN, states have the ability to assume that individuals receiving services at IHS facilities are AI/AN. Unlike IHS facilities, Tribal 638 facilities have the option to serve both AI/AN and other individuals. For 638 facilities, States receive 100 percent FFP for those services provided to AI/AN people, while receiving its usual State match for services provided to non-AI/ANs at the same facility. For this reason, MAA will want to determine the number of AI/AN accessing services to ensure full federal matching funds.

One way to ensure that all AI/AN persons are appropriately identified is to determine the number of people who receive services through both an IHS facility and a Tribal 638 facility.

Because IHS facilities only serve the AI/AN population, states are allowed to assume that if a person generates a claim from an IHS provider, that person is an AI/AN. Once the person has been identified in the State's eligibility system as an AI/AN, the State can claim 100 percent reimbursement when he/she later accesses services at Tribal 638 facilities; without using the IHS encounter to establish AI/AN status, the 638 claim otherwise might have been matched at the State's standard matching rate.

According to the most recent census and data provided to us by MAA, between 93,000 and 105,000 persons identify themselves as AI/AN. MAA has identified approximately 26,000 AI/AN Medicaid beneficiaries in the State currently. It is unknown how many beneficiaries may be AI/AN but have not been identified as such. To identify at least some of the AI/AN persons in the Medicaid population and claim 100 percent federal match, MAA would need to conduct a data match of claims from individuals who have received services at IHS and individuals who have received services at Tribal 638 facilities. By identifying this overlap, MAA can automatically recognize that those people identified in the data match are AI/AN and can begin to claim additional federal match for the cost of services rendered at a Tribal 638 facility.

At the time of publication of this report, we did not have the data available to us to determine the potential increase in revenue that may result from implementing this system change. MAA was unsure of the level of overlap between those people who use IHS and those who use Tribal 638 facilities. However, we encourage MAA to examine the costs of conducting such a match and determine whether the potential additional federal revenue may outweigh these administrative costs.

C. Employer Premium Assistance Program

Health Insurance Premium Payment (HIPP) programs exist in Washington and other states as a means for providing payment for private health insurance coverage when: (a) a Medicaid beneficiary has access to private coverage through an employer or spouse's employer, and (b) it is more cost effective for the program to buy this private health insurance than it is to pay for his/her care solely through Medicaid. MAA is currently exploring the possibility of expanding its HIPP program but has not yet been able to determine whether the current program will meet the needs of a potential expansion population.

Washington may be able to benefit from the Rhode Island experience of creating and managing its HIPP program. The following provides an overview of Rhode Island's RIte Share program and discusses some of the key differences between the programs in Washington and Rhode Island.

1. The Development of RIte Share

RIte Share grew out of Rhode Island's RIte Care Medicaid Managed Care Program, which was established in 1994 through an 1115 Medicaid Waiver. RIte Care includes TANF and related populations; SSI is excluded from managed care in Rhode Island. Children are eligible for RIte Care up to 250 percent FPL; parents up to 185 percent FPL are covered. From 1998 to 2000, Rhode Island experienced double digit increases in health insurance premium rates and RIte Care enrollment increased beyond projections, from 75,000 to over 100,000. In response to the

rapid growth in RIte Care enrollment, Rhode Island enacted the Health Reform Act of Rhode Island in 2000.

Established in February 2001, RIte Share is designed to encourage RIte Care eligible families who have access to a qualified employer health insurance program to enroll in the employer's health plan rather than in the RIte Care program. The Rhode Island Department of Human Services subsidizes the employee's portion of the premiums. In addition, the Department also provides wrap-around benefits such as co-payments and services not covered by employer based insurance. While eligibility guidelines are the same for both the RIte Share and RIte Care programs, the RIte Share Premium Assistance Program covers working families with access to employer-based health insurance; the RIte Care Medicaid Managed Care Program covers unemployed and working families without access to employer-based health insurance. RIte Share's goal is to limit the number of people dropping employer sponsored health coverage while maintaining eligibility for those who are uninsured and who do not have access to employer sponsored coverage.

One way that premium assistance programs help the Medicaid budget is that these programs incorporate the employer's contribution in the financing. Thus, for example, an employer might pay 60% of its employees' premiums, and Medicaid pays the remaining 40% with its combination of state and federal funds. Absent this approach, Medicaid would pay all of the eligible person's health care costs, and the potential employer contribution is omitted from the financing mix.

To determine cost effectiveness, Rhode Island calculated the average cost of covering a family under the RIte Care program. This average, $450 per month, is the cost effectiveness threshold. If a family's premium contribution is less than that amount, the State will subsidize the premiums. In addition, the State provides wrap-around services. Going forward, Rhode Island is reevaluating its cost-effectiveness strategies to accommodate changes in commercial health care, including increased deductible requirements and other added costs that may make the program less effective.

Voluntary enrollment into RIte Share began in February 2001. Rhode Island's Department of Human Services focused on encouraging employers to participate in the RIte Share program. However, enrollment into the RIte Share program has been slow for various reasons. When the program was implemented, it was estimated that about half of all working families would have access to employer sponsored health insurance, which would amount to about 20,000 persons in FY 2002 and about $8.5 million in savings. As of June 2002, the program had enrolled 2,000 persons and achieved relatively modest savings of $75,000.

While total enrollment has been less than initially anticipated, it has been on the rise recently. Table 30 shows that, as of April 2002, 866 persons were enrolled in RIte Share. By June 30, 2002, 2,000 Rhode Island residents were signed up for RIte Share. As of December 2002, Rhode Island reports 3,241 beneficiaries enrolled in RIte Share. (Current enrollment in RIte Care is approximately 117,000.) The Department of Human Services projects that by the end of FY 2003 an estimated 6,000 people will be enrolled in the program, which is expected to save the State an additional $900,000.

Table 30. Enrollment Increases in RIte Share

	Enrollees	Increase
April 2002	866	N/A
June 2002	2,000	131%
December 2002	3,241	62%
June 2003 (expected)	6,000	85%

2. Differences Between the Washington and Rhode Island Programs

There are important differences between the RIte Share program and the current HIPP program in Washington State. In Washington, once a beneficiary enrolls in HIPP, that person is disenrolled from managed care and enrolled in the FFS program. Rhode Island keeps all RIte Share beneficiaries in managed care. In addition, enrollment in the RIte Share program is mandatory for beneficiaries who have access to employer-sponsored coverage that is accepted by Rhode Island. Washington does not mandate enrollment.

Should Washington consider implementing some of Rhode Island's strategies, there are several important issues to consider. Using the managed care plans to provide wrap-around services has the potential to be less costly than FFS; however, the State would need to discern whether that is truly the case currently and whether inflationary trends in managed care and FFS would maintain the cost-effectiveness relationship. In addition, continuing managed care enrollment for HIPP program members has the potential to create confusion for beneficiaries around the coordination of benefits between the employer-sponsored plan and the Medicaid plan. If the State assumes responsibility for the coordination benefits between employer-sponsored and Medicaid plans, this may also create a more administratively difficult program for the State.

Secondly, Washington does not mandate enrollment in its HIPP program, as Rhode Island does. Since the mandatory phase of RIte Share began, Rhode Island has seen marked increases in enrollment, which has increased the State's cost avoidance. However, should Washington consider making its HIPP program mandatory as a strategy for increasing enrollment, the State will need to consider the administrative implications of ensuring employer cooperation and beneficiary participation.

D. Pharmacy Supplemental Rebates

State governments receive rebates from drug manufacturers based on the drugs Medicaid programs buy. The rebate program has been an important source of revenue to Medicaid. In addition to the federal rebate, many states are now assessing or implementing supplemental rebates that exceed the standard rebate, and are negotiated and collected directly at the state level. Florida and Michigan have implemented supplemental rebate programs, while Oregon has plans underway to do so.

Due to a growing Medicaid budget deficit, the legislature in Florida adopted a supplemental rebate program in 2001. In May 2001, Florida implemented a law allowing Medicaid to negotiate supplemental rebates from manufacturers that want to be included on Florida's

Medicaid preferred drug list. In lieu of cash rebates, Florida's Medicaid agency could accept a manufacturer's plan to provide disease management and other services that guarantee Medicaid program savings. Two manufacturers, Pfizer and Bristol-Myers Squibb, have agreed to sponsor such programs to date.

Michigan had its state plan amendment approved by CMS in January 2002, allowing Michigan to expand its prior authorization and supplemental rebates. Michigan's initiative began in February 2002 and covers 1.5 million Michigan residents. The new program was initiated in response to $1.1 billion in annual drug expenditures, with a FFS pharmacy expenditure growth rate of over 100 percent in four years. In addition, Medicaid recipients in Michigan were growing at a rate of 10,000 per month. Michigan's preferred drug list (PDL) is a clinically-based model, where the preferred drug in each drug class is chosen by a Pharmacy and Therapeutics (P&T) Committee. Then, a price equity evaluation determines supplemental rebate amounts required from drugs priced higher than preferred drug, in exchange for "preferred drug" status. The PDL is comprised of preferred drugs selected by the P&T Committee, supplemental rebate drugs (wherein the State receives a supplemental rebate from a manufacturer in exchange for "preferred drug" status), and drugs priced lower than the preferred drug. Michigan includes 15 therapeutic classes on its PDL. They have experienced significant increases in utilization for the drugs on the PDL, as shown in Table 31.

Table 31. Experience with a PDL in Michigan

Therapeutic Class	March 2001 PDL Utilization	March 2002 PDL Utilization	May 2002 PDL Utilization
ACE Inhibitors (Cardiovascular)	65.7%	88.6%	97.8%
Acid Reducers	39.6%	57.4%	91.5%
Antibiotics – Quinolones	53.8%	83.5%	96.4%
Antifungal Agents	75.0%	90.2%	94.2%
Antihistamines – 2nd Generation	79.1%	97.0%	95.9%
Calcium Channel Blocking Agents	59.9%	69.3%	85.8%
Coronary Vasodilators	85.2%	89.6%	98.6%
Glucocorticoids	79.4%	87.9%	97.2%
Hypotensives – Angio Receptor Antagonists	10.8%	78.4%	85.3%
Lipotropics	73.9%	90.5%	95.6%
Nasal Steroids	61.9%	86.5%	98.4%
Oral Hypoglycemics	58.3%	90.1%	91.8%
Topical Antifungals	41.0%	67.7%	73.6%
Topical Anti-inflammatory	63.6%	78.5%	84.3%
Sedative-Hypnotics	44.6%	52.1%	59.8%

Source: Presentation by David Viele, Deputy Director of Budget and Finance, Michigan Department of Community Health

The Michigan Legislature identified a savings of $42 million in pharmacy expenditures in the FY 2002 appropriation for the State's Department of Community Health based on the supplemental rebate initiative. Since the implementation of the program, the weekly pharmacy

expenditures for the Medicaid FFS have declined steadily and are $260,000 below the average weekly expenditures of January 2002. Additionally, the average claim cost has been reduced by over $3.60 per claim, which represents approximately seven to eight percent of the average pharmacy claim.

In Washington, MAA has taken steps to implement a similar supplemental drug rebate program to the program in Michigan. MAA began this process by first implementing its PDL. Four drug classes were recommended for the PDL: proton pump inhibitors (PPI), H2 receptor antagonists (H2RA), non-sedating antihistamines, and statin-type cholesterol lowering agents. Two have been implemented on a mandatory basis: H2RAs and PPIs. MAA imposes a prior authorization requirement on any non-preferred drug in these two drug classes that is prescribed by a physician.

The State has taken concrete plans for implementing a pharmacy supplemental rebate program. MAA will work with manufacturers, on a voluntary basis, to negotiate contracts in which the manufacturer may volunteer to provide to the State a supplemental rebate to lift the prior authorization on its drug in a class where a preferred drug exists, and the manufacturer's drug is not the preferred drug. MAA only will enter into this arrangement if the manufacturer's drug is essentially equal to the preferred drug in safety and effectiveness.

It is envisioned that the only additional administrative effort will be to send a duplicate copy of the Federal rebate invoice to the manufacturer. The State has started this type of arrangement with one manufacturer: TAP Pharmaceuticals has agreed to pay a supplemental rebate to lift the prior authorization requirement for its drug Prevacid, which is a PPI in the class, This only applies to those drugs in a drug class that are safe and effective to the preferred drug where the preferred drug is Protonix.

Washington may be considering several therapeutic classes and/or specific drugs to include in the supplemental rebate program. For the purposes of this analysis, we reviewed the potential for savings to be achieved considering only the drugs on the State's established PDL. Additionally, we only considered the potential savings to the Medicaid program. In our discussions with MAA, we learned that MAA is currently working with the state Health Care Authority and the Department of Labor and Industries to develop a consolidated pharmaceutical purchasing program that may take advantage of some of the strategies already implemented in MAA for Medicaid.

Currently, Washington has established two preferred drugs: Protonix in the PPI class and Ranitidine in the H2RA class. To evaluate the potential Medicaid savings that could be achieved by negotiating supplemental rebates with drug manufacturers, we calculated the annual effect of achieving the same average price for other drugs in the same therapeutic class, as the State currently pays for Protonix and Ranitidine.

In order to estimate the potential savings, we reviewed the average monthly number of prescriptions and total dollars spent on Protonix and Ranitidine versus those of the other drugs

in their therapeutic class for the period from February 2002 to August 2002.[19] We calculated annualized anticipated expenditures for each of the drugs based on these data points; however, we excluded March and April 2002 in our analysis.[20] We then ran several scenarios to calculate the potential savings if the State is able to achieve the supplemental rebates on a certain percentage of the non-preferred drugs. The results of our analysis are in Tables 32 and 33.

Table 32. Utilization and Cost of PDL and Non-Preferred Drugs

	PPI	H2RA
Annualized Number of Prescriptions for PDL Drug	290,594	164,594
Average Cost per Prescription for PDL Drug	$90.61	$14.37
Annualized Cost of PDL Drug (in millions)	$28.1	$2.5
Percentage of PDL Drug Prescribed in Therapeutic Class	85.4%	96.7%
Percentage of Dollars Paid for PDL Drug in Therapeutic Class	80.0%	92.8%
Annualized Number of Prescriptions for Non-Preferred Drug	42,466	5,369
Average Cost per Prescription for Non-Preferred Drug	$131.98	$33.06
Annualized Cost of Non-Preferred Drug (in millions)	$5.6	$0.2
Percentage of Non-Preferred Drug Prescribed in Therapeutic Class	14.6%	3.3%
Percentage of Dollars Paid for Non-Preferred Drug in Therapeutic Class	20.0%	7.2%

Using these data as a starting point, we calculated the potential savings should the State be able to negotiate a discount on 25, 50 and 75 percent of the non-preferred drugs, such that their price is the same as the preferred drug. Thus, in just these two drug classes, the State potentially could generate $1.4 million in supplemental rebates (at the 75 percent shift level). While aggressive, we believe this is realistic. The results of our analysis of savings are in Table 33.

[19] We chose not to include data prior to February 2002 because the TCS program had not been implemented at that point. There was a significant shift in the utilization of Protonix and Ranitidine after the implementation of the TCS program. We feel the time period after February 2002 is more reflective of the utilization and dollars from which the State is likely to generate savings currently

[20] During this time period, dually eligible beneficiaries were excluded from the TCS program. The data from these time period appear to be outliers in terms of the percentage of non-preferred drugs prescribed. Because the TCS program has again been implemented for this population, we feel these data points would artificially inflate the base utilization and dollars from which the State will be able to generate future cost savings.

Table 33. Potential Savings from Supplemental Rebates in SFY 2003

Protonix			
Percentage of Non-Preferred Drug Prescriptions Shifted to PDL Price	25.0%	50.0%	75.0%
PDL Priced Prescriptions as a Percentage of Total Therapeutic Class Prescriptions	89.0%	92.7%	96.4%
Total Additional Dollars Rebated (in thousands)	$439	$879	$1,318
Ranitidine			
Percentage of Non-Preferred Drug Prescriptions Shifted to PDL Price	25%	50%	75%
PDL Priced Prescriptions as a Percentage of Total Therapeutic Class Prescriptions	97.6%	98.4%	99.2%
Total Additional Dollars Rebated (in thousands)	$25	$50	$75

The range of savings estimates above does not include the additional costs of administering a supplemental rebate program. As demonstrated by the varying magnitudes of savings potential, the State must carefully consider the drugs for which it attempts to obtain supplemental rebates.

E. Nursing Facility Tax

Provider taxes were widely used by states beginning in the mid-1980s. Under provider tax programs, states would collect tax revenue from health care providers and use these funds as the state Medicaid share. Typically, the providers' rates were increased to offset the effect of the provider tax. Because the rates included federal and state Medicaid funds, whereas the tax receipts went entirely to the state general fund, states generated new revenue using this tool. Moreover, at the end of the transaction, the providers were fully reimbursed for their contribution. Provider tax programs typically included hospitals, ICFs/MR, nursing homes, and physicians.[21]

Congress enacted legislation in 1991 to restrict state use of provider taxes as a way of gaming additional federal funds. Now, provider assessments must be broad-based and applied uniformly to classes of providers. In addition, federal law prohibits state "hold harmless" provisions that allow providers to receive back in increased Medicaid payments the precise amount they will owe under the provider tax.

Wisconsin uses the currently-allowed provider assessments as a strategy to increase federal matching dollars. The State assesses a provider payment on all nursing homes, per occupied bed, that applies to all nursing home beds, except those in the state Centers for the Developmentally Disabled, the Veterans Home and beds occupied by Medicare beneficiaries. The current monthly rate is $32 per bed for nursing facilities and $100 for ICFs/MR. The

[21] "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences." Teresa A. Coughlin and Stephen Zuckerman, Urban Institute, June 2002.

estimated $16 million in assessments in 2000/2001 will generate approximately $23 million in federal dollars.[22]

Washington State currently assesses ICFs/MR providers but not nursing facilities. To estimate the increase in Medicaid revenues that Washington could expect should it adopt a permissible provider bed tax on nursing facilities, The Lewin Group calculated the effect of instituting a nursing facility provider tax at several levels. At $0.75 per occupied bed per day, approximately $1.8 million in additional federal revenue could be generated. Table 34 outlines the results of our analysis.

Table 34. Potential Medicaid Revenue Generated Through a Nursing Facility Provider Tax

Tax per Occupied Bed per Day	Additional Federal Revenue (in millions)
$0.25	$0.60
$0.50	$1.20
$0.75	$1.80
$1.00	$2.40

There are several important assumptions to note about these estimates, which utilized Washington data on filled beds and the proportion of Medicaid-sponsored nursing facility residents. First, the calculated increase in federal revenue is based on the assumption that all Medicaid bed days are supported through a federally matched Medicaid category of eligibility. Specifically, we assumed that no bed days were used by persons in state-only funded categories. Secondly, we assumed that 100 percent of the Medicaid revenue generated by the assessment would be given back to the nursing facilities in the form of increased payment rates without violating the "hold harmless" provision. The State has the option of passing along more than 100 percent of the assessment in increased rates to compensate nursing facilities for the additional taxes they would pay on their other bed days (e.g., private pay beds) and the additional administrative burden of paying the assessment.

Finally, this analysis does not include assumptions for the additional administrative cost to the State for administering the tax or the additional revenue the State would realize from non-Medicaid paid bed days. These are both important factors Washington must consider in determining whether a nursing facility tax is feasible and cost-effective to implement.

[22] "Medical Assistance and BadgerCare #43: Informational Paper." State of Wisconsin, Legislative Fiscal Bureau, January, 2001.

IV. CONCLUSION

All states are facing difficult decisions in containing their Medicaid costs. Washington moved earlier than most states toward "working smarter," hoping to stave off program cuts in Medicaid. In Report Two in this project, we documented the success of the State's UCCI program, in its effort to "work smarter." We applaud the State for these efforts, which it has aggressively pursued to avoid benefit, rate and eligibility cuts.

Should Washington need to find deeper cost containment in Medicaid, the State may wish to consider areas where the rates appear to have room for short-term cost savings (hospitals, HMOs), where the State's eligibility standards exceed federal requirements (12 months' continuous eligibility), and where the State's benefits are more generous than other states (long term care). In addition, the State could also consider revenue enhancement strategies (dual eligible cost shifting, supplemental pharmacy rebates, IHS/Tribal 638 FFP enhancement, and a nursing facility tax).