



Recent trends in Medicaid: *Implications for surgeons*

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States are in a fiscal crisis and the rising cost of their Medicaid programs imperils other priorities and makes Medicaid a prime target for cutbacks. Low-income and disabled Americans who rely on Medicaid for their health care and the physicians, hospitals, and other providers who serve them are likely to be caught in the financial squeeze. Surgeons should be aware of the effect these cutbacks have on Medicaid benefits, eligibility, and payment.

Medicaid is the major federal-state health insurance program for low-income families, people with disabilities, and the impoverished aged. With an enrollment of more than 47 million, Medicaid has more beneficiaries than Medicare and is almost its equal in terms of total federal and state expenditures (about \$155 billion in federal dollars and \$98 billion in state dollars in fiscal year 2002). Medicaid is also one of the largest and fastest-growing components of state budgets, comprising approximately 20 percent of all state spending and ranking second only to education in consumption of state revenues.

The sustained prosperity of the late 1990s allowed states to reduce taxes and still expand services. However, the recent recession has created severe shortfalls in tax revenues and has resulted in frantic efforts by state governments to balance their budgets. State “rainy day funds” are drying up and tobacco settlement money that had been reserved for health care purposes is now being diverted to meet other budget needs. To add to the states’ difficulties, there has been an increased demand for Medicaid due to expanded eligibility measures that were implemented in the late 1990s. Coupled with the increased need created by the rise in unemployment, the state budgets are under considerable stress. Medicaid costs are rising because of the general health care cost inflation for providers and increased use and cost of prescription drugs (see Figure 1, p. 16). However, it is important to note that reimbursement to nursing homes and hospitals represents the lion’s share of state Medicaid spending (see Figure 2, p. 16).

To make matters worse, federal matching rates for Medicaid are actually declining for some states. Medicaid is jointly funded by states and the federal government based on a matching percentage determined by the per capita income of the state relative to other states. The rate is redetermined

annually, but the percent paid by the federal government cannot be less than 50 percent or more than 83 percent. The federal Medicaid matching rates reflect state incomes between 1997 and 1999, which ultimately means that if a state had a higher per capita income during those years, its federal share of program revenues is lower. Proposals in Congress have stalled to temporarily increase the matching rates for all states or those most adversely affected by a payment formula that has not kept pace with current economic realities.

Recent state action

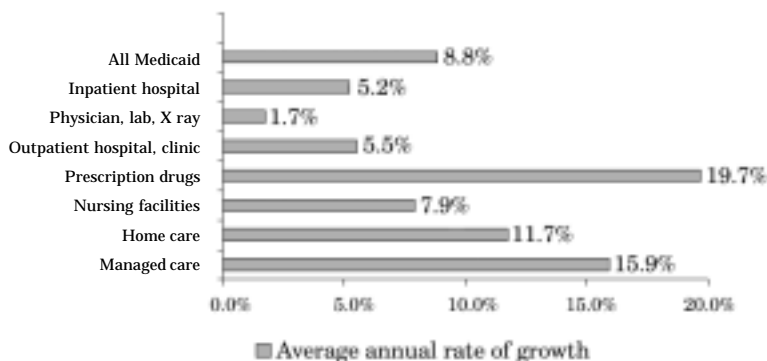
These harsh budget realities are forcing states to consider extreme measures to balance their budgets. Such actions could reduce access to services in multiple ways: limiting benefits, raising out-of-pocket costs, restricting eligibility, and reducing provider participation in the Medicaid program.

A recent survey of state Medicaid programs found that the vast majority of states have taken or will soon take steps to reduce Medicaid expenditures. Surgeons should know that 22 states have imposed freezes or cuts in provider reimbursement in fiscal year (FY) 2002, and 29 states are implementing the same measures for FY 2003. Of those 29 states, 17 plan to cut reimbursement to physicians, 20 to decrease hospital payments, and 16 to reduce payments to nursing homes (see Figure 3, p. 17).

Even before these budget adjustments were considered, Medicaid physician payment rates

Figure 1

Average annual rate of growth in selected Medicaid expenditures, 1998-2000

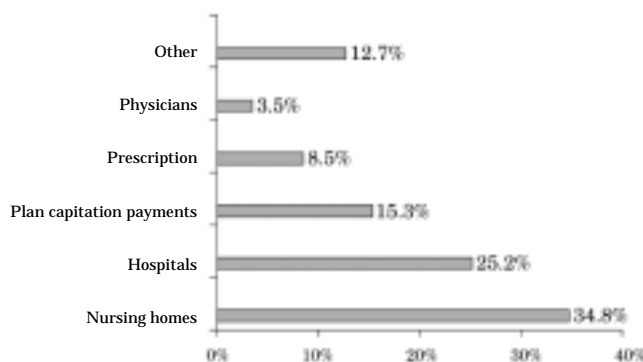


Note: All growth rates shown represent changes in total fee-for-service expenditures for the types of services listed (except for "managed care," which includes a wide range of medical services).

Source: Smith V, et al: *Medicaid Spending Growth: Results from a 2002 Survey*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2002.

Figure 2

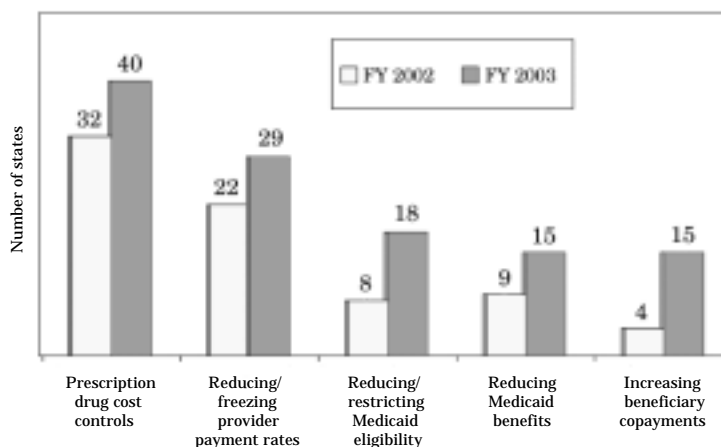
Medicaid expenditures by type of service, 2000



U.S. Department of Health and Human Services: *2002 CMS Statistics*. Web site: www.cms.gov.

Figure 3

States' FY 2002 and FY 2003 cost-containment strategies to control spending growth



Source: Smith V, et al: *Medicaid Spending Growth: Results from a 2002 Survey*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2002.

which parents become eligible for Medicaid. In the same period, 24 states have made or will implement benefit reductions, including cutbacks in adult dental care, home health, podiatric, chiropractic, and vision services. In addition, 19 states have established or will implement new copayments for services, including physician care.² These cutbacks will be significant for patients, but may also mean a greater demand for charity care and higher uncompensated care loads for physicians and hospitals.

It's ironic that the state budget crunch may also reverse or at least slow the shift to managed care for Medicaid beneficiaries. An estimated 12 to 13 million Medicaid beneficiaries currently are enrolled in managed care plans. Although many state Medicaid programs would like to direct more of their eligible populations to managed care plans, it may be difficult because the states do not have the bud-

get to handle private plan rate increases. Increased pharmaceutical and other health care costs may also encourage some states to pursue limited risk models to hold the line on managed care plans. Plans, reluctant to assume limitless exposure, are pushing back and asking the states to assume responsibility for more expensive procedures and products.³ Ultimately this means that Medicaid contracts are in flux; surgeons may end up dealing directly with the state Medicaid office rather than a health plan for payment for certain cases. It is hoped that these new configurations or ceilings might limit plans' exposure and insulate them from some of the impact of rising pharmaceutical and other health care costs.

rarely matched Medicare reimbursement and often failed to cover the actual cost of care. This new wave of cuts exacerbates an already difficult situation and could lead to more physicians dropping out of the program. The Medicare Payment Advisory Commission's recent physician access survey found that the proportion of practices open to all new Medicaid patients dropped from 48 percent in 1999 to 37 percent in 2002. Although some state cost-cutting strategies may produce greater efficiencies in their Medicaid programs, many are likely to reduce the number of poor people who are eligible for Medicaid or, for those poor who remain eligible, reduce available services or increase out-of-pocket costs.¹ In FY 2002 and 2003, 26 states have either implemented or plan to implement eligibility reductions. Massachusetts, for example, will eliminate Medicaid coverage for about 50,000 long-term unemployed individuals as of April 2003. Missouri will drop almost 33,000 people by lowering the threshold at

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Federal initiatives

In the midst of state Medicaid cutbacks, the Bush Administration has proposed an initiative to give states more flexibility in designing their Medicaid programs as well as their State Children's Health

SCHIP

SCHIP was designed in 1997 as a capped entitlement to states that elect to provide health insurance coverage to uninsured children with family incomes generally below 200 percent of the federal poverty level. SCHIP was allotted \$40 billion to be used over a 10-year period. States receive an “enhanced” match from the federal government (a higher match than they receive for Medicaid) to finance their SCHIP coverage. States may cover SCHIP-eligible children through their Medicaid programs or separate programs that meet specific benefit and other criteria, or through a combination of both. In fiscal year 2001, about 4.6 million children were enrolled in SCHIP.

Insurance Programs (SCHIPs) (see sidebar, this page). The new Health Insurance Flexibility and Accountability (HIFA) demonstration initiative encourages states to develop comprehensive approaches to increase the number of individuals with health insurance coverage. These eligibility expansions must be done using current-level Medicaid and SCHIP resources and remain budget-neutral. As of November 2002, six state HIFA proposals had been approved and another three were pending.

The Bush Administration says that the HIFA waivers are intended to expand the number of people who are insured under Medicaid and SCHIP. Opponents of these waivers, including Medicaid patient advocacy groups, say that HIFA waivers will reduce access for the optional populations already covered by Medicaid and SCHIP. This could occur either as a result of actual reductions in the generosity of the benefits or because program beneficiaries will be unable to afford the increased copayments outlined in the waiver proposals.

Future prospects

Although Medicaid was not a major election issue in most 2002 congressional races, the declining health of state Medicaid programs is likely to persist as a concern for the new Congress. Governors will continue to press for increases in federal payments for their Medicaid programs, although they are competing with equally problematic and

pressing demands on the federal budget. The Bush Administration’s efforts to give states more flexibility in running Medicaid and SCHIP through HIFA and other types of waivers are likely to go forward. For surgeons, 2003 promises few improvements in Medicaid reimbursement rates. It could also be a year in which many low-income Americans experience erosions in their benefits as some new populations gain access to scaled-down Medicaid as a result of the HIFA waivers. ^Q

References

1. There are certain populations, referred to as “mandatory” that states must cover. Other populations, termed “optional,” may be covered at a state’s discretion. Likewise, some benefits are mandatory and others, such as prescription drugs, are optional. It is the optional populations and benefit categories that are the targets for Medicaid spending reductions.
2. Smith V, et al: *Medicaid Spending Growth: Results from a 2002 Survey*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2002.
3. Medicaid: State budget problems seen threatening continued managed care arrangements, *BNA Health Care Daily*, October 10, 2002.

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