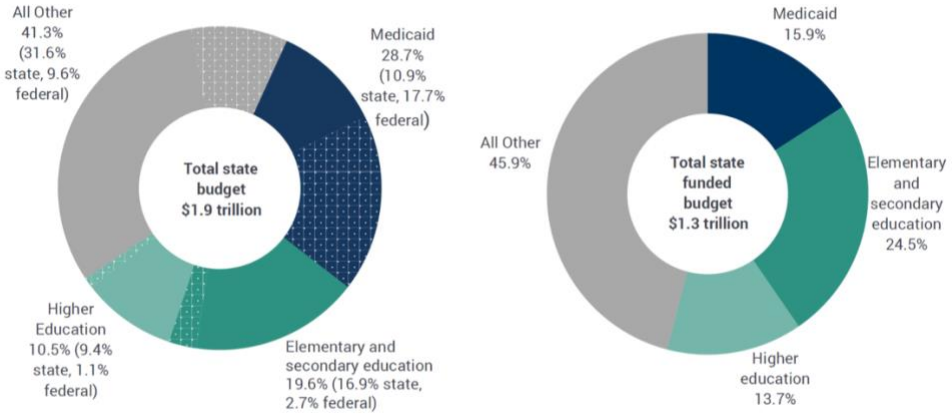
CASE STUDY: Managing a Medicaid Budget

There's a saying: "If you know one state's Medicaid program, you know one state's Medicaid program." As you'll recall from your preparatory materials, the Medicaid program varies considerably across the country because it is jointly financed and administered by the federal and state governments. The differences across states include how much of the program is financed by the federal government—as opposed to financed by the state—which populations are covered, which benefits are covered, and how much Medicaid pays physicians and other providers.

Medicaid represents a substantial share of state budgets; including federal contributions, spending on Medicaid is about as much as spending on elementary/secondary education and higher education combined (Figure 1). States, unlike the federal government, must "balance" their budget each year—they cannot spend more than the revenue they have brought in through taxes and other means.

FIGURE 1. *Distribution of Medicaid, Education, and All Other Spending from Total State Budgets versus State-Funded State Budgets, 2016*



Source: MACPAC analysis of data in National Association of State Budget Officers 2017. Total state budgets include all state (solid segments) and federal funds (dotted segments). State-funded state budgets include all non-federal funds, and consist of state general funds (expenditures from revenues raised through income, sales, and other broad-based state taxes); other state funds (expenditures from revenue sources that are restricted by law for particular government functions or activities, which for Medicaid includes provider taxes and local funds); and bonds (expenditures from the sale of bonds, generally for capital projects).

Medicaid's share of state budgets has been growing over time (Figure 2). To keep their budgets balanced, states have had to offset this growth in Medicaid spending. States have a number of tools at their disposal for doing this, including (1) reducing program generosity in terms of what it covers, (2) removing certain groups from eligibility or otherwise making continuous coverage harder to maintain, (3) raising additional tax revenue, (4) paying providers lower rates, which may also shrink the network of providers willing to participate, and (5) reducing state spending

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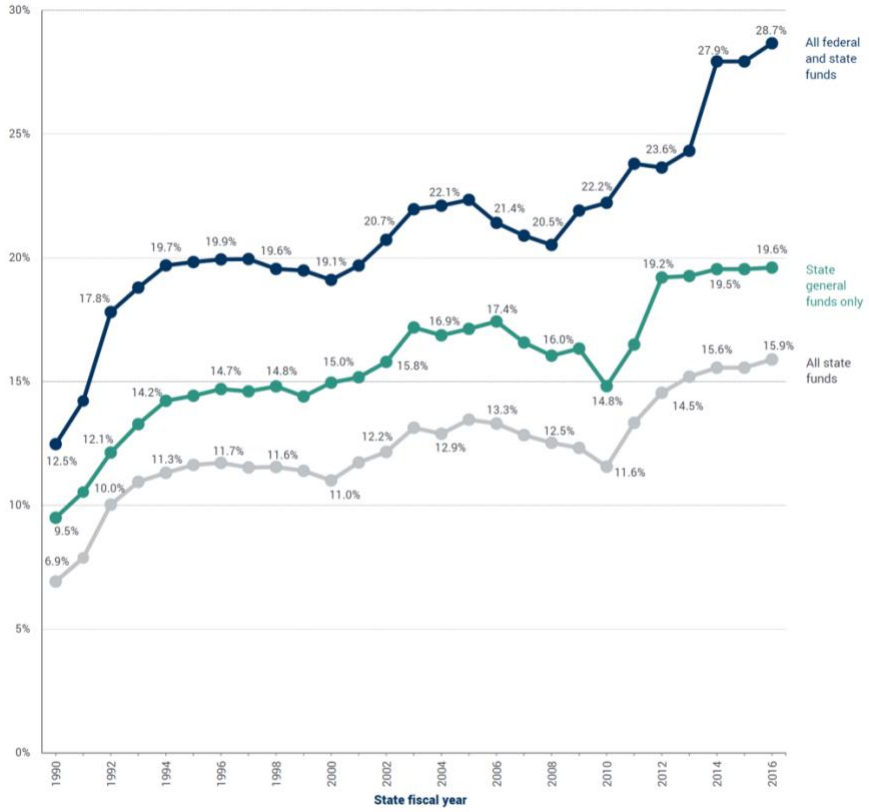
in other priority areas, such as education, transportation, infrastructure, some forms of public aid, and policing/corrections/criminal justice.

Many states have also shifted responsibility for administering Medicaid to private managed care organizations, which are paid a fixed (capitated) amount for each of their enrollees. Though there is limited evidence to support this claim, states hope these organizations can deliver the same benefits more efficiently than the state would itself. States may also favor this approach because paying managed care plans on a prospective per-patient basis establishes predictability in state expenditures.

Figure 2: *Medicaid's Share of State Budgets, Including and Excluding Federal Funds*



Source: Medicaid and CHIP Payment Advisory Commission, April 2018. The all federal and state funds *category reflects amounts from any source. The* state general funds *category reflects amounts from revenues raised through income, sales, and other broad-based state taxes. The* all state funds *category reflects amounts from any non-federal source; these include state general funds, other state funds, and bonds.*

Indeed, Medicaid program spending in a given year can be unpredictable. When new treatments become available, states must decide whether and for whom to cover the treatments. For example, a major therapeutic breakthrough for Hepatitis C (sofosbuvir, brand name Sovaldi) entered the market in 2013. This drug, which can cure the disease, had a hefty price tag; a full course of treatment had an initial price of over $100,000. Hepatitis C prevalence is higher in Medicaid than in other insured populations, and in response to these high prices, many states chose to impose restrictions on which Medicaid beneficiaries could receive the

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therapy. In 2014, 31 states required patients to have advanced fibrosis or cirrhosis of the liver; in four of those states, only patients with cirrhosis were eligible. These limits were controversial, and the subject of legal challenges. As of 2018, many states continued to restrict access to new Hepatitis C therapeutics, despite prices falling meaningfully after the introduction of new competitor therapies (e.g., Harvoni, Mayvret).

Other events can unexpectedly affect a state's Medicaid budget, too. A particularly bad flu season or a natural disaster can cause surges in demand for health care. A recession can diminish the state's tax base while increasing the number of people eligible for Medicaid. This "countercyclical" nature of Medicaid is a particular challenge for states; during the Great Recession (2007-2009), this problem was so acute that the federal government temporarily boosted federal contributions to Medicaid in all states.

The 2020 COVID-19 pandemic bundled financial stressors. The virus caused an increase in demand for some types of care (though lowered demand in other settings). Residents in nursing homes—about two-thirds of whom are on Medicaid—were disproportionately affected. Legislation passed in late March 2020 increased the share of federal funding for Medicaid programs in each state by 6.2 percentage points, which offered some financial relief. However, as a condition of receiving this funding boost, states were required to offer continuous coverage to all enrollees in (or entering) the program until the end of the public health emergency, even if an enrollee's eligibility status changed.

* * *

Required readings:

- HL Allen, BD Sommers. "Medicaid and COVID-19: At the Center of Both Health and Economic Crises." *JAMA* (2020); 2020; 324(2): 135-136.
- BD Sommers, DC Grabowski. "What Is Medicaid? More Than Meets the Eye." *JAMA*. 2017; 318(8): 695–696.
- M Fox. "Hepatitis C cure eludes patients as states struggle with costs." *CBS News.* May 6, 2018. https://www.nbcnews.com/health/health-news/hepatitis-c-cure-eludes-patients-states-struggle-costs-n870846
- H Meyer. "New Medicaid barrier: Waivers ending retrospective eligibility shift costs to providers, patients." *Modern Healthcare*. February 9, 2019. https://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients
- D Winters. "Care Providers Stuck with Transportation Costs for Iowa Medicaid Patients." WHO-HD (local NBC affiliate). January 26, 2018. https://whotv.com/2018/01/26/care-providers-stuck-with-transportation-costs-for-iowa-medicaid-patients/

Optional Readings

- "Addressing Growth in Medicaid Spending: State Options." Medicaid and CHIP Payment and Access Commission. June 2016. https://www.macpac.gov/publication/addressing-growth-in-medicaid-spending-state-options/
- D. Altman, W.H. Frist. Medicare and Medicaid at 50 years: perspectives of beneficiaries, health care professionals and institutions, and policy makers. *JAMA* 2015; 314(4):384-395.

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THE CASE:

For this case, you will pretend that you are the Medicaid administrator for your assigned state. As a result of her experience with the COVID-19 pandemic, your governor wants the state to have a strategic plan in place for dealing with future budget uncertainties. To this end, she has asked you to advise her on the following two scenarios: how the state's Medicaid program could best adapt to accommodate a 5% budget shortfall and, under opposite conditions, how the program would best absorb a 5% budget surplus. Imagine you expect the shortfall or surplus to persist for at least three years.

The tables below provide some general information about each state's program. In your groups, please identify three policy options for each budget scenario, and discuss the pros and cons of each. Then, rank these options from best to worst, thinking carefully about the criteria you are using to judge relative favorability.

Table 1: General overview

	Expanded Medicaid under ACA?	Federal match (FMAP multiplier)*	Medicaid's share of total state budget	Share in private managed care	Medicaid-to-Medicare fee index (all services)	Percent uninsured (2018)
Alabama	No	72% (2.57)	25.4%	N/A**	0.75	10.0%
California	Yes	50% (1.00)	32.6%	80%	0.52	7.2%
Florida	No	61% (1.60)	32.1%	81%	0.56	13.0%
Indiana	Yes	66% (1.93)	32.1%	77%	0.77	8.3%
Kentucky	Yes	72% (2.55)	30.3%	89%	0.77	5.6%
Maine	No	64% (1.76)	33.1%	N/A**	0.64	8.0%
Massachusetts	Yes	50% (1.00)	28.8%	45%	0.79	2.8%
Mississippi	No	77% (3.34)	23.6%	69%	0.89	12.1%
Ohio	Yes	63% (1.70)	38.0%	83%	0.63	6.5%
Texas	No	61% (1.56)	30.9%	92%	0.65	17.7%
National average	*36 states + DC expanded*	*60% (1.51)*	*29.7%*	*69%*	*0.72*	8.9%

** The federal match tells you what percent of nonexpansion Medicaid costs the federal government shoulders. The FMAP multiplier tells you how many federal dollars flow to the state for every $1 spent by the state. For example, in 2020, the federal government paid 63% of Ohio's Medicaid costs; that means for every state-raised dollar Ohio spent on the program, the federal government matched it with $1.70 in additional funding (0.63=1.70/(1.00+1.70).*

*** Alabama does not have managed care. Maine uses a PCCM model; over half of Mainecare enrollees are in PCCM plans, but KFF does not report this enrollment percent in their MCO enrollment resource.*

Sources:
https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/
https://www.nasbo.org/reports-data/state-expenditure-report
https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/
https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/
https://www.census.gov/library/publications/2019/demo/p60-267.html

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Recall that states can adjust Medicaid expenditures by changing "prices," "quantities," or both. For instance, states can intervene on price by altering payments to providers (e.g., physicians, hospitals). Indeed, states vary considerably in how Medicaid physician fees compare to Medicare's payment for the same services; this is called the Medicaid-to-Medicare fee ratio. Medicare is useful for comparison because payment is fairly consistent across the country, with some geographic adjustments. Medicaid payment is most generous in Alaska, where Medicaid paid, on average, 1.26 times what Medicare did in 2016; the program is least generous in Rhode Island, where the ratio was 0.38.

States can intervene on "quantity" by changing *what* is covered and *who* is covered. As you learned from your preparatory material, many Medicaid benefits are optional; states can decide not to cover the benefit at all, or to impose annual and lifetime limits. Some states have explored using clinical criteria to define coverage restrictions, like those imposed for hepatitis C treatments. Occasionally, states also ask the federal government to waive or let them limit their responsibility to cover certain mandatory benefits, like non-emergency transportation to medical appointments.

Table 2: Benefit coverage and limits, by state (2018)

	Dental[1]	**Vision[2]**	**Prescription drug copays and limitations[3]**	**Non-emergency medical transport[4]**
Alabama	Not covered	Limit one visit every 3 years	Copay: $0 to $3.90 depending on drug cost. Limit 5 prescriptions (max 4 brand name prescriptions) per month, with allowances for antipsychotics, antiretrovirals and anti-epileptic drugs.	Covered without copays or restrictions
California	$1 copay per visit. $1,800 annual cap on nonemergency services, but can be waived with prior authorization	Not covered	$1 copay per outpatient drug prescription. Prior authorization required to exceed 6 prescriptions per month.	Requires attestation from beneficiary that other resources have been exhausted
Florida	Covers problem-focused visits, extractions, pain management, and dentures as medically necessary (no copay)	Limit one pair of lenses/year, one set of frames every 2 years	No copay, but day and amount limits might apply, depending on the drug.	Covered with $1 copay per one-way trip
Indiana	Covered without copay, some services require prior authorization (e.g., oral surgery) or are subject to volume limits (e.g., x-rays)	Limit one pair of eyeglasses every 5 years	Copays ranging from $3 to $8. Prior authorization required for some drugs; age, quantity, and step therapy limits may apply depending on the drug.	Only available for 19 and 20-year olds subject to EPSDT, pregnant women and those who are medically frail
Kentucky	$3 copay per visit. Limit one comprehensive exam per year, certain age restrictions	Not covered	Prior authorization required for some drugs. Age, quantity, and step therapy* limits may also apply.	Only available if there is no working vehicle in the household

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Maine	Covered without copay, but limit 2 exams per year with cleanings and 1 orthodontia treatment per lifetime	Limit one pair of eyeglasses per lifetime	$3 per prescription, capped at $30 per month. Mail order drugs exempt. Limit 2 branded drugs per month, unless no generic equivalent is available.	Covered without copays or restrictions
Massachusetts	Covered without copays or restrictions	Covered, no reported restrictions	Copays of $1 (for preferred generics) or $3.65 per drug, capped at $250 per year	Covered without copays or restrictions
Mississippi	$3 copay per visit. $2,500 annual cap on benefits.	Limit one pair of eyeglasses every 5 years	$3 copay per prescription. Limit 2 brand drugs/5 prescriptions total per month.	Covered without copays or restrictions
Ohio	$3 copay. Some services require prior authorization	Limit one pair of eyeglasses every 1 or 2 years (depending on age)	$2 copay for some branded drugs; $3 copay for drugs requiring prior authorization.	Covered without copays or restrictions
Texas	Not covered	Covered with prior authorization	Limit 3 prescriptions per month for enrollees *not* in MCOs (smoking cessation products exempt). Non-preferred drugs require prior authorization. MCOs may use their own utilization management techniques.	Covered without copays or restrictions, but requires public authorizatioin

*** Notes: "**Step therapy" requires patients to "fail" a therapy (often a less-expensive treatment) before moving on to another drug for the same disease.

Sources:

1. https://www.kff.org/medicaid/state-indicator/dental-services/
2. https://www.kff.org/medicaid/state-indicator/eyeglasses/
3. https://www.kff.org/medicaid/state-indicator/prescription-drugs/; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4714442/
4. https://www.kff.org/medicaid/state-indicator/non-emergency-medical-transportation-services

States can sometimes adjust *who* is eligible for the program, though it is legally and politically difficult to make the program less generous by explicitly lowering eligibility thresholds. Historically, states have been required to cover pregnant women and young children (ages 0 to 5) up to 133% of the federal poverty level (FPL), children ages 6 to 18 up to 100% FPL, and persons with disabilities up to 74% FPL. In reality, states have eligibility thresholds that are more generous than that for these populations.

States that have expanded Medicaid under the Affordable Care Act must cover all adults up to 138% FPL and they cannot scale back that eligibility threshold without forfeiting all federal support that comes with expansion. However, in states that *haven't* expanded Medicaid there is no requirement to cover parents or childless adults through Medicaid.

There are also more nuanced ways to limit who has Medicaid coverage at a given time. Under existing federal law, someone newly enrolled in Medicaid receives "retroactive coverage"; states take on responsibility for uninsured medical claims incurred in the 90 days prior to enrollment.

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States have sought permission from the federal government to limit these obligations. The amount of paperwork required to enroll in the program (and demonstrate continued eligibility over time) also varies by state and can affect how many eligible residents are in the program.

Other Medicaid reforms that states have explored have implications for enrollment, whether or not that's the primary aim of the policy. For example, some states have proposed requiring certain enrollees to be working or actively searching for work as a condition of program eligibility, collecting nominal monthly premiums (with disenrollment for nonpayment), and imposing a surcharge on coverage for tobacco users. (Note: Medicaid work/community engagement requirements are the subject of ongoing litigation.)

Table 3: Income eligibility limits by population, as a percent of the federal poverty level (FPL)

	Children (Ages 6-18)	Pregnant Women	Parents & Caretakers	Childless Adults
Alabama	317%	146%	18%	*Not covered*
California	266%	213%	138%	138%
Florida	215%	196%	32%	*Not covered*
Indiana	262%	218%	138%	138%
Kentucky	218%	200%	138%	138%
Maine	213%	214%	105%	*Not covered*
Massachusetts	305%	205%	138%	138%
Mississippi	214%	199%	27%	*Not covered*
Ohio	211%	205%	138%	138%
Texas	206%	207%	17%	*Not covered*
National Median	*255%*	*210%*	*138%*	*138%*

Notes: All data is for 2019. In 2019, the federal poverty line (100% FPL) was $21,330 for a family of three. Medicaid coverage is generally modestly more generous for children under 6 years of age.
Source: https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/

Table 4: State Medicaid policies with implications for enrollment, as of September 2019

Alabama	None currently. *Proposed/pending approval*: Work or community engagement requirements of 35 hours per week for non-exempt adults, with coverage termination after 3 months of noncompliance. Exemptions include pregnant women, persons with disabilities, caretakers of children or frail household members, persons with substance use disorder, and students, among others.
California	California has plans to use state-raised revenue to fund a full Medicaid expansion for undocumented immigrants (it is illegal to use federal Medicaid dollars for this population, except for costs related to emergency care and labor/delivery). This, unlike other policies in this table, will have the effect of *increasing* enrollment and Medicaid spending.
Florida	The state received permission from the federal government to only provide retroactive coverage to the first day of the month in which a beneficiary applied, instead of the 90 days of retroactive coverage that is standard.

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Indiana	Beneficiaries with incomes between 100 and 138% FPL must pay monthly premiums to maintain enrollment; failure for pay for more than 60 days results in being locked out of Medicaid coverage for six months. For those below 100% FPL, premiums are not mandatory, but failing to pay premiums results in being moved to a less generous Medicaid plan that has copays at point-of-service. Indiana does not cover non-emergency medical transportation. Indiana has received permission to waiver retroactive coverage. For enrollees above 100% FPL who are required to pay premiums, coverage does not take effect until the first premium is paid.
Kentucky	As of March 2019, policies in Kentucky are on hold due to a court ruling related to work requirements; the state had previously been implementing the following policies.
Maine	None currently. Maine had *previously* been approved to charge premiums (with disenrollment after 90 days of noncompliance), a waiver of retroactive coverage, and work requirements, but the state's new governor ceased efforts to implement these policies in January 2019.
Massachusetts	None currently. *Proposed/pending approval:* Waiving the state's obligation to pay for non-emergency medical transportation for the Medicaid expansion population, with an exception for transportation to substance use disorder-related services.
Mississippi	None currently. *Proposed/pending approval*: Work requirements (20 hours/week) for caretakers/parents, with termination for noncompliance. Exemptions for pregnant women, persons with disabilities, students, among others. Working 20 hours per week at minimum wage ($580/month) would has the potential to lift compliant individuals above Mississippi's eligibility limit of 27% FPL ($370/month for a single parent with a child, $480/month for a household of 3), without a guarantee that these adults would find employment-based coverage.
Ohio	None currently. *Proposed/pending approval*: Work or community engagement requirements (80 hours/month) for non-exempt adults under 50 years of age. Exemptions include persons with disabilities, caretakers of children or frail household members, pregnant women, students, persons seeking substance use treatment, among others.
Texas	None currently.

Sources: https://familiesusa.org/initiatives/waiver-strategy-center; https://www.politico.com/states/california/story/2019/06/15/california-relies-on-federal-funds-to-expand-undocumented-health-coverage-1061599

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In your small groups, spend fifteen minutes identifying, discussing, and ranking three policy options for each budget scenario, from the perspective of your assigned state.

Please note: We understand that you may not have a strong frame of reference for what "5% of Medicaid spending" would be for a given state The point of this exercise is not to exactly reach that target, but to think critically about what actions could be prioritized in response to meaningful (but plausible) shocks to program funding, what the tradeoffs of those actions might be, and how choices might vary based on state context.

Options for adjusting to an unexpected 5% Medicaid budget *shortfall (lasting at least 3 years)*:

Policy option	Pros	Cons	Rank

Options for adjusting to an unexpected 5% Medicaid budget *surplus (lasting at least 3 years)*:

Policy option	Pros	Cons	Rank

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