

Preliminary Observations about the Report of the House Interim Committee on Medicaid Cost and Containment: Analysis of Key Provisions

This paper provides some brief observations regarding the report published by the Interim Committee on Medicaid Cost and Containment.¹ The paper discusses the potential impact of some of the Committee's recommendations. As discussed below, implementation of some of the Report's recommendations would have negative consequences for Medicaid beneficiaries, for the state, and for the health care system. In particular, new asset limitations and verification provisions would likely cause many more low-income Missourians to become uninsured and diminish their access to health care while simultaneously denying Missouri substantial federal funds and reducing state and local economic activity.

The Committee's 94-page report provides a detailed description of the Missouri Medicaid program and a 3-page set of recommendations for containing Medicaid costs. The report does not include a discussion of the potential impact of each cost-cutting measure, nor does it propose that each of the recommendations be implemented. For the most part, the report proposes that the Agency *review the impact* of each of the ten recommendations included in the report.

It is also important to point out that the Interim Committee's report focuses on "Medicaid Cost-Containment," rather than on the overall effectiveness of the Medicaid program or Medicaid's impact on the health system, the economy, or the health status of low-income Missourians. With one limited exception (the report recommends expansion of Federally Qualified Health Centers), the report does not address Medicaid reforms that would expand coverage or services or improve the program for Medicaid beneficiaries. The Report also does not include a discussion of the ways in which Medicaid improves access to health care or generates economic activity and jobs through the additional Federal dollars that it brings into the state.

This paper discusses the potential impact of some of the Committee's recommendations. The paper is divided into two sections. The first section addresses some of the specific proposals relating to services and eligibility reforms, while the second raises more general concerns about the recommendations.

I. Comments about Some Specific "Cost-Containment" Recommendations

- **Additional Asset Requirements for Families and Pregnant women**

The Committee recommends "reviewing the impact of adding an asset limit of \$1000 for MAF [Medical Assistance for Families]." The likely impact of this proposal is discussed below.

Missouri is certainly not the only state that fails to impose an assets test in its Medicaid program for pregnant women and families. In fact, only seven states do

impose an assets test for pregnant women, while thirty states impose an assets test in their family Medicaid programs.²

There are very strong reasons why many states have eliminated their assets tests in Medicaid programs for children and families. These reasons need to be taken into account before adopting new assets tests. **Missouri and other states eliminated asset tests for these Medicaid beneficiaries because they were administratively burdensome and resource-intensive for the State agency and created barriers to health care access for children and families.** A Kaiser Commission review of state experiences in eliminating the assets test noted states' overwhelmingly positive experiences in eliminating the assets test.³ In particular, Missouri state officials reported that “[d]ropping the assets test was an important part of a package of changes that resulted in savings, because the process took less paper and less time.”⁴

Why Many States Have Eliminated the Assets Test in their Family Medicaid programs

States have given the following reasons for eliminating the assets test in their Medicaid Programs for children and families:

- Not having an asset test made the program “easier to administer.” (Mississippi)
- Eliminating the asset test “was a removal of a procedural barrier and efforts required by agency eligibility staff have been reduced.” (New Mexico)
- Dropping the asst test for families “made the workload more manageable for eligibility workers. It was simplifying while still considering all the factors important to eligibility.” (Massachusetts)
- “By not having an asset test, we could ask fewer questions and the eligibility workers’ jobs would be easier.” (District of Columbia)
- **“The cost the eligibility agency was incurring exceeded the cost of benefits that might have been denied.** These families are usually young, and we would rarely see younger families with assets. The process is slow and cumbersome to verify bank account balances and the cash value of life insurance. It delays the eligibility process and resulted in so few denials that it was cheaper to make them eligible for the benefit without checking.” State officials further noted that the most important impact on families is the “expediency in getting them certified. There is a reduction in time and in the hassle factor.” Making an eligibility decision on applications used to take 45 days, but the new standard is 20 days, “and most are processed now in 5 days.” (Oklahoma)

(Oklahoma officials reported that they had previously spent \$3.5 million in general revenue dollars for administrative activities related to the verification of assets and noted that removing the asset test for

families has “dramatically reduced” staff time required to process an application.”)

- Dropping the asset test had streamlined the process and removed a significant barrier: “There were families who had not gone through the entire process because it was long, complex and intrusive. The state further stated: “Without a doubt there have been savings [from dropping the asset test].” (Pennsylvania)
- “Very positive, especially as the state is focusing on stable jobs and stable families. We want to minimize barriers. People are very pleased. Dropping the asset test was a very good thing in terms of access. A lot of the tests in place represented barriers to the program. The net effect of the hoops was to weed out people who did not follow through because the process was complex and error prone.” (Ohio)
- “We are glad we don’t have it [the asset test]. **It would cost more in administrative costs than the savings in denying care to low-income people.** We want to have a mainstream group [in RiteCare], not just high-risk. We made the process simple so the people who are enrolled are not just the ones who want health coverage so bad they are willing to go through an onerous process.” (Rhode Island)
- The process of applying is now “less intimidating.” (Delaware)

Kaiser Commission on Medicaid and the Uninsured (April 2001).⁵

It is clear from this discussion that **there are very good reasons why Missouri and many other states eliminated the assets test for children and families.** Imposing a new assets test would make the program more burdensome for families and the state agency. In addition, this proposal would cause *significant numbers of individuals to lose their Medicaid coverage.* While undoubtedly many of the children and families in the Medical Assistance for Families program will not have \$1000 in assets, some of these families will lose eligibility, as will the pregnant women who are subject to a higher income standard.

The Department of Social Services has estimated that **1572 parents and 276 pregnant women would lose health coverage if a \$1000 assets test were imposed** in these programs.⁶ While children in the MAF families with resources in excess of \$1000 would still be eligible for Medicaid coverage (under the “Medicaid for Children” program, which has no asset limit), it is not clear that, in practice, all such children would *automatically* be transferred to that program when their family loses eligibility for MAF. The Department also notes that “[n]ewborns whose mothers lose their eligibility as pregnant women would lose their automatic entitlement to Medicaid,” although they “*might still be eligible*” for Medicaid (under the Medicaid for Children program).⁷

Furthermore, this discussion only addresses those who are made financially ineligible by the new limits. However, a new assets test would likely cause a much *greater reduction in eligibility than the number who are made financially ineligible for the program*. Research indicates that imposing new administrative barriers also causes people who are still *eligible* for the program to lose coverage (see verification discussion below). This consequence occurs because of the additional questions that have to be asked by caseworkers, the additional items that have to be verified, and confusion about what types of paperwork are required by the Agency. As discussed above, these barriers are the reason why many states have eliminated asset tests for children, families and pregnant women in their Medicaid programs. Thus, many more families would lose health insurance than are financially ineligible under the new asset test.

To summarize, it is likely that **significant numbers of eligible families and pregnant women would lose health insurance through Medicaid if a \$1000 asset test were implemented in the MC+ program. There would also be additional financial costs to the state and administrative burdens for caseworkers if such tests were imposed.**

- **Additional Verification Requirements**

The Committee recommends “reviewing state resources to determine if information exists that can be utilized to verify applicant’s statements.” The “committee also recommends considering that additional documentation be provided at the time of application in order to be considered for Medicaid coverage. This may include mandatory disclosure of pay stubs.” These recommendations are based on an inaccurate description of the eligibility determination process. In discussing the application process, the report states, “[o]n questions such as income, resources, and access to health insurance an applicant’s word is accepted as fact.”⁸

In fact, the Family Support Division’s current policies *already* require verification of income, in the form of pay stubs, or based on the IMES system, under which the Agency can obtain employment information without getting it directly from the client.⁹ In programs that have resource tests (such as Medical Assistance), the Agency also requires verification of resources.

To the extent that any *new* verification requirements are imposed, the impact would surely be that greater numbers of individuals are denied Medicaid coverage. There is substantial research that imposing additional procedural obstacles, such as new verification requirements, causes *eligible* people to lose Medicaid coverage.¹⁰ This means that **more low-income Missourians would become uninsured if the verification process is made more stringent than it is now**. Moreover, additional verification requirements mean greater administrative burdens and greater costs to the state agency, including more staff time to process the additional paperwork and ask additional questions.¹¹ As a recent Kaiser report notes:

While requiring families to comply with added paperwork and reporting procedures may save money by reducing the number of people participating in the programs, it should be noted that costs also are incurred as a result of making such changes. **In addition to the large costs associated with uncompensated care when uninsured people seek needed medical attention, and the serious financial burdens low-income families must shoulder to pay for treatment on their own, there are expenses associated with the administrative tasks necessary to implement more labor-intensive procedures.** Where financial pressures have already resulted in state workforce reductions or hiring freezes, it is important to keep in mind that changes such as increasing reporting and verification requirements are likely to require more staff time.¹²

Such costs should be factored into any analysis of the “savings” from new verification proposals.

- **Optional Services Reduction**

The report “recommends the review of optional services for possible program reduction.” The recommendations section of the report states that optional services cost Missouri \$1,584,413,849 each year (based on FY 2002 data).¹³ However, *because over 60% of this \$1.5 billion figure is federal matching funds, these optional services actually cost the state about \$634 million per year.*¹⁴

The report also notes that optional services include pharmacy, which itself costs more than \$930,000,000 in FY 2003.¹⁵ Even though pharmacy services are optional, *every* state in the country provides them, so they are hardly a service that the state could consider eliminating. The reality is that many services that are *technically* optional are services that almost no state would eliminate. In fact, 83% of optional Medicaid spending nationwide is for elderly and disabled beneficiaries and over two-thirds of optional spending is for prescription drugs and long-term care.¹⁶

Other “optional” services that the state has considered eliminating in the past are far less expensive and cutting them would not generate substantial savings. For example, eliminating adult dental and optical services would save the state about \$7 million in general revenue, while depriving the state of about \$11 million in federal funds. At the same time, these optional services have a positive health impact on the people who receive them. It is widely acknowledged, for example, that preventative dental care can forestall greater health problems and more costly medical expenses (which can mean higher costs in other parts of the Medicaid budget) later on, and prevent serious illnesses.¹⁷ **Policymakers clearly need to consider the health impact of reducing or eliminating these types of services, not simply the short-term financial impact.**

- **Managed Care for Elderly, Blind and Disabled**

The report recommends that “the State of Missouri further investigate the possibility so expanding the current Managed Care system to include the elderly, blind, and disabled populations into the area of the state already participating in Medicaid managed care.” This recommendation was based in part on the testimony of former Missouri Medicaid director, Donna Checkett, now the Chief Executive Officer of the Missouri Care Health Plan (a managed care plan that participates in the Missouri Medicaid program) who estimated that “the State of Missouri has realized a \$200 million savings under the current MC+ Managed Care Program.”¹⁸ The Committee also notes that 36 states enroll some people with disabilities in some form of managed care.¹⁹

Putting aside the question of whether managed care will work effectively for people with disabilities (let alone the elderly), there are serious questions as to whether the same kinds of “costs-savings” can be realized in serving people with disabilities -- who have more severe and chronic health needs – that are realized in serving children. Bruce Vladeck, former Administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services), has noted that providing managed care to this population could cost *more* money, not less. Vladeck states:

Part of the problem with mandatory managed care for seriously disabled people is that **when done right, it may cost more than traditional FFS care, not less. The disabled are a severely underserved population; effective assessment, care planning, and case management may greatly increase their use of services.** Moreover, as compared with low-income children and their mothers, who have traditionally encountered barriers to access for relatively inexpensive primary care and preventive services while overusing expensive emergency rooms and inpatient hospitalizations, **the disabled have traditionally experienced access barriers to specialized therapists, sophisticated equipment, and so forth, which are themselves quite expensive.** That is why appropriate risk adjustment is so important to mainstream plans’ ability to adequately serve disabled beneficiaries and why, when dealing with specialized plans serving only disabled beneficiaries, states are becoming less and less enamored with capitation. Capitating children at \$150 or \$200 a month is one thing; capitating disabled beneficiaries at \$1,500 or \$2,000 a month is an entirely different policy question.²⁰

The Kaiser Commission has similarly noted that “the inherent financial incentives to provide fewer services under capitated rates may cause people with chronic conditions to be underserved” under managed care.²¹ The Interim Committee’s Report similarly notes that “in any capitated arrangement, especially in the elderly and disabled populations, there is a fear that managed care will result in under-treatment.”²² Moreover, a new Missouri State Auditor’s report raises questions about the adequacy of the State’s monitoring of its current Medicaid managed care program with regard to the provision of dental services, including the underpayment of dental providers.²³ Such findings raise concerns about the State’s ability to monitor the provision of quality health

care services to individuals with far more chronic and severe health conditions than the current MC+ managed care program enrollees.²⁴

For these reasons, any attempt to explore this option ought to proceed slowly and cautiously, if at all.

- **Level of Care**

The Committee also recommends considering the impact of revising the level of care required for Medicaid coverage for long term care, including home and community based services, and nursing home care. Previously proposed reforms in this area have included increasing the level of care required for qualifying for these services.²⁵ If similar reforms are contemplated here, then increases in “levels of care” required for long-term care would deny services to individuals who currently qualify for these services. The report indicates that over 9200 of the individuals who qualify for HCB services have the minimum 18 points needed to qualify for these services, which are designed to enable them to remain in the community.²⁶ Certainly, one possible outcome from imposing more restrictive standards is that the people who would lose eligibility would lose the services that enable them to remain in the community. Their conditions would deteriorate to the point where they could no longer function with HCB-based care and would instead require more expensive nursing home care. These potential consequences should be considered as the point system is re-evaluated.

II. Unintended Consequences of “Cost-Containment” Proposals that Reduce Eligibility or Services

As stated earlier, the recommendations in the report focus exclusively on ways to cut costs in the Missouri Medicaid program. The report *does not explore the consequences* of cutting costs by making individuals ineligible (through new asset tests or new verification requirements) or by reducing optional services from the Missouri Medicaid program. It is clear however, that these proposals would have significant consequences that must be weighed before any of these options are implemented:

- **Medicaid helps to reduce Missouri’s rate of uninsured individuals by providing health coverage to low-income Missourians.**

The Interim Committee’s report notes that Missouri’s Medicaid enrollment has been rising during the last several years.²⁷ The report *also* notes that Missouri’s rate of uninsurance is significantly lower than the national average.²⁸ United States Census data show that Medicaid and SCHIP programs have helped combat rising rates of uninsured nationwide and in Missouri.²⁹ The rate of uninsured children in the United States and Missouri have remained steady, despite the decline in employer-based coverage, *due to the Medicaid and SCHIP programs*. Moreover, Census data show that the rising rate of uninsured adults would have been far worse, if not for the role of Medicaid and SCHIP in responding to increased need during a recession. **If people lose Medicaid coverage as a**

result of new eligibility restrictions, Missouri's rate of uninsured is likely to increase.

Any consideration of further eligibility restrictions must consider the increase in uninsured that would result from additional Medicaid cuts.

- **Medicaid brings new federal funds into the state; these funds generate economic activity and jobs for Missouri.**

As discussed in the Interim Committee's Report, Medicaid brings significant federal matching dollars into the state. State Medicaid funds generate federal matching funds at a 61% rate for most individuals and a 72% rate for SCHIP children. Missouri Medicaid spending generates \$1.6 in federal matching funds for every state dollar spent while SCHIP spending generate nearly \$3 in federal matching funds. A wide variety of studies have shown that state Medicaid spending generates economic activity and jobs throughout state and local economies based on the "multiplier effect" from such spending.³⁰ Federal Medicaid dollars generate spending in the health sector, which generate other spending that flows throughout the state and local economies. **When services and eligibility are cut, these federal funds are lost, and hence, economic activity and jobs, are lost as well.**

- **By providing health insurance to eligible Missourians, Medicaid provides them with better access to health care.**

There is significant evidence that *having health insurance* improves access to health care and health outcomes..³¹ The uninsured receive less preventative care, are diagnosed at more advanced disease states, and once diagnosed, tend to receive less therapeutic care (drugs and surgical interventions) that people who have health insurance.³² Moreover, a wide array of studies demonstrate that Medicaid and SCHIP coverage improve access to health care and improve health outcomes.³³ Such coverage can decrease emergency room usage, reduce preventable hospitalizations, and improve access to primary health care.³⁴ Studies also have found that Missouri's Medicaid program has had a number of positive impacts on children's health care.³⁵

- **Any policy proposals that reduce Medicaid eligibility increase the likelihood that the individuals terminated from the program will lose access to health care and that their health status will worsen.**

A loss of insurance coverage also increases the amount of "uncompensated care" (care that is not paid for by private or public insurance), thus transferring these health care costs to other parts of the health system, driving up costs, and straining health resources for people who are not covered by the Medicaid program. In testimony before the Interim Committee, the Missouri Hospital Association pointed out the substantial "cost-shift" that would have occurred if Missouri's rate of uninsured had been equal to the national average.³⁶ As pointed out already, Medicaid and SCHIP are a significant

reason why Missouri's rate of uninsured has not grown even more over the last several years.

Conclusion

The foregoing discussion indicates that several of the recommendations in the report, if implemented, would have severe negative consequences. In particular, proposals that limit Medicaid eligibility and services can raise Missouri's rate of uninsured, increase the degree of uncompensated care, decrease access to health care, and diminish the health status of our state's low-income residents.

-- Joel Ferber --
-- February 9, 2004 --

Endnotes

¹ See *Report of the Interim Committee on Medicaid Cost and Containment* ("Report"), January 27, 2004.

² Center on Budget and Policy Priorities, *Asset Limits for Pregnant Women and Section 1931*.

³ Vernon Smith et al., *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*, Kaiser Commission on Medicaid and the Uninsured, April 2001.

⁴ *Id.* at ii.

⁵ *Id.* 1-15.

⁶ Letter from Brian D. Kincaid, Director, Missouri Division of Budget and Finance, to Amy Woods, Legislative Analyst, December 23, 2003. The Department assumes that 1% of MAF parents and 2% of Medicaid for Pregnant Women recipients would lose health coverage.

⁷ *Id.* (emphasis added)

⁸ Report at 49.

⁹ See Missouri Income Maintenance Manual, "Verification Requirements for Medicaid/MC+ and Adult Cash Assistance," Section 0110.025.00.

¹⁰ Donna Cohen Ross and Laura Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge, A 50 State Update on Eligibility, Enrollment, Renewal and Cost-sharing Practices in Medicaid and SCHIP*, July 2003; Ellen O'Brien and Cindy Mann, *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP*, Covering Kids and Families, June 2003, at 9; Laura Cox, *Allowing Families to Self-Report Income: A Promising Strategy for Simplifying Enrollment in Children's Health Coverage Programs*, Center on Budget and Policy Priorities, December 28, 2001.

¹¹ Cohen Ross and Cox, at 16.

¹² *Id.* (emphasis added)

¹³ Report at 11, 49.

¹⁴ Report at 11.

¹⁵ Report at 3, 86

¹⁶ Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance*, January 2004.

¹⁷ See, e.g., U.S. Dept. of Health and Human Services, *Oral Health in America: A Report of the Surgeon General*, 2000.

¹⁸ Report at 24, 93

¹⁹ Report at 25.

²⁰ Bruce C. Vladeck, *Where the Action Really Is: Medicaid and the Disabled*, Health Affairs, January-February 2003, at 97.

²¹ Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Disabled Population and Managed Care*, March 2001.

²² Report at 26.

²³ Office of the State Auditor of Missouri, *Oversight Controls and Management of the State's Managed Care Program*, January 13, 2004.

²⁴ It is also worth noting that parents of children with disabilities have the option to remove their children from the managed care program and choose fee-for-service medical care instead; many in fact take advantage of this option.

²⁵ For example, the Governor's FY 2003 budget proposed increasing the level of disability required for nursing home and home and community-based services.

²⁶ Report at 33.

²⁷ Report at 4,6.

²⁸ Report at 8.

²⁹ U.S. Census Bureau, *Health Insurance Coverage in the United States: 2002* (issued September 2003). Center on Budget and Policy Priorities, *Number of Americans Without Health Insurance Rose in 2002*, September 30, 2003.

³⁰ National Conference of State Legislatures, *State Medicaid and Health Multiplier Studies: Reports, News Accounts, and Sources and Explanations of Economic Models* (and citations therein), July 22, 2003.

³¹ Kaiser Commission on the Future of Medicaid and the Uninsured, *The Uninsured and their Access to Health*, January 2003.

³² See Jack Hadley, Sicker and Poorer: *The Consequences of Being Uninsured: Executive Summary*, The Kaiser Commission on Medicaid and the Uninsured, February 2003. www.kff.org/uninsured/20020510-index.cfm, 1.

³³ O'Brien and Mann.

³⁴ Id. (and citations therein).

³⁵ Department Of Social Services, State of Missouri, *Since MC+ Began*, February 10, 2003.

³⁶ Missouri Hospital Association, *Missouri Medicaid Briefing*, House Interim Committee on Medicaid Cost and Containment, October 10, 2003, at 37.