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MEDICAID WHITE PAPER ON OPTIONAL PROGRAM EXPENDITURE AND COST SAVINGS IMPLEMENTATION

January 15, 2003

The federal government mandates State Medicaid Agencies to provide medical, hospital, long-term care (ages 21 and older) and other core medical services to all eligible groups. Other services – such as prescription drugs, chiropractic services, hospice care, eyeglasses and rehabilitative services – states have the option of covering. If the State chooses to offer an optional service, it must be offered to all eligible groups. The optional services are offered because the cost of providing them is deemed to be less than the cost of treating the more severe illnesses that may result from not covering the cost of the optional service. For individuals under 21 years of age, all mandatory and optional services must be provided, if medically necessary.

In 1991, budget cuts were necessary. Therefore, chiropractic and podiatric services were cut from the Nevada Medicaid State Plan and are only provided to federally required groups (EPSDT and QMB). For example, if a Medicaid recipient over the age of 21 who is not a qualified Medicare beneficiary (QMB) has an ingrown toenail, the recipient would be treated by a physician rather than a podiatrist. Typically the cost of reimbursement to a physician is higher than for a podiatrist. Medicaid still pays for the treatment, but at a higher rate to a more expensive clinician.

The Division of Health Care Financing and Policy is frequently asked to analyze the feasibility of cutting optional program services. The following information demonstrates the risks associated with making choices related to eliminating optional health care program services. Medicaid services are segregated into groups by whether that service was federally mandatory or optional, or if it supports another state program.

MANDATORY PROGRAMS AND FY02 EXPENDITURES

PROVIDER NUMBER	EXPENDITURE IN FY02	SERVICE
10	$ 4,129,232	Hospital, Outpatient Surgery
11	106,054,436	Hospital, Inpatient
12	10,979,004	Hospital, Outpatient
15	1,126,629	Rural Clinics & FQHCs
18	13,847,977	Nursing Facilities/Skilled
20	58,307,660	Physician/Osteopath
24	1,311,028	CRNA, Nurse Anesthesia, Nurse Mid-Wife, Pas
27	635,430	Radiology & Noninvasive Diagnostic
29	4,923,768	Home Health Agencies
31	3,569,721	Health Kids -- EPSDT
32	2,223,403	Ambulance – Air & Ground
35	1,120,883	Transportation
43	1,571,525	Laboratory – Path/Clinical
47	1,757,956	IHS & Tribal Clinics
49	15,590	IHS Transportation
51	0	IHS Tribal Hospital – Inpatient
52	137,367	IHS Hospital - Outpatient
TOTAL	$211,711,609.	

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SUBCOMMITTEE K-12/Human Resources
DATE: 2/27/03 ROOM 3137 EXHIBIT G
SUBMITTED BY: Jan Sasser

The following non-mandatory or **optional** programs are identified separately, as they support another state or county program and generally pass through federal revenue. These programs are generally not subject to Medicaid program cuts in this review.

OPTIONAL PROGRAMS THAT SUPPORT GOVERNMENT SERVICES AND FY02 EXPENDITURES

PROVIDER NUMBER	EXPENDITURE IN FY02	SERVICE
13	$ 6,035,282	Psych Hospital Inpatient
14	6,760,658	Mental Health, Outpatient
16	26,822,398	ICF/MR
38	23,721,865	MR Waiver
48	7,092,054	Senior Waiver
54	18,101,246	DHR Case Management
57	640,833	Adult Group Care Waiver
58	817,505	Physically Disabled Waiver
60	8,391,990	School Based Services
61	20,864,908	Mental Health Rehab Services
TOTAL	$119,248,739	

The next table is a summary of the remaining optional programs and the total amount spent in FY02 on each of those programs. This table also indicates the percentage of each program that has EPSDT or QMB participation. Federal Medicaid regulations require Nevada Medicaid to provide service to EPSDT and QMB clients. The total expended on all optional services was $244,369,632 in FY02.

COSTS FOR OPTIONAL PROGRAMS

PROVIDER NUMBER	EXPENDITURE IN FY02	SERVICE	% EPSDT AND QMB	% STRAIGHT MEDICAID
17	$ 488,258	Special Clinics	31.78%	68.22%
19	87,757,605	Nursing Facility – Intermediate Care	.05%	99.95%
21	57,647	Podiatrist	14.22%	85.78%
22	16,780,606	Dental	46.71%	53.29%
23	348,689	Hearing Aids	5.08%	94.92%
25	1,288,662	Optometrists	39.19%	60.81%
26	1,192,144	Psychologists	69.06%	30.94%
28	78,814,166	Pharmacy	6.06%	93.94%
30	11,487,577	Personal Care Aids	0.55%	99.45%
33	10,313,497	DME, Supplies, Prosthetics, Orthotics	9.55%	90.45%
34	2,115,685	Therapies (ST, OT, PT)	7.90%	92.10%
36	3,077	Chiropractor	2.25%	97.75%
37	3,705,738	IV Therapy (TPN)	.02%	99.98%
39	567,983	Adult Day Health Care	0%	100%
41	245,119	Opticians	27.03%	72.97%
42	1,084	Out-Patient Psych. Hospital, Etc.	0%	100%
44	4,952	Swing Bed (Acute Hospitals)	0%	100%
45	2,725,673	End Stage Renal Disease (ESRD) Facility	13.19%	86.81%
46	5,254,913	Ambulatory Surgery Ctrs (Medicare Certified)	40.01%	59.99%
50	58,908	Health Insurance Premiums	0%	100%
55	2,615,500	Transitional Rehab Centers	0%	100%
56	2,427,641	Rehab Hospital – Inpatient	0%	100%
63	13,756,087	Residential Treatment Centers (RTC)	77.47%	22.53%
64	915,814	Hospice	4.86%	95.14%
65	1,442,607	Hospice	0%	100%
TOTAL	$244,369,632			

*PCCM shifted to managed care and other providers after FY99.

In the following table, the dollar amount required for EPSDT/QMB is identified as an amount that cannot be cut as the services are federally mandated. The last two columns indicate the amount of optional services provided (straight Medicaid) to non-mandatory groups and the impact that the loss of this services would have on other Medicaid programs and society.

FISCAL IMPACT OF CUTTING ALL OPTIONAL PROGRAMS

PROV. NO	FY02 $	SERVICE	EPSDT & QMB	STRAIGHT MEDICAID	CONSEQUENCES IF PROGRAM CUT
17	$ 488,257.97	Special Clinics	$ 155,164	$ 333,094	Increase in TB Treatment and community exposure to infectious disease
19	87,757,604.81	Nursing Facility/Intermediate	40,796	87,716,809	Increased inpatient hospitalization and home health services.
21	57,646.64	Podiatrist	8,196	49,451	This optional service was cut in 1991. Medicaid still pays for foot care but an MD CPT code is paid at a higher rate than a podiatry CPT code.
22	16,780,605.64	Dental	7,838,738	8,941,868	Increase in heart disease, suffering, dental infection, no dentures-resulting in nutrition deficits, and related problems.
23	348,688.92	Hearing Aids	17,724	330,965	Decrease in hearing and many related problems, such as depression. Safety issues overtime may contribute to perceived need for LTC placement.
25	1,288,661.78	Optometrists	505,044	783,618	Decrease in vision and increase in falls.
26	1,192,143.94	Psychologists	823,352	368,792	Increase in hospital usage, increased crime. Family practice physicians prescribe medications.
28	78,814,165.69	Pharmacy	4,778,848	74,035,318	Increase in hospital and ER use, possible deaths, and much more intense treatment.
30	11,487,576.63	Personal Care Aids	63,297	11,424,280	Costs increase due to institutional placement or home health & waivers.
33	10,313,497.08	DME, Supplies, Prosthetics, Orthotics	985,092	9,328,405	Increase in institutionalization and long-term care. Affects diabetics, bed-ridden community placements, etc. increasing unnecessary hospitalization episodes.
34	2,115,684.89	Therapies	167,186	1,948,499	Decrease in function of patients. Negative impact on rehabilitation.
36	3,077.01	Chiropractor	69	3,008	Pay MD CPT code at higher rate than Chiropractor. Increased pain meds prescribed. Cut in 1991.
37	3,705,738.00	IV Therapy	863	3,704,875	Increase in hospitalization and deaths.
39	567,983.10	Adult Day Health Care	---	567,983	Increase in long-term care and hospitalization.
41	245,118.50	Opticians	66,244	178,874	Increase in long-term care, poor vision resulting in falls.
42	1084.24	Out-Patient Psych. Hosp. Etc.	---	1,084	Increased inpatient hospitalization. Cuts in State program in '91 resulted in Mojave.
44	4,952.23	Swing Bed (Acute Hosp.)	---	4,952	Patients would revert to hospitals, increased transportation costs.
45	2,725,673.00	End Stage Renal Disease Facility	359,531	2,366,142	Increased death and suffering, increased ER visits.
46	5,254,912.66	Ambulatory Surgery Centers	2,102,246	3,152,667	Increase in hospital and outpatient services.
50	58,908.01	Health Insurance Premiums		58,908	Increase costs in all areas without third party liability as an offset.
55	2,615,499.86	Transitional Rehab Centers		2,615,500	Increase in long-term care and acute care.
56	2,427,640.65	Rehab. Hosp.-Inpatient		2,427,641	Increase in long-term care and acute care.

63	13,756,086.91	Residential Treatment Centers	10,656,997	3,099,089	Increased inpatient hospitalization for extended stays.
64	915,813.53	Hospice	44,492	871,322	Increase in nursing costs, medications, long-term care and acute care.
65	1,442,607.44	Hospice		1,442,607	Increase in nursing costs, medications, long-term care and acute care.
TOTAL	$244,369,629.13		$ 28,613,878	$215,755,751	

As demonstrated, cutting optional services does not really save money. The elimination of services in one area will generally shift costs in another, sometimes more expensive service category. For example, by cutting $3,705,738 in services of Provider 37 (IV Therapy), there would be a shift to hospitals where the costs would be higher. In FY02 there were 532 IV Therapy clients served (straight Medicaid), at an average cost of $6,966. If the IV Therapy program were eliminated, those clients would have to be treated in a hospital. The average comparable hospital cost is $9,095 per recipient. The total cost to serve 532 clients in a hospital would be $4,838,540. This is an increase in costs of $1,132,802.

A similar shift would occur in almost every situation. Therefore, Medicaid supports the existing distribution of services as the most cost effective means of providing health care. The primary goal of healthy Nevadans is achieved in the least restrictive setting.

OPTIONAL ELIGIBILITY GROUPS

It might appear as if cost containment could occur by eliminating the payments to optional Aid Groups. However, evaluation of each area reflects the lack of true savings and the reality of cost shifting.

OPTION A – COUNTY MATCH

AID GROUP	RECIPIENTS	$ CUT	DESCRIPTION
19	14,104	$ 36,536,137	County Match -- Aged
39	6	1,144	County Match -- Blind
99	1,626	6,474,046	County Match -- Disabled
	15,736	$ 43,011,327	**County Match -- Subtotal**

If the County Match Aid Group is eliminated the counties would have to pick up that amount. The cost to the counties would double because they are picking up the Medicaid match. This would not save any general fund.

OPTION B – GROUP CARE

AID GROUP	RECIPIENTS	$ CUT	DESCRIPTION
14	2,249	$ 1,117,568	Group Care -- Aged
34	12	24,822	Group Care -- Blind
94	948	1,854,216	Group Care -- Disabled
	3,209	$ 2,996,606	**Group Care -- Subtotal**

The patients in these aid classifications have all been determined to be eligible for institutionalization. Most of them are on a waiver. Eliminating the group care aid expenses would increase the long-term care number of patients and their expenses. It is more expensive to treat patients in long-term care than in group care.

OPTION C – HOME AND COMMUNITY BASED WAIVER

AID GROUP	RECIPIENTS	$ CUT	DESCRIPTION
17	14,589	$ 11,968,320	Home and Community Based Waiver -- Aged
37	35	38,008	Home and Community Based Waiver -- Blind
97	10,581	26,355,882	Home and Community Based Waiver – Disabled and Mental Retardation
	25,205	$ 38,362,210	**Home and Community Based Waiver–Subtotal**

If this Aid Group were eliminated, the clients on the waiver would be placed in hospitals or other institutions. They are currently on the waiver because the waiver is the most cost-effective treatment.

OPTION D – SPECIAL INCOME – IN INSTITUTIONAL CARE

AID GROUP	RECIPIENTS	$ CUT	DESCRIPTION
11	9,895	$ 26,882,036	Special Income -- Aged
31	12	68,530	Special Income – Blind
91	2,601	12,949,265	Special Income – Aged
	12,508	$ 39,899,831	**Special Income – In Institutional Care Subtotal**

If this Aid Group were eliminated, the clients would have to be placed in acute-care facilities or remain in-home without proper care. Payment sources would be unknown.

OPTION E – WOULD BE ELIGIBLE IF NOT IN LONG-TERM CARE

AID GROUP	RECIPIENTS	$ CUT	DESCRIPTION
13	5,759	$ 18,069,015	Would be eligible SSI if not in long-term care -- Aged
33	55	157,082	Would be eligible SSI if not in long-term care – Blind
93	2,093	13,548,056	Would be eligible SSI if not in long-term care – Disabled
	7,907	$ 31,774,153	**Subtotal**

If this Aid Group were eliminated, clients would have to be placed in acute-care facilities or remain in-home without proper care. Payment sources would be unknown.

OPTION F – TANF

AID GROUP	RECIPIENTS	$ CUT	DESCRIPTION
40	223,208	$ 49,463,861	TANF Cash
41	3,448	1,116,280	TANF Incapacity
42	23,846	5,956,840	Two-Parent TANF Cash
43	0	0	
44	1	5	TANF Cash With Stepparent In Home
	250,503	$ 56,536,986	**TANF Subtotal**

If these Aid Groups were cut, clients in this group would suffer from untreated illness, or be served in county hospitals and emergency rooms, with unknown payment sources.

OPTION G – OTHER AID GROUPS

AID GROUP	RECIPIENTS	$ CUT	DESCRIPTION
4	9,078	$ 10,898,491	Emergency Medical – Illegal Alien and OBRA Baby
61	4,495	7,472,923	Children In Custody of Other Public Agency
92	6,307	6,380,118	Katie Beckett -- Disabled
	19,890	24,751,532	**Other Subtotal**

If the emergency medical aid for illegal aliens and their OBRA babies were cut, the expense would have to be picked up by county hospitals and emergency rooms. Federal statutes state that illegal aliens are eligible for emergency services. If the children in custody of other public agencies were cut, there would be corresponding or increased cost to DCFS. The Katie Beckett program allows children to be treated in their home. If the Katie Beckett Aid Group were cut, those children would have to enter long-term care facilities.

CO-PAYMENTS

Another alternative could be to add co-payments on every medical provider visit and prescription. The following table shows that a maximum of about $8,911,728 could be recovered through charging a co-payment on each of the services provided.

OPTION 6 – CO-PAYMENT FOR ALL SERVICES

PROV. NO	MAX CO-PAY	SERVICES	# SERVICES	MAX $
10	$3.00	Outpatient Surgery	2,922	$ 8,766
11	3.00	Hospital, Inpatient	133,717	401,151
12	3.00	Hospital, Outpatient	249,030	747,090
13	3.00	Psychiatric Hospital	17,489	52,467
14	2.00	Mental Health, Outpatient	228,183	456,366
15	3.00	Rural Health Clinics	13,666	40,998
16	3.00	Intermediate Care Facility	96,803	290,409
17	0.50	Special Clinics	67,307	33,653>50
18	3.00	Skilled Nursing Facility	111,224	333,672
19	3.00	Nursing Facility – Intermediate Care	925,689	2,777,067
20	3.00	Physician	981,704	2,945,112
21	0.50	Podiatrist	8,680	4,340
22	3.00	Dental	300,182	900,546
23	2.00	Hearing Aids	7,030	14,060
24	2.00	Nurse	31,066	62,132
25	2.00	Optometrists	34,603	69,132
26	3.00	Psychologists	2,935	65,805
27	3.00	Radiologist	11,985	35,955
28	2.00	Pharmacy	1,347,647	2,695,294
29	1.00	Home Health Agency	190,448	190,448
30	0.50	Personal Care Aids	681,031	340,515.50
31	3.00	EPSDT	56,635	169,905
32	3.00	Ambulance	17,169	51,507
33	3.00	DME, Supplies, Prosthetics, Orthotics	189,323	567,969
34	1.00	Therapies (ST, OT, PT)	107,892	107,892
35	0.50	Non Emergency Transportation	119,646	59,823
36	0.50	Chiropractor	476	238
37	3.00	IV Therapy (TPN)	20,937	62,811
38	1.00	Home & Community Based Waiver	438,165	438,165
39	2.00	Adult Day Health Care	17,811	35,622
41	2.00	Opticians	7,157	14,314
42	2.00	Out-Patient psyche. Hosp, etc.	87	174
43	0.50	Laboratory – Pathology/Clinical	260,535	130,267.50
44	3.00	Swing Bed (Acute Hospitals)	70	210
45	2.00	End Stage Renal Disease (ESRD) Facility	38,873	77,746
46	3.00	Ambulatory Surgery Centers	3,930	11,790
47	3.00	Indian Health Services	9,778	29,334
48	1.00	Senior Waiver	343,344	343,344
49	0.50	IHS Transportation	173	86.50
50	0.50	Health Insurance Premiums	296	148
51	3.00	IHS Hospital, Inpatient	---	---
52	3.00	IHS Hospital, Outpatient	746	2,238
54	3.00	Case Management	170,967	512,901
55	3.00	Transitional Rehab Centers	65,101	195,303

56	3.00	Rehab Hosp – Inpatient	6,086	18,258
57	1.00	Group Care Waiver	45,019	45,019
58	1.00	Physically Disabled Waiver	48,276	48,276
60	1.00	School Based Services	194,482	194,482
61	3.00	Mental Health Rehabilative	389,307	1,167,921
62	3.00	Managed Care	825,943	2,477,829
63	3.00	Residential Treatment Centers (RTC)	48,193	144,579
64	3.00	Hospice	5,562	16,686
65	3.00	Hospice	17,408	52,224
Total	116		8,911,728	19,442,115

The maximum co-payment chargeable to recipients is set in federal regulations (21-842-744.54.a.3) and is based on the table in those regulations. The co-payment maximum is based on the normal payment for the service. One restriction is that clients below age 19 are prohibited from being charged a co-payment. This is about one-third of the total Medicaid clients served, so that would reduce the total expected net from a co-payment program to less than $12,961,410.

Another limiting factor would be the specific programs where a co-payment would be charged. For example, all Indian Services (Providers 47, 49, 51 and 52) have been included, but since these are pass-through programs, it is not likely that a co-payment would be collected. Another example of groups that would probably not be required to co-pay is the waivers. There are other restrictions such as the maximum amount per family per month that have not been included.

Since federal Medicaid regulation prohibits providers from refusing service to clients who claim inability to pay co-payments, requiring co-payments effectively places the co-payment burden on the providers. Co-payments are therefore considered a disguised reduction in provider payments. Past attempts to impose a client co-payment policy was detrimental to Medicaid's provider retention efforts.

As has been previously discussed, eliminating optional services, eligibility groups or imposing co-payments do not necessarily lead to program savings. Expenditure shifts will occur with the Medicaid program, sometimes to higher costing service categories. Additionally, shifts will occur within the health care marketplace creating a cost "ripple effect." Careful analysis and consideration must occur before precipitous reductions in benefits are made. These changes not only affect the lives of recipients, but also the livelihoods of health care providers and facilities throughout the state.