REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Cost-Sharing Proposals for Virginia's Medicaid Program

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Executive Summary

In 2004, the General Assembly placed language in the Appropriations Act (Item 326 EEE) directing the Department of Medical Assistance Services (DMAS) to implement a plan of increase cost sharing for recipients of the Medicaid program through enhanced copayments. The uses of copayments are believed to reduce the cost of public healthcare in two ways. First, by requiring a large number of recipients to pay slightly more for the services they receive, significant aggregate savings can be realized for the Commonwealth. Second, proponents of greater cost sharing for Medicaid recipients contend that such strategies discourage participants from purchasing unnecessary care, thereby lowering utilization and slowing the rate of growth in public healthcare spending.

Based on federal law and within the prescribed regulatory framework governing the administration of cost sharing for Medicaid, Virginia charges standard (fixed) copayments for eight different services. Based on the state's average daily payment, recipients are typically charged between $1.00 and $3.00 copayments depending upon the services they receive.

There are a number of changes that can be made by DMAS to the State's Medicaid copayment policies that would generate savings for the Commonwealth. However, it is important to note that not all of the available options can be easily implemented. Moreover, some others lack the necessary probity that should be associated with healthcare policy for the poor and disabled. This in mind, DMAS recommends several changes to the State's existing policy for its fee-for service Medicaid recipients (see table). It is estimated that these changes will produce more than $308,000 in annual savings to the State's general fund.

Medicaid Service	**Co-payment Amount**	***Annual Savings**	**General Fund Savings**
Durable Medical Equipment	$1.00	$282,903	$141,451
Inpatient Hospital Stays	$3.00	$17,649	$8,825
Clinic Visits	*$2.00	$39,235	$19,618
Vision Screenings	*$2.00	$14,157	$7,079
Outpatient Psychological Care	$2.00	$28,030	$14,015
Lab and X-rays	$1.00	$235,718	$117,859
Total Savings	**X**	**$617,692**	**$308,846**

Notes: *The savings reported in this table have not been offset by the administrative cost that will be associated with implementing these changes. Also, as noted in the report, it is unlikely that providers will be able to collect the increased co-payments from a majority of Medicaid recipients. **This represents a $1.00 increase over existing co-payments presently required for these services.

DMAS plans to generate the additional savings required by the General Assembly by imposing co-payments on recipients who receive their care through Health Maintenance Organizations (HMO). However, because of the length the State's existing HMO contracts, this policy change will not take effect until FY 2006.

Notwithstanding the proposals presented in this report, it should be noted that there is a growing body of research that calls into question the effectiveness of cost-sharing policies as a means of lowering healthcare cost for low-income individuals. Rather than limit the consumption of unnecessary care, cost-sharing policies have been found to suppress access to important preventive and diagnostic healthcare, thereby raising the long-term cost of healthcare for the poor. Findings of this nature argue for prudence in the application of copayments in the Medicaid program.

Introduction

In 2004, the General Assembly placed language in the Appropriations Act directing the Department of Medical Assistance Services (DMAS) to implement a plan of increased cost sharing for recipients of the Medicaid program. The language in the Appropriations Act – Item 326 EEE -- sets out two requirements. First, it requires DMAS to establish a cost savings plan that generates $500,000 in general fund savings that are assumed for Medicaid in the 2004-2006 budget. Second, recognizing the difficulty that can accompany attempts to levy co-payments through the Medicaid program, the language provides DMAS with the discretion to temper its plan based on the agency's assessment of the administrative complexity that might be associated with attempts to increase cost sharing for eligible recipients.

This paper presents a proposal for increasing co-payments in Virginia's Medicaid program. The first section of the paper summarizes the federal rules governing co-payments under Medicaid and discusses Virginia's current policy. The last section of the paper presents the methodology used by DMAS to estimate the potential savings from an enhanced co-payment program and outlines the elements of the recommended policy change. Included in this section is a discussion of the agency's general policy concerns with plans to increase cost sharing for Medicaid recipients.

Parameters for Medicaid Cost-Sharing Established at the Federal Level

Due to concerns about the rapidly increasing costs of the Medicaid program, it has been reported by the Kaiser Commission that at least 17 states have made plans to charge the poor higher amounts for the care they receive through the program. While the range of strategies under consideration in these states varies, raising co-payment amounts remains a popular policy in many states. In crafting these strategies, states must work within the statutory and regulatory framework established at the federal government.

Section 1902(a)(14) of the Social Security Act permits states to require certain Medicaid recipients to share in the costs of the healthcare services they receive through the program. The primary vehicle that states are permitted to use in bringing about this cost sharing is co-payments. Based on federal regulations, states are permitted to apply co-payments to services received by recipients who are either categorically eligible for Medicaid (e.g. women with children) or medically needy (persons who establish eligibility based on their large medical expenses). However, in designing a program of co-payments, federal regulations sharply limit the amounts that can be charged recipients to a fraction of what the State reimburses the provider for the service. Table 1 lists the maximum amounts that states can charge based on the payments it makes for the service.

Table 1 Medicaid Co-payment Amounts Permissible Under Federal Regulations	
State Payment For Service	**Maximum Allowed Co-payment**
$10 or less	$.50
$10.01 to $25	$1.00
$25.01 to $50	$2.00
$50.01 or more	$3.00
Source: 42 C.F.R Section 447.54	

Using the scale in Table 1, states are allowed to establish a "standard co-payment" by determining the average or typical payment made for that service. For example, if the state paid more than $50 on average for clinic visits, it would be permissible to set a fixed co-payment of $3.00 for each such service received by Medicaid recipients, regardless of the actual cost of the visit.

Federal regulations also exempt some Medicaid recipients from this cost-sharing requirement. The following categories of recipients cannot be subject to the cost sharing policy established by the states:

- Children who are under the age of 18;
- Pregnant women who receive services related to their pregnancy or any other condition that might complicate the delivery of their infants;
- Persons in an inpatient hospital or institutional setting who are required to spend all of their income for these services except for a minimal amount reserved for personal needs; and
- Persons receiving specific types of services, including emergency care, which prevents the onset of more serious conditions.

Virginia's Current Policy. Within this statutory and regulatory framework, Virginia charges standard (fixed) co-payments for eight different services. Based on the state's average daily payment, recipients are typically charged between $1.00 and $3.00 co-payments depending upon the services they receive (Table 2).

Table 2 Co-payments Currently Charged Under Virginia's Medicaid Program		
Service	**Average Daily Payment**	**Co-payment Amount**
Outpatient Clinic Care	$136	$3.00
Clinic Visit	$29	$1.00
Physician Office Visit	$23	$1.00
Eye Examination	$30	$1.00
Prescriptions:		
Generic	$25	$1.00
Brand	$97	$3.00
Home Health Visit	$56	$3.00
Other Physician Service	$56	$3.00
Rehabilitation Services	$78	$3.00
Source: DMAS' Medicaid State Plan.		

Potential for Expanding the Reach of Co-payments in Virginia. There are a number of changes that can be made by DMAS to the State's Medicaid co-payment policies that would generate savings for the Commonwealth. For example, DMAS could seek a waiver of the nominal payment limit from CMS and substantially increase the cost sharing requirements for certain recipients of non-emergency services that are provided in a hospital setting. Such policies are viewed as ways to discourage and penalize recipients for the inappropriate use of emergency care services.

Additionally, DMAS does not presently impose co-payments for any person who receives their health services through a managed care plan. Co-payments for durable medical equipment purchases, certain inpatient hospital stays, outpatient psychological care, and laboratory and x-ray work would all represent enhancements to DMAS' current cost sharing policy. Finally, based on the average costs paid for vision screenings and clinic visits, DMAS could increase the co-payments charged for these services.

However, it is important to note that not all of these options can be easily implemented. Moreover, some others lack the necessary probity that should be associated with healthcare policy for the poor and disabled. The final section of this paper provides DMAS' proposal for increasing co-payments and discusses some of the policy concerns that accompany this general concept.

Savings from Increased Cost-Sharing: Proposal and Cost Savings Methodology

A major consideration by DMAS in developing the cost-sharing proposal presented in this paper was the administrative burden that would be posed by each of

the available options. As a part of this deliberation, agency staff recognized that whatever burden created by the policy would largely rest with providers. With its current claims payment system, DMAS has the capacity to establish new or higher co-payments for any given service through a reduction of the payment made to the provider by the amount of the new co-payment. This effectively shifts the responsibility for the collection of the co-payment to the provider. Accordingly, agency staff considered whether the relevant providers could routinely collect new or increased co-payments without substantially changing existing administrative operating procedures. For example, co-payments charged for each trip made by Medicaid transportation providers would be deducted from the payment the agency makes to the transportation broker. The broker would, in turn, reduce its payment to the actual providers who would be forced to collect the payment from the recipient when responding to the call for service. Staff did not feel that this arrangement would be in the best interest of the vendor or the recipient.

Methodology to Assess Potential Savings. For options believed to meet the agency's ease of administration criterion, DMAS staff considered whether the potential savings from the co-payments would be sufficient to justify the effort associated with putting the policy in place. This required an analysis of existing claims files to simulate the impact of changes to the agency's cost sharing policy. The following general steps were made to evaluate each service for which the possibility of increased cost sharing was considered:

1. Using the agency's recipient file from the MMIS system, all persons who were enrolled in the program but are not legally subject to co-payment requirements were identified and excluded from further analysis. Information on only those eligible recipients who would be subject to the co-payments was saved in a separate file.

2. All files that contained the paid claims for the service of interest -- for example durable medical equipment -- were selected and merged with the recipient file that contained only those fee-for-service Medicaid recipients who would be subject to the proposed co-payment.

3. The amounts paid for the relevant service on behalf of persons subject to the co-payment were averaged. This average payment was then used to establish a maximum standard co-payment that could be charged for that service.

4. This maximum standard co-payment amount was imputed on the claims file and summed as an estimate of the possible savings that might be generated by the change in policy.

Table 3 reports the services to which DMAS recommends the new co-payment policy be applied and identifies the estimated annual savings that would likely accrue to both the Medicaid program and the Commonwealth. As shown, based on the average payments the agency currently makes for the identified services, DMAS estimates general fund savings of more than $308,000, leaving the agency nearly $200,000 short of its savings target.

Table 3

***Estimated Savings From Increased Cost Sharing For Fee-For-Service Recipients In Virginia's Medicaid Program**

Medicaid Service	Co-payment Amount	Annual Savings	General Fund Savings
Durable Medical Equipment	$1.00	$282,903	$141,451
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Source: DMAS 2003 recipient and claims files

Rather than increase co-payments on other services delivered to fee-for-service Medicaid recipients, DMAS plans to increase co-payments for those whose care is managed through Health Maintenance Organizations (HMOs). Precise estimates of the savings that will be generated through this policy change are not possible at this time. Given the volume of recipients who receive their care through HMOs, DMAS believes the co-payments will produce the additional savings required in the Appropriations Act. However, these changes cannot be implemented until the HMO contracts are renewed in May 2005 and the savings will be captured in FY 2006.

Policy Concerns. From a policy perspective, it should be noted that providers are required to administer Medicaid-funded healthcare services regardless of the recipients' ability to pay the required co-payments. Thus, when faced with recipients who are either unwilling or unable to make the co-payment, providers have found that it

is in their best financial interest to forego collection. Because of this, providers essentially view any increase in required co-payments as a cost shift. Accordingly, the benefit of the savings that will accrue from this policy should be weighed against the opposition that will likely be expressed by those providers faced with this potential cost shift.

Also, while increased cost sharing for recipients is gaining currency as a reliable method for defraying the cost of the Medicaid program, there is a reliable body of research that indicates such policies may have adverse effects on low-income program participants while generating higher healthcare costs overtime. Most notably, the RAND health insurance experiment -- widely regarded as one of the most rigorous health policy studies yet conducted -- found that low-income children and adults reduced their consumption of medical care by 44 percent when faced with higher co-payments.

More importantly, there was little evidence found in the study to support the notion that higher co-payments encourage "cost-conscious" consumers to become more selective and avoid the consumption of unnecessary or ineffective healthcare services. Rather, it was discovered that consumers of healthcare do not possess the requisite clinical knowledge to make informed choices and, when faced with higher co-payments, often fail to seek necessary care. This was shown to give rise to poorer health outcomes and, ironically, higher healthcare costs in the long-term. These findings and others argue for prudence in the application of co-payments in the Medicaid program.

Finally, it is important to note that additional administrative costs will be incurred with this policy change. DMAS estimates that system's changes and the mailing costs associated with notifying recipients and providers will cost the agency more than $200,000 in the first year of the new policy. These costs will drop significantly in subsequent years.