fiscal forum

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MANAGING MEDICAID COSTS IN MICHIGAN

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Medicaid is a joint federal-state program that pays for health care services to 1.5 million low-income Michigan residents at an annual cost of almost $9 billion. In the past six years, Michigan's Medicaid program has dealt with unprecedented caseload levels, federal funding reductions, and declines in state General Fund/General Purpose (GF/GP) revenue that have posed many challenges for the state's primary health care safety net program.

As the largest single program administered by the state, and among the fastest growing, Medicaid has placed enormous pressure on Michigan's budget. Nearly 25% of state GF/GP revenue is now allocated to Medicaid; by comparison, only 8.3% of state GF/GP was expended on Medicaid in 1980, and 17.5% in 1990.[1]

Based on current national estimates, future Medicaid expenditures are anticipated to grow at an annual rate of 8% over the next ten years—more than twice what might be considered the typical 3.5% average growth rate of GF/GP revenue in non-recessionary years.[2] If Michigan's Medicaid costs escalate at the projected national rate during the next decade, the Medicaid program will be difficult to maintain without additional funding and/or major changes in eligibility, benefits, and provider reimbursement levels. This report highlights the major economic and spending pressures affecting Medicaid and the actions taken to contain costs, replace lost revenue, and restructure the program to meet the health care needs of Michigan's low income population.

Medicaid Population

A significant number of Michigan's 10.1 million citizens rely on Medicaid coverage for their health care needs:

- 1 out of every 7 Michigan residents (15% of the population) receives Medicaid, and more than 30% of the 2.5 million children in the state are enrolled in the program.[3]
- Over one-third of the 127,500 Michigan births in 2005 and two-thirds of the state's 43,000 long-term care patients in nursing homes are financed through Medicaid.[4,5]
- 75% of those receiving Medicaid in Michigan (1.1 million individuals) are from low-income families including pregnant women, children, and parents or other caretaker relatives. The remaining 25% of the caseload is comprised of nearly 400,000 elderly and disabled individuals—most of whom reside in home- and community-based settings.[6]
- Although low-income families are the largest component of the Medicaid population, they are the least expensive group to cover—representing only 30% of total Medicaid costs.[7]
- Medical services provided to aged, blind, and disabled persons account for 70% of all Medicaid expenditures, even though they are only one-fourth of the Medicaid-eligible population.[8]

Medicaid Eligibility Requirements

Medicaid is a means-tested program that considers an applicant's income and assets in determining who qualifies for coverage. In general, the maximum asset level allowed for Medicaid eligibility purposes is $2,000 to $3,000, depending on the eligibility category. Certain assets—including a home, a vehicle, and personal belongings—are exempt from consideration, and there is no asset test for some eligibility groups.

Medicaid income eligibility levels are often compared to the federal poverty level, which is $9,800 per year for a single individual and $16,600 per year for a family size of three in 2006; for each additional family member, the poverty level increases by $3,400.[9] The income eligibility guidelines for Medicaid vary according to the population groups covered and the family size.

- For pregnant women and newborns seeking Medicaid, the maximum income level is equal to 185% of poverty ($18,130 for a single person or $30,710 for a family of three). Older children can qualify for Medicaid with family income up to 150% of poverty ($24,900 for a family of three). The MIChild program provides similar health care coverage to over 30,000 children in households with income up to 200% of poverty, and who do not otherwise qualify for Medicaid.

- The income limit for families who receive Medicaid through eligibility for cash assistance under the Family Independence Program is $6,228 for a three-person family—about 38% of poverty.

- Aged, blind, and disabled persons who qualify for the federal Supplemental Security Income (SSI) program are automatically eligible for Medicaid. The income threshold for a single person on SSI is currently $7,236, which represents about 74% of the poverty level.

- Non-institutionalized elderly and disabled individuals not on SSI are eligible for Medicaid if their income is no more than 100% of the poverty level ($9,800 for a single person and $13,200 for a married couple). Those who qualify for a nursing home level of care are eligible at incomes up to 220% of the poverty level.

Medicaid Eligibility/Expenditure Trends

In large part, Medicaid costs are driven by the size of the caseload, the range of services covered, and the payment rates that reimburse medical providers under the program. A comparison of Medicaid trends during the last 12 years identifies the major differences that occurred between the first and second half of the 12-year period.

Table 1 and Table 2 indicate that Medicaid caseload and cost trends were significantly higher during the last six years (fiscal years 2001-2006), when compared to the prior six years ending in fiscal year (FY) 2000.

Table 1
MEDICAID ELIGIBILITY TRENDS
(# in thousands)

	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995–FY 2000 Change
Medicaid Caseload	1,131.4	1,122.9	1,093.7	1,093.9	1,070.0	1,063.4	(68.1)
Percent Change	(3.3)%	(0.8)%	(2.6)%	0.0%	(2.2)%	(0.6)%	(6.0)%
	FY 2001	**FY 2002**	**FY 2003**	**FY 2004**	**FY 2005**	**FY 2006**	**FY 2001–FY 2006 Change**
Medicaid Caseload	1,114.7	1,212.3	1,296.4	1,374.2	1,442.5	1,490.4	375.6
Percent Change	4.8%	8.8%	6.9%	6.0%	5.0%	3.2%	33.7%

Table 2
MEDICAID EXPENDITURE TRENDS
($ in millions)

	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995–FY 2000 Change
Medicaid Services	$4,006.0	$4,305.3	$4,489.8	$4,525.9	$4,895.7	$5,082.0	$1,076.0
Percent Change	5.3%	7.5%	4.3%	0.8%	8.2%	3.8%	26.8%
	FY 2001	**FY 2002**	**FY 2003**	**FY 2004**	**FY 2005**	**FY 2006***	**FY 2001–FY 2006 Change**
Medicaid Services	$5,678.3	$6,071.2	$6,929.7	$7,474.1	$8,065.3	$8,169.7	$2,491.4
Percent Change	11.7%	6.9%	14.1%	7.9%	7.9%	1.3%	43.9%

**FY 2006 total includes state share of Medicare Part D drug costs formerly financed by Medicaid.*

The number of persons receiving Medicaid-funded services and the program's costs have increased dramatically since FY 1999-00, while the Medicaid caseload actually declined and the expenditure growth rate was about 40% lower during the prior six-year period.

- Since FY 2000-01, the Medicaid caseload has grown by 33.7%, to a record high annual average of 1,490,384 individuals in 2006. In September 2006, the monthly number of Medicaid recipients topped 1.5 million; this includes 17,513 women of childbearing age who only qualify for family planning services under a new federal Medicaid waiver. Most of the Medicaid caseload growth has occurred among pregnant women, low-income children, and families; the number of elderly and disabled beneficiaries has also increased, but to a much lesser extent.

- The number of Medicaid beneficiaries fell by 6.0% in the preceding six-year period through FY 1999-00, primarily due to welfare reforms and an improved economy that led to a nearly 70% reduction in the number of public assistance recipients (who automatically qualify for Medicaid).

- Medicaid costs increased by $2.5 billion or 43.9% in the last six years; the growth in the prior six-year period ending in FY 1999-00 was 26.8%.

- Escalating Medicaid costs are due to the increase in the caseload as well as inflation in health care prices, additional utilization of medical services by the Medicaid population, and higher provider reimbursement rates.

- A part of the increase in Medicaid hospital, nursing home, mental health, and HMO costs since 2001 is attributable to the provider taxes, which totaled $636.8 billion last year. Most of the revenue from the quality assurance assessment program (QAAP) is used to finance Medicaid payment increases above and beyond the aggregate tax payments by over $500 million in FY 2005-06. The remaining amount of the provider tax revenues ($142 million) is utilized to replace GF/GP that otherwise would be needed to fund Medicaid services.

Economic and State Budget Trends

Fiscal challenges facing Michigan's Medicaid program have been exacerbated by the overall economic climate and health care trends in the state during the last six years. This explosion in Medicaid costs has occurred during a time when Michigan's economy languished, unemployment escalated, the number of persons without health insurance increased, and state revenue plummeted. Twelve-year economic and budget trends, by calendar year (CY), are shown in Table 3.

- Michigan wage and salary employment grew steadily from 1995 through 2000; the state's unemployment rate declined during the same period—from 5.3% to 3.8%. Since 2001, wage and salary employment has fallen consistently while unemployment increased to 7.1% before decreasing to 6.7% in 2005 and 2006.

Table 3
MICHIGAN ECONOMIC AND STATE BUDGET TRENDS
(# in thousands; $ in millions)

	CY 1995	CY 1996	CY 1997	CY 1998	CY 1999	CY 2000	CY 1995–CY 2000 Change
Number Employed	4,274	4,361	4,448	4,510	4,582	4,674	400
Percent Change		2.0%	2.0%	1.4%	1.6%	2.0%	9.4%
Unemployment Rate	5.3%	4.9%	4.3%	4.0%	3.8%	3.8%	(1.5%)
State GF/GP*	$7,838.5	$8,569.2	$8,420.0	$8,473.8	$9,028.1	$9,404.6	$1,556.1
Percent Change	1.5%	9.3%	(1.7%)	0.6%	6.5%	4.2%	19.9%

	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2001–CY 2006 Change
Number Employed	4,556	4,478	4,410	4,395	4,384	4,366	(190)
Percent Change	(2.5%)	(1.7%)	(1.5%)	(0.3%)	(0.3%)	(0.4%)	(4.2%)
Unemployment Rate	5.2%	6.2%	7.1%	7.0%	6.7%	6.7%	1.5%
State GF/GP*	$9,859.2	$9,298.0	$8,999.6	$8,722.5	$8,794.1	$9,222.9	($636.3)
Percent Change	4.8%	(5.7%)	(3.2%)	(3.1%)	0.8%	4.9%	(6.5%)

**GF/GP data is based on the state's fiscal year; all other data is on a calendar year basis.*

- State GF/GP expenditures grew by over $1.5 billion between FY 1994-95 and FY 1999-00; this was an increase of nearly 20%. In FY 2005-06, state GF/GP expenditures were $636 million below the FY 2000-01 level—a decline of 6.5%.

- One factor that affects Medicaid program costs is the number of persons in the state who do not have other health care coverage. The percentage of Michigan's population that is uninsured has increased from 11% in 2000 to 13.2% in 2004. Employers have reduced or dropped health care coverage due to rising costs, and thousands of jobs have been eliminated, particularly in the manufacturing sector where health benefits were historically very good.

Federal Medicaid Funding Issues

Against the backdrop of Michigan's economic and state budget trends, it is important to examine policies at the federal level that have had a major impact on the Medicaid program costs. In the 1990s, the federal government encouraged (and in some cases required) states to broaden Medicaid eligibility, expand services, and increase medical provider reimbursement rates. National Medicaid policies related to special financing payments, the federal match rate, and other program requirements have also heavily influenced Medicaid expenditures in Michigan.

Under federal Medicaid law, coverage is required for certain populations and services in order to receive federal matching funds. States, however, are given the option to cover additional eligibility groups and benefits. Coverage is mandatory for the following:

- Low-income families that qualify for the Family Independence Program (FIP), and aged, blind, and disabled persons receiving Supplemental Security Income.

- Pregnant women and children under age six up to 133% of the poverty level.

- Children age six years or older up to 100% of the poverty level.

- Hospital and physician/nurse practitioner services; nursing home/home health care (for persons aged 21 or older); laboratory and x-ray services; family planning; medical transportation; early and periodic screening, diagnosis and treatment for children; and federally-qualified health centers and rural health clinics.

In addition to the federally-required eligible groups, Michigan has elected to expand optional coverage to certain population groups at higher income levels—particularly for pregnant women, children, and the elderly/disabled as noted earlier. More recently, the state won federal approval for its Adult Benefits Waiver Program that provides basic outpatient care to very low income single adults and childless couples who otherwise would not be eligible for Medicaid. In July 2006, Michigan implemented its "Plan First!" family planning waiver, which provides family planning services to women of childbearing age up to 185% of the poverty level who do not now qualify for Medicaid.

Over the last five years, there have been increasing efforts by the federal government to restrict creative financing mechanisms that many states, including Michigan, have used to earn extra federal Medicaid revenue and reduce state Medicaid costs. Under these arrangements, Michigan claimed federal match on special financing payments it made to certain government-operated health facilities in addition to the state's regular Medicaid reimbursement amounts. Subsequently, all or most of the special payments have been returned to the state through intergovernmental transfer.

These measures enabled Michigan to maximize federal funding and replace state GF/GP that otherwise would be needed to fund the Medicaid program, saving the state over $700 million per year in GF/GP costs before the federal rule changes began to phase out the special payments. In FY 2005-06, the GF/GP savings from the various special financing payments were less than $200 million, and are at risk of further reductions in the future.

Federal action was also taken to sharply reduce Michigan's Medicaid claims for certain school-based services costs related to administration, outreach, and family planning. Since the early 1990s, 40% of the federal Medicaid funds for school-based services have been retained by the state to offset GF/GP costs; the remaining amount has been passed on to local school districts.

Under a negotiated settlement in 2002, the state agreed to pay a $33 million penalty. The settlement also revised the methodology for determining what expenditures would qualify for federal Medicaid matching funds—resulting in a nearly 50% reduction in federal reimbursement for school-based services. These funds may also be in jeopardy going forward due to the potential for further cuts.

During the economic downturn in 2003 and 2004, the federal government temporarily increased the Medicaid

match rate for all states. In Michigan, this resulted in an additional $317.2 million in federal Medicaid funds spread over two fiscal years, and equivalent savings in state GF/GP that otherwise would have been required to maintain the program.

The Federal Deficit Reduction Act (effective in early 2006) made significant Medicaid changes, primarily to reduce program costs in such areas as premiums and co-payments, eligibility restrictions, benefit changes, and other program revisions. A number of the Act's provisions and anticipated savings are reflected in the FY 2006-07 Department of Community Health (DCH) Budget. Major Medicaid changes in the Federal Deficit Reduction Act include the following:

- More stringent documentation of citizenship status as a condition of Medicaid eligibility.
- Additional options for states to impose premiums and cost sharing, but with certain limits and exceptions.
- Opportunities to replace the current Medicaid benefits package with a new "benchmark" plan for certain eligibility groups.
- Changes to the penalty and look-back period for asset transfers to prevent or delay Medicaid eligibility for persons with more financial resources.
- Establishing a $500,000 Medicaid exemption limit on the value of a home to qualify for Medicaid.
- New Medicaid Integrity Program to prevent, detect, and address fraud and abuse.

While many of these changes have yet to be implemented in Michigan, they are still likely to have an impact on the program in the future.

Medicaid Cost Containment Measures

To maintain a balanced budget and keep the Medicaid program afloat in Michigan, more than $900 million of program savings and reductions have been appropriated since FY 2001-02. Among the actions that Michigan has taken to reduce Medicaid costs are the following:

- Freezing and lowering health care provider payment rates, some of which have been restored through provider tax arrangements described elsewhere.
- Reducing enrollment levels in the Home and Community Based Services program and the Adult Benefits Waiver program through a cap or freeze on the number of eligibles.
- Eliminating non-emergency adult dental care, hearing aids, podiatric and chiropractic care (subsequently restored).
- Establishing an asset test for parents/caretaker relatives and 19-20 year olds in optional eligibility groups.
- Tightening eligibility and coverage requirements for the Adult Home Help program.
- Increasing prescription drug co-payments for adult Medicaid recipients and reducing dispensing fees to pharmacists.
- Adopting new co-payments for physician office visits, non-emergency ER use, and outpatient and inpatient hospital services.
- Implementing a preferred drug list, seeking supplemental rebates, lowering the price paid for generic drugs, and joining with other states in an effort to obtain greater discounts from drug manufacturers.
- Strengthening efforts to reduce Medicaid overpayments, recover funds from other responsible third party insurers, minimize Medicaid eligibility error rates, and address fraud and abuse.

Not all of the cost containment measures have been fully implemented, and some have since been restored. A more detailed listing of Medicaid cost containment measures and the appropriated savings associated with each action appears on the last page of this document.

Medicaid Financing and Revenue Enhancements

Medicaid services are jointly financed by the state and federal governments according to a formula based on each state's per capita income, which is adjusted annually. At this time, the federal Medicaid match, known as the Federal Medical Assistance Percentage (FMAP), ranges from a low of 50% to a high of 75%; Michigan's FMAP rate is currently 56.38%.

While most of the state share of Medicaid costs is financed by GF/GP revenue ($2.1 billion in FY 2005-06), Michigan has undertaken a variety of actions to enhance restricted and other available non-GF/GP revenue to help fund the state's share of its Medicaid program and

reduce the GF/GP that otherwise would be required. These actions include:

- Utilizing Healthy Michigan Funds to help finance the state share of Medicaid costs ($17.1 million in FY 2005-06).
- Increasing tobacco taxes and earmarking the additional revenue to Medicaid through the Medicaid Benefits Trust Fund ($379.2 million in FY 2005-06).
- Establishing provider taxes to finance Medicaid payment rate increases and reduce state GF/GP costs ($636.8 million from provider taxes and $142.4 million GF/GP savings in FY 2005-06).
- Allocating tobacco settlement revenue to the Medicaid program ($87.8 million in FY 2005-06).
- Maximizing federal revenue for indigent health care through the Medicaid Adult Benefits Waiver program ($118.6 million in FY 2005-06).

The FY 2005-06 DCH budget appropriates nearly $1.4 billion in non-GF/GP funds for Medicaid—40% of the state match requirement for Medicaid services. The FY 2006-07 budget increases the non-GF/GP state matching funds to almost $1.7 billion and includes additional federal funding to expand health care services through the "Plan First!" family planning waiver. It also includes the proposed Michigan First Healthcare program, which utilizes financing mechanisms that would not require any new state funding costs.

Implications for the Future of Medicaid

One of the major challenges for future state budget planning is addressing the ongoing growth in annual Medicaid costs—which is largely driven by factors outside the control of state policy makers. Increases in caseload, utilization of services, and inflationary pressures in the cost of services provided are inevitable—perhaps at lower rates in some years, but higher in others.

Looking ahead to FY 2007-08, it is possible to identify Medicaid spending pressures that could increase the state share of annual Medicaid costs by $300 million GF/GP or more due to the following:

- Caseload, utilization, and inflation growth.
- Federally-required "actuarially sound" rates to managed care providers.
- Replacement of one-time or unrealized savings in the current fiscal year budget.
- Federal actions to reduce or eliminate other state cost savings initiatives.

On the positive side, Michigan's federal match rate will increase from 56.38% to 58.1%, bringing in an estimated $165 million in federal funds that can be allocated in place of state funds.

The choices for dealing with the gap between revenue and expenditures in the next fiscal year and beyond will be difficult. Following is a list of some of the potential options that may be considered:

- Increase revenue for the Medicaid program through new funding sources or by reducing spending in other parts of the state budget in order to redirect existing funds to Medicaid.
- Reduce the size of the Medicaid caseload through restricting eligibility for optional populations or finding alternative coverage for those who otherwise would qualify for Medicaid.
- Restrict the range of services provided by limiting coverage or better coordinating care—particularly for persons with high cost, chronic health conditions.
- Shift more of the cost of Medicaid onto providers by lowering payment rates, or to beneficiaries through various cost-sharing mechanisms.
- Change the mix of services utilized from higher-cost care in institutional settings to lower-cost care in the community.
- Promote healthy behaviors and preventive care to reduce the demand for future health and medical services.
- Improve efficiencies in the delivery of care by preventing unnecessary utilization, reducing medical errors, and facilitating the exchange of health information through improved technology.

Policy or program changes such as those cited above to reduce or limit the growth in Medicaid expenditures may have potential adverse consequences for those served by the program and for the health care system in general, including:

- Reduced access to health care services.

- Greater utilization of more costly emergency and acute care services.

- Increased uncompensated care provided by hospitals.

- Lower rates of provider participation in the Medicaid program.

Finally, it is important to remember that every $1.00 spent by the state on Medicaid is matched by $1.29 from the federal government, so a $1.00 state cut to Medicaid is actually a $2.29 reduction in the Medicaid program. The economic impact of Medicaid reductions was addressed in a recent study prepared by the Institute for Health Care Studies and the Institute for Public Policy and Social Research at Michigan State University. This report estimated that a $100 million cut in state Medicaid spending (and the associated loss of federal funds) would reduce income to Michigan residents by $180 million and reduce state employment by 6,300 jobs.

A simple or painless "cure" to the Medicaid funding challenge is unlikely to be found. In all probability, a combination of several or all of the above options may be necessary to sustain the Medicaid program over the long term. The Federal Deficit Reduction Act and other actions at the federal level to provide states with greater flexibility to experiment with innovative approaches could also play a role in bringing greater financial stability to Medicaid and the entire state budget.

ENDNOTES

[1]Medicaid Expenditures as a Percent of State GF/GP Revenues, State Budget Office document, 2003.

[2]The Budget and Economic Outlook: An Update, Congressional Budget Office, August 2006.

[3]Children's Medicaid Profile, Department of Human Services, March 2005.

[4]Michigan Department of Community Health data, December 2006.

[5]Distribution of Certified Nursing Facility Residents by Primary Payer Source, 2005, Kaiser Family Foundation StateHealthFacts.Org.

[6]Average Monthly Eligible Recipients, Michigan Department of Community Health, November 2006.

[7]Medicaid Caseload and Expenditures by Eligibility Group, Michigan Department of Community Health FY 2005-06 Budget Presentation, May 2005.

[8]Medicaid Caseload and Expenditures by eligibility Group, Michigan Department of Community Health FY 2005-06 Budget Presentation, May 2005.

[9]Poverty Thresholds and Poverty Income Guidelines, Department of Human Services, January 2006.

[10]Effects of Changes in Medicaid on Incomes and Jobs in Michigan, John H. Gooderis and Yong Li, Institute for Health Care Studies and Institute for Public Policy & Social Research, Michigan State University, February 2005.

MEDICAID COST CONTAINMENT MEASURES AND APPROPRIATED SAVINGS

	Gross	GF/GP	Current Status
Pharmaceutical Cost Reductions			
Preferred drug list and supplemental rebates	($39,062,000)	($17,617,800)	Implemented
Pharmacy drug price adjustments and multi-state drug compact	(44,863,200)	(20,000,000)	Implemented
Contract savings for incontinent supplies	(5,042,200)	(2,069,500)	Implemented
Pharmacy dispensing fee reduction from $3.77 to $2.50 ($2.75 for nh's)	(16,722,000)	(5,320,400)	Implemented
Pharmacy Quality Improvement Program savings	(13,360,800)	(5,808,600)	Implemented
Subtotal	**($119,050,200)**	**($50,816,300)**	
Eligibility/Enrollment Changes			
Eliminate optional Medicaid eligibility for parents and caretaker relatives	(128,371,900)	(55,527,200)	Not implemented
Freeze enrollment for optional 19-20 year old Medicaid population	(5,000,000)	(2,170,500)	Not implemented
Asset test for optional Medicaid caretaker relatives and 19-20 year olds	(7,832,300)	(3,400,000)	Implemented
Eliminate 3 month retroactive Medicaid eligibility prior to application	(28,300,000)	(12,285,000)	Not implemented
Increase asset look back period to 5 years and change penalty period	(16,047,700)	(7,000,000)	Pending
Savings from new Plan First! family planning waiver coverage	(11,476,000)	(7,746,900)	Implemented
Subtotal	**($197,027,900)**	**($88,129,600)**	
Long Term Care Reductions			
Enrollment cap for Home and Community Based Services Waiver	(51,020,600)	(22,627,400)	Implemented
Adult Home Help program eligibility and coverage restrictions	(29,000,000)	(12,693,500)	Implemented
Long-term care admission screening and assessment tool	(11,541,200)	(5,090,900)	Implemented
Establish Medicaid estate recovery program	(16,800,000)	(7,410,400)	Not implemented
Subtotal	**($108,361,800)**	**($47,822,200)**	
Benefit/Services Reductions			
Eliminate adult dental, hearing aids, podiatric, and chiropractic services	(27,204,700)	(12,000,000)	Restored
Freeze Adult Benefits Waiver program enrollment at 62,000	(26,402,700)	(8,000,000)	Implemented
Increase co-payments on brand name prescription drugs from $1 to $3	(7,000,000)	(3,030,300)	Implemented
$2 physician visit co-pay, $1 for hospital outpatient visit, and $50 inpatient	(5,421,200)	(2,353,300)	Implemented
Increase non-emergency ER visit co-payment to $6	(1,600,000)	(527,800)	Implemented
Subtotal	**($67,628,600)**	**($25,911,400)**	
Fraud, Abuse, and Third Party Liability Savings			
Coordination of benefits savings	(2,000,000)	(865,800)	Implemented
Medicaid recoveries and mis-payment savings	(13,821,700)	(6,000,000)	Implemented
Close Medicaid eligibility asset loophole	(28,428,900)	(12,341,000)	Implemented
Reduce Medicaid eligibility error rate	(20,000,000)	(8,724,000)	Implemented
Increase Medicaid Third Party Liability Savings	(36,877,600)	(16,086,000)	Pending
Recover pharmaceutical overpayments (Auditor General report)	(22,924,800)	(10,000,000)	Pending
Subtotal	**($124,053,000)**	**($54,016,800)**	
Provider Payment Reductions			
Hospital DRG Rebasing	(34,533,700)	(15,278,000)	Implemented
Eliminate outpatient hospital adjustor payment	(16,500,000)	(7,355,700)	Implemented
1.85% rate reduction to hospitals, nursing homes, home health, HMOs	(59,734,800)	(26,510,600)	Partially restored
4% Provider rate reductions	(126,906,600)	(55,235,500)	Partially restored
7.5% Graduate Medical Education Reduction	(13,745,200)	(6,018,400)	Implemented
Eliminate Rural Hospital Adjustor	(5,220,000)	(2,278,000)	Implemented
Nursing Home Rate Freeze/ Variable Cost Reduction	(14,894,600)	(6,500,000)	Implemented
Eliminate Ambulance Mileage Surcharge	(1,000,000)	(436,400)	Implemented
Reduce Physician ER case rate to 70% of Medicare Rate	(3,465,000)	(1,500,000)	Implemented
Revise nursing home hospital leave day policy	(12,705,000)	(5,500,000)	Implemented
Subtotal	**($288,704,900)**	**($126,612,600)**	
TOTAL MEDICAID REDUCTIONS	**($904,826,400)**	**($393,308,900)**	