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Fact Sheet:
Medicaid Cost Containment without Harming Beneficiaries

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Introduction

Given the current economic climate, there are a number of proposals by states to reduce Medicaid benefits and payments to providers and to increase cost-sharing by beneficiaries for services. The Kaiser Commission on Medicaid and the Uninsured's annual review of the 50 states found that 20 states reduced benefits in fiscal year (FY) 2010—the largest number of states reporting such restrictions in one year since the annual surveys began in 2001—and 14 states planned to implement service reductions in FY 2011.[1] In addition, 39 states implemented provider rate cuts or freezes in FY 2010, and 37 states planned to do so in FY 2011.[2]

As states focus on cutting Medicaid benefits and provider payments, many have not adequately considered alternative measures that can be adopted to reduce costs in the program without harming Medicaid beneficiaries. This fact sheet identifies actions that, when taken correctly, can save states money without impacting eligibility, services or imposing harmful co-payments. It can be used by advocates as they engage in policy and litigation advocacy with state officials.

To maintain brevity, limited descriptive comments can be found after each item listed. If applicable, the initials of one or more states that implemented or considered the measure are included. Most of the items on the list only require administrative action to implement, and will not require a waiver or demonstration.

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[1] Robin Rudowitz, Assoc. Dir., Kaiser Commission on Medicaid & the Uninsured, Workshop Presentation at National Health Law Program Health Advocates Conference: State Budgets and Medicaid—Moving Toward Health Reform 16 Fig. 16 (Dec. 6, 2010); *see also* Kaiser Commission on Medicaid & the Uninsured, *State Fiscal Conditions and Medicaid*, 3 (2010), *available at* http://www.kff.org/medicaid/upload/7580-07.pdf.
[2] Robin Rudowitz, *supra* n. 1, at 13 fig. 13.

Cost-Containment Measures

Hospital care:

Medicaid accounts for 17% of all hospital spending.[3]

- Cost-saving measures for inpatient hospital services*:* [4]
    - Require second opinions for specified procedures. (CO, IL, IN, NJ, OR).
    - Pre-surgical days limited to 1 unless medically justified. (DC, IL). In VA, any number of pre-surgical days before elective surgery must be medically justified.
    - Weekend admissions:
        - Weekend admissions must be medically justified. (DC, VA).
        - Non-emergency weekend admissions must have procedures same or next day. (PA).
        - Weekend admissions limited to hospitals providing full services every day. (WI).
    - Length of stay less than 24 hours considered outpatient except for newborns. (IN).
    - All Medicare benefits/days are exhausted before Medicaid billed. (ME).
    - Allow for 3 administrative leave days to facilitate transfer to less restrictive setting. (NC).
    - Check for double-billing, e.g., by hospital-based physicians and by pharmacies and hospitals for drugs at the time of discharge. (NY).
    - Perform diagnostic tests on outpatient basis prior to inpatient admission (except by prior authorization).
- PA's Medicaid managed care program saved money by using "observation day" rates for low-acuity patients during short hospital stays (less than 2 days) rather than the higher rate normally used for inpatient care.[5]

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[3] *Medicaid Cost-Savings Opportunities*, U.S. Department of Health & Human Services (Feb. 3, 2011), http://www.hhs.gov/news/press/2011pres/02/20110203tech.html.

[4] Kaiser Commission on Medicaid and the Uninsured, *Inpatient Hospital Services, other than in an Institution for Mental Diseases*, Medicaid Benefits: Online Database (Oct. 2008), http://medicaidbenefits.kff.org/service.jsp?gr=off&nt=on&so=0&tg=0&yr=4&cat=12&sv=14.

- Reduce readmission rates: 16% of people with disabilities covered by Medicaid (excluding dual eligibles) were readmitted to the hospital within 30 days of discharge. Half of those readmitted had not seen a doctor since discharge. Using a nurse discharge advocate to arrange follow-up appointments and conduct patient education or make follow-up calls has yielded reductions in readmission rates. One CO project reduced its 30-day readmission rate by 30%.[6]

Disease and Care Management Programs

Five percent of Medicaid enrollees account for over half (54%) of Medicaid spending.[7] Many of these enrollees are elderly or disabled.[8] The goal of disease management and care management programs is to assure appropriate care, improve quality and ensure "Medicaid funds are being used wisely in the care of individuals with specific conditions."[9]

Over both FY 2010 and FY 2011, at least 23 states were implementing or had implemented new policies/programs for disease management/care coordination.[10]

- CO formed a public-private stakeholder group, representing varied health care perspectives to work on the following initiatives:
    - Avoiding hospital readmissions by encouraging providers to focus on managing patients' care in a collaborative, sustainable way.[11]
    - Reducing unnecessary acute and emergency care visits (in particular for those with chronic conditions) by encouraging comprehensive and coordinated care to help patients manage long-term conditions and recovery.[12]

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[5] The Lewin Group, *An Evaluation of Medicaid Savings from Pennsylvania's HealthChoices Program* (2011), *available at* http://www.lewin.com/content/publications/MedicaidSavingsPAHealthChoices.pdf.
[6] *Medicaid Cost-Savings Opportunities*, *supra* note 1.
[7] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Matters: Understanding Medicaid's Role in our Health Care System* (2011), *available at* http://www.kff.org/medicaid/8165.cfm.
[8] *Id.*
[9] Kaiser Commission on Medicaid and the Uninsured, *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011*, at 58 (2010), *available at* http://www.kff.org/medicaid/8105.cfm.
[10] *Id.*
[11] *Hospital Readmissions*, Center for Improving Value in Health Care, http://www.civhc.org/CIVHC-Initiatives/Health-Care-Delivery-Redesign/Hospital-Readmissions.aspx (last visited June 30, 2011).
[12] *Emergency Room Utilization*, Center for Improving Value in Health Care, http://www.civhc.org/CIVHC-Initiatives/Health-Care-Delivery-Redesign/Emergency-Room-Utilization.aspx (last visited June 30, 2011).

- Offering the Program of All-Inclusive Care for the Elderly (PACE), which is a capitated benefit that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. ('08).

- Partnering with public hospitals to improve diabetes care and reduce inpatient Emergency Room (ER) utilization and to develop cost-effective care strategies for obesity. (LA, '05).[13]

- Implement a "total health management" program to provide care management for mental health and all chronic illnesses. Every care management intervention addresses mental health, substance abuse and weight management. (WY, '05).[14]

- Patient centered medical home: In NC this has led to a 40% decrease in hospital admission rates, 16% lower ER use, and 93% receipt of appropriate maintenance medications. (Models in NC, OK, OR).

- Care management with both patient and provider components, e.g., call center, educational materials specific to a disease, self-management education and skill-building, in-home monitoring devices, support for patient health risk assessments and plans of care. (Proposed in AK, '11).

- Establish a "lock-in" program for beneficiaries identified for over-utilizing services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the state. The beneficiary is "locked-in" to a primary care provider (PCP), pharmacy, controlled substance provider (if different from PCP) and hospital for all non-emergency care. These restrictions may be set as long as the conditions of 42 C.F.R. 431.54(e) are met.

- Programs in WA:[15]

    - Care management programs for patients with chronic conditions

    - Lock-in program for certain patients who abused drug, hospital or emergency department services

    - A narcotic review program focusing on very high use cases

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[13] Kaiser Commission on Medicaid and the Uninsured, *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in FY 2004 an 2005: Results from a 50-state Survey*, at 72 (2004), *available at* http://www.kff.org/medicaid/upload/The-Continuing-Medicaid-Budget-Challenge-State-Medicaid-Spending-Growth-and-Cost-Containment-in-Fiscal-Years-2004-and-2005-Results-from-a-50-State-Survey.pdf.

[14] *Id.*

[15] George Washington University School of Public Health and Health Services, *Medicaid Cost Containment Options for Washington State* (2011), *available at* http://www.wsipp.wa.gov/rptfiles/11-04-3402.pdf.

- An extensive second opinion program and mental health consultation services targeting high use of mental health services by youths and high use of mental health drugs

- Improve care coordination to reduce premature births: In NY, one model of coordinated prenatal care reduced the chances of a mother giving birth to a low-birth weight infant by 43% in an intervention group as compared with a group of women receiving care under standard practices.[16]

- Promoting better care management for children and adults with asthma: In NY, focused on patient self-management and tailored case management and reduced asthma-related ER visits by 78%.[17]

Prescription Drugs

Pharmacy costs account for 8% of Medicaid program spending. In 2009, states spent $7 billion on prescription drugs.[18]

- Drug Utilization Review (DUR) can help contain costs by evaluating duplicative prescriptions, drug interactions, and improper prescription writing practices.

  - Only active Medicaid providers are reimbursed for prescriptions in order to help reduce the likelihood of duplicative or contraindicated medications being prescribed. (KY, '10).[19]

- Generic Substitution: States can mandate generic substitution at the pharmacy level.
  - Implement a generic first dispensing policy (RI, '10).[20] *Note:* DE, NM, and VA already had policies indicating that medications must be generic unless the order states "dispense as written."[21]

  - Cover only the generic version of over-the-counter medications that are on a specified list and are prescribed by a provider. (KY, '10).[22]

- "Fail first" policies (aka step therapy): A less expensive alternative must have failed for the beneficiary to be eligible for the more expensive medication.

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[16] *Medicaid Cost-Savings Opportunities*, *supra* note 1.
[17] *Id.*
[18] *Id.*
[19] *Medicaid Announces Actions to Reduce Expenditures, Minimize Impact on Recipients and Providers*, Kentucky Cabinet for Health and Family Services (Jul. 2, 2010), http://chfs.ky.gov/news/Medicaid+savings+2010.htm.
[20] *Hoping for Economic Recovery, Preparing for Health Reform*, *supra* note 7, at 52.
[21] Kaiser Commission on Medicaid and the Uninsured, *Prescription Drugs*, Medicaid Benefits: Online Database (Oct. 2008), http://medicaidbenefits.kff.org/service.jsp?yr=4&cat=5&nt=on&sv=32&so=0&tg=0.
[22] Kentucky Cabinet for Health and Family Services, *supra* note 17.

- Supplemental Rebate Programs: In addition to the rebates received from manufacturers (in accordance with OBRA 1990), many states have implemented supplemental rebates negotiated and collected at the state level.

    - In order for a brand name drug to be listed in the state's Preferred Drug List, the drug manufacturer must offer a minimum rebate of 29.1% of the average manufacturer price (AMP). There's no upper limit on the rebate the state can negotiate. (FL, '05).[23]

    - In 2005, 26 states sought supplemental rebates.[24] By FY 2010, this number had increased to 44 states.[25]

- Preferred drug list (PDL) or formularies: Prescription drugs on this list are covered with no need for prior authorization (fewer administrative burdens for providers).

    - In 2005, 29 states implemented PDLs.[26] By FY 2010, this number had increased to 44 states.[27]

- Dispensing drugs/supplies:

    - Require the dispensing of a 100-day supply. (WI, '10).[28]

    - Beneficiaries have to use 90% of their medication (rather than 80%) before they are allowed to obtain a refill of the prescription. (KY).[29]

    - As a condition of contracting, require out-of-state Durable Medical Equipment (DME) distributors to offer the lowest rate possible. The DME distributors are guaranteed volume, while states negotiate for the best possible rate.

- Ingredient costs and dispensing fees: On average, ingredient costs comprise about 90% of all Medicaid pharmacy spending, with a high percentage (nearly

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[23] Sybil M. Richard, Assistant Deputy Secretary for Medicaid Operations, Florida Agency for Health Care Administration, *Overview of Selected Cost-Containment Strategies for Medicaid Prescription Drug Spending*, *in* North Carolina Family Impact Seminar: Medicaid Cost-Containment Strategies in North Carolina and Other States 41, 48, *available at* http://familyimpactseminars.org/s_ncfis01c04.pdf.
[24] Vernon K. Smith, Jr., Principal, Health Management Associates, *A National Challenge: How States Try to Control Medicaid Costs and Why It Is So Hard*, *in* North Carolina Family Impact Seminar: Medicaid Cost-Containment Strategies in North Carolina and Other States 14, 22, *available at* http://familyimpactseminars.org/s_ncfis01c04.pdf.
[25] *Hoping for Economic Recovery, Preparing for Health Reform*, *supra* note 7, at 51.
[26] Vernon, *supra* note 22, at 22.
[27] *Hoping for Economic Recovery, Preparing for Health Reform*, *supra* note 7, at 51.
[28] *Id.* at 52.
[29] Kentucky Cabinet for Health and Family Services, *supra* note 17.

80%) spent on brand name drugs, even though these drugs are less than 30% of all Medicaid prescriptions.[30] In addition, Medicaid also pays pharmacies a fee for dispensing a prescription.

  - To address the issue of some pharmacies accepting lower dispensing fees and ingredient cost payments from other payers compared to Medicaid rates, some states have implemented a "most favored nation" policy that stipulates a pharmacy cannot bill Medicaid more than the lowest price reimbursed to the pharmacy by other third party payers and managed care organizations or the lowest price routinely offered to any segment of the general public. (CT, GA, MA, and SC).[31]

  - Review current reimbursement methodologies for ingredient costs and dispensing fees as they compare to Average Acquisition Cost (AAC) models. Two states, AL (in September 2010) and OR (in January 2011) have implemented AAC reimbursement methodologies for ingredient costs. AL estimates a six percent net savings, while OR projects $1.6 million annual savings, with an additional $1.3 million annual savings from the state's dispensing fee adjustment implemented in August 2011.[32]

- Usual and Customary Policies: Pharmacies must pass their usual and customary charges onto the Medicaid program. "Usual and customary" definitions vary from state-to-state. In CT, effective May 2010, pharmacies must bill Medicaid "the lowest amount accepted from any member of the general public who participates in the pharmacy provider's savings or discount program."[33] This means any program, club or buying group offered by a pharmacy provider to any member of the general public for the purpose of obtaining a lower charge for any good or service.[34] In MI, "usual and customary" is defined as the pharmacy's charge to the general public, which must reflect all advertised discounts, special promotions, or other programs initiated to reduce prices for product costs available to the general public or to a special population.[35]

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[30] Kaiser Commission on Medicaid and the Uninsured, *Managing Medicaid Pharmacy Benefits: Current Issues and Options* at 2, 6 (2011), *available at* http://www.kff.org/medicaid/upload/8234.pdf.
[31] *Id.* at 10.
[32] *Id.* at 8.
[33] *Id.* at 11.
[34] *Id.*
[35] *Id.*

Transportation

- Establish new ambulette dialysis transportation fee: The Medicaid program currently reimburses for dialysis ambulette trips at the same level as individual ambulette medical trips. However, because dialysis trips are predictable, regularly recurring, and can accommodate a group of riders, Medicaid is paying a higher fee than necessary. These trips are similar to ambulette trips provided to Adult Day Health Care (ADHC) programs, which are reimbursed statewide at a lower fee than that paid for individual ambulette medical transportation. This involves administrative action only and would take minimal time to implement, since it just requires updating the procedure code file with the new fee. (NY, '11).[36]

- The passage of the Deficit Reduction Act of 2005 (DRA) had considerable impact on Medicaid transportation. It created the state option to establish a non-emergency medical transportation brokerage program to help states provide medical transportation services. Transportation brokerages are entities that coordinate transportation services for Medicaid recipients, including the screening of recipients, determination of eligibility and arrangement and payment of actual transportation. The purpose of this program is to more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan that need access to medical care or services and have no other means of transportation.

    - States must assure that non-emergency transportation services furnished by transportation brokerage systems are medically appropriate and offer a full-range of services.

    - There must be comprehensive state monitoring and oversight of non-emergency transportation brokerage systems.

    - Non-emergency medical transportation services should be provided to Medicaid beneficiaries who need access to medical services regardless of whether they have other means of transportation.

Bargaining Power

States leverage their bargaining power by "pooling" or grouping both drug and DME purchases (between states and within the state). Special procedures may be established for the purchase of medical devices or laboratory and x-ray tests through a competitive bidding process.[37]

- CMS approved a plan for 7 states (AK, HI, MI, MN, NH, NV, and VT) to participate in a joint purchasing pool, which also included a supplemental rebate component. (According to CMS, the pool would be purchasing drugs for 1.1

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[36] *Establish New Ambulette Dialysis Transportation Fee*, Proposal to Redesign Medicaid No. 22, *available at* http://www.health.state.ny.us/health_care/medicaid/redesign/docs/proposals_being_rated.pdf.
[37] 42 C.F.R. § 431.54(d) (West 2011).

million Medicaid beneficiaries, with $19.5 million in savings generated in FY 2004).[38]

- As of mid 2010, there were several operating multi-state bulk buying pools, not counting other variations and single-state initiatives:[39]

    - The "National Medicaid Pooling Initiative" was first announced in early 2003 with four states. In 2009 the total number of pooled states was eleven and DC. (AK, KY, MI, MN, MT, NV, NH, NY, NC, RI, SC, and DC). States were able to negotiate lower prices and save on drug costs.

    - The Top Dollar Program is the State Medicaid Pharmaceutical Purchasing Pool started by Provider Synergies for LA and MD in 2005. DE, ID, NE, PA, and WI joined more recently for a total of seven participants since 2009.

    - The Sovereign States Drug Consortium was founded as a non-profit structure by the states of IA, ME, and VT for Medicaid in October 2005. IA, ME, OR, UT, VT, WV, and WY are operational members. This is the first state-administered multi-state Medicaid supplemental drug rebate pool, which is entirely owned by the participating states. Each state in the consortium has its own PDL. All participating states have access to all bids by pharmaceutical manufacturers; bids are collectively reviewed and states independently decide which approach is most appropriate for their individual program.

- States can also "pool" DME supplies, e.g., volume purchasing of hearing aids and batteries. ('03).[40] This can also be done with eyeglasses, x-ray film, catheters, etc.

- NC anticipates saving $15 million per year on disposable briefs and similar products by streamlining the supply chain. The NC Department of Health and Human Service entered into a one-year contract (with two renewable one-year options) with an incontinence products supply company. As of May 2011, Medicaid providers can purchase incontinence supplies such as: disposable briefs, pads, liners, and rubber gloves from this company at a guaranteed rate.[41]

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[38] Richard, *supra* note 21, at 48.
[39] *Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans*, National Conference of State Legislature (Jul. 2010), http://www.ncsl.org/default.aspx?tabid=14464.
[40] Kaiser Commission on Medicaid and the Uninsured, *States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions*, at 7 (2004), *available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30453.
[41] *N.C. Medicaid to Save $25 Million Annually on Incontinence Supplies*, N.C. Department of Health and Human Services (Mar. 3, 2011), http://www.ncdhhs.gov/pressrel/2011/2011-03-03-incont_supp.htm.

Scope of practice

- Change in scope of practice for mid-level providers to promote efficiency and lower cost: Expand scope of practice for Registered Nurses, Licensed Practical Nurses and home health aides to improve access to services and decrease associated costs in delivering services. (NY, '11).[42]

Program Enhancements

- Health Insurance Premium Payment (HIPP) program pays private health insurance premiums for certain Medicaid beneficiaries with high medical costs. States may create a mechanism to identify eligible beneficiaries and provide marketing and education about the benefits of enrolling in HIPP. Also, provides "wraparound coverage" to give beneficiaries access to services not covered by their employer-sponsored plan. (KY, '10).[43]

- Adopt uniform forms for inpatient hospital care and other claims.

Using Technology

- Implement electronic prescribing to reduce errors and improve efficiency and quality, and use electronic prior authorization systems for the approval of medications, and other services that require authorization.

- Implement a paperless process for submitting provider reimbursement claims.

Increase Fraud and Abuse Investigations

- Involve outside contracts with organizations that specialize in fraud or abuse investigations or hire additional staff to focus on this area. (AK, CA, CO, CT, KS, ME, MD, MI, NV, NH, NJ, NM, MY, OK, PA, TN TX WI, WY, '03).[44] *Note:* When the states involve outside contracts, then there should also be a reduction in staffing at the Attorney General's office for staff members who had previously been covering this work.

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[42] *Change in scope of practice for mid-level providers to promote efficiency and lower Medicaid cost*, Proposal to Redesign Medicaid No. 200, *available at* http://www.health.state.ny.us/health_care/medicaid/redesign/docs/descriptions_of_recommendations.pdf .

[43] Kentucky Cabinet for Health and Family Services, *supra* note 17.

[44] Kaiser Commission on Medicaid and the Uninsured, *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004, Results from a 50-State Survey*, at 31, 52-53 (2003), *available at* http://www.kff.org/medicaid/upload/States-Respond-to-Fiscal-Pressure-State-Medicaid-Spending-Growth-and-Cost-Containment.pdf.

- Increase field audits (as opposed to desk audits), e.g., enhanced home care agency audits. (CT, '03).[45]

- Provider lock-out: Physicians' practices are monitored and abusive providers are locked-out and restricted from participating in the Medicaid program for a reasonable period of time as long as the conditions set forth in 42 C.F.R. §431.54(f) are met.

Cost avoidance--Third Party Liability

- Other health coverage: Federal regulations require state Medicaid agencies to identify third party payers that are responsible for the care and services provided to Medicaid beneficiaries, and to make sure Medicaid is the secondary payer when other health coverage exists. States must have effective systems in place to identify these third party payers, and aggressively pursue third party reimbursement when a third party payer exists and should have been responsible for the care received.

    - In AL, the Third Party Division ensured that claims were submitted to the primary payer before Medicaid paid. When primary coverage was identified after Medicaid had paid, this division sought reimbursement from the primary coverage. Through a combination of cost avoidance and collection of health insurance benefits, AL's Third Party Division saved over $83 million in FY 2003.[46]

- Trauma-related claims*:* In CA, when a Medicaid beneficiary receives treatment for an injury, the beneficiary receives a questionnaire asking if the injury was caused by another person and whether there is a potential third party payer. These third party payers may include: homeowner's, automobile, malpractice, and other liability insurance, as well as court-ordered restitution. Once identified, reimbursement is sought for medical bills related to the injury.

- Adverse events: Since 2006, WA has a law requiring facilities to report hospital acquired conditions (HACs) and adverse events (preventable actions that compromise patient care and require costs to address) to the Department of Health and/or Department of Social and Health Service. There were no sanctions associated with the law, but in 2010, the U.S. Department of Health and Human Services approved a state plan amendment that authorized WA to disallow payment for HACs and adverse events. The plan took effect January 2011.[47]

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[45] *Id.* at 41.
[46] Alabama Medicaid Agency, *Annual Report FY2003*, *available at* http://medicaid.alabama.gov/documents/2.0_Newsroom/2.3_Publications/2.3.4_Annual_Report_Archive/2.3.4_FY03_Annual_Report.pdf.
[47] George Washington University School of Public Health and Health Services, *supra* note 13.

- CMS recently issued a final rule governing non-payment of adverse events in Medicaid, which will be effective as of July 2011.

- Collecting outstanding debt by providers: KY partnered with the Department of Revenue to increase collaboration in collecting outstanding debt by providers. After the Kentucky Department for Medicaid Services exhausts all collection efforts, the Department of Revenue is informed of the debt and helps locate the provider and begin the collection process through a "tax interception" program. ('10).[48]

- Concurrent Medicaid eligibility in neighboring states: A report by the Office of the Inspector General found that Medicaid payments were made for services provided to beneficiaries with concurrent eligibility in Florida and Georgia. The recommendations made by the report involved determining accurate beneficiary eligibility status and reducing the amount of payments made on behalf of beneficiaries residing in the neighboring state.[49] Similar audits were conducted in Illinois and Indiana.[50]

- Medical support orders: Ensuring that child support orders require that non-custodial parents who have access to health insurance provide coverage for their children. (KY).[51]

Conclusion

The cost-containment measures listed in this fact sheet, when taken correctly, can save states money without impacting eligibility, services or imposing co-payments. Advocates should make sure that these options are on the table and considered first, before reducing benefits or implementing other cuts which harm Medicaid beneficiaries' coverage.

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[48] Kentucky Cabinet for Health and Family Services, *supra* note 17.
[49] U.S. Department of Health and Human Services, Office of Inspector General, OIG Report No. A-04-08-03034, *Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Florida and Georgia for July 1, 2005, Through June 30, 2006* (Jun. 3, 2008), *available at* http://oig.hhs.gov/oas/reports/region4/40803034.pdf.
[50] U.S. Department of Health and Human Services, Office of Inspector General, OIG Report No. A-05-06-00069, *Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Illinois and Indiana for July 1, 2005, Through June 30, 2006* (Jan. 17, 2008), *available at* http://oig.hhs.gov/oas/reports/region5/50600069.pdf; U.S. Department of Health and Human Services, Office of Inspector General, OIG Report No. A-05-06-00070, *Medicaid Payments for Services Provided to Beneficiaries With Concurrent Eligibility in Indiana and Illinois for July 1, 2005, Through June 30, 2006* (Jan. 25, 2008), *available at* http://oig.hhs.gov/oas/reports/region5/50600070.pdf.
[51] Kentucky Chamber, *Testimony to Task Force on Medicaid Cost Containment* (Sept. 21, 2010), *available at* http://kyvoicesforhealth.com/images/files/pdfs/MCCTF/KYChamber-MedicaidCostContainment%209-21-10.pdf.