



THE KAISER COMMISSION ON
Medicaid and the Uninsured

Medicaid and State Budgets: A Case Study of Indiana

Prepared by

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1. The State of Indiana

Indiana, a mid-western farming and manufacturing state, is the 14th most populous state in the United States. The state ranks in the top five nationally for producing items as diverse as pharmaceuticals, surgical supplies, aircraft engines and parts, truck and bus bodies, and steel. It is a largely rural state with two major cities – Indianapolis and Gary.

1.1 Indiana's Population

According to U.S. Census data, Indiana's population is 5,902,333, of which 87.7% is white, 7.7% is African American, 3.0% is Hispanic, and 1.1% is Asian. The age distribution of Indiana's population is as follows: 28.7% -- under age 19, 12.5% -- age 65 or above.

In 2000, the average percentage of population living in poverty in Indiana was 8.2% compared to 11.9% nationwide. Further, 1.3% of Indiana's population (or 29,922 families) received Temporary Assistance to Needy Families in SFY 2000. Also, in 2000, 11.9% of Indiana's population had no health insurance compared to 14% of the national population.

1.2 Indiana State Government

Indiana's government is divided into three branches: executive, legislative and judicial. In the executive branch, there are eight officers elected on a statewide basis, including the governor, lieutenant governor, secretary of state, attorney general, treasurer, auditor, superintendent of public instruction, and the clerk of the supreme and appellate courts. When office holders belong to different parties, there is a political division in the executive branch that can affect the efficiency and direction of government. Since 2000, the governor has been Democratic and the attorney general Republican. Between 1992 until 2000, both the governor and attorney general were Democrats.

1.2.1 Indiana's Medicaid and Health Agencies

The executive branch contains the two agencies which administer the Medicaid and other state health care programs. The Indiana Family and Social Services Administration (FSSA) and its Office of Medicaid Policy and Planning (OMPP) are responsible for the Medicaid program.

The Indiana State Department of Health (ISDH) is the public health agency for the state and oversees the local health departments.

The Secretary of FSSA is appointed by the Governor and has responsibility for the administration of family and social services in the state. The Secretary of FSSA has authority to make legislative rules, although rules must be approved by the relevant programmatic advisory council before submission to the attorney general for final action. By statute, the Secretary of FSSA must meet requirements for federal funding of federal entitlement programs under the Social Security Act, including Medicaid.

OMPP, within FSSA, is responsible for the administration and policy oversight of Indiana's Medicaid program and is the designated state agency under the federal Medicaid statute. However, Indiana has multiple health services programs with overlapping constituencies in both FSSA and ISDH. Other divisions in FSSA have responsibilities in the Medicaid program as well. They include the Division of Disability, Aging and Rehabilitation Services, which administers Medicaid waivers for home-based long term care for the elderly, disabled and other special populations, and the Division of Family and Children which has eligibility determination responsibilities in programs for children, pregnant women and low income families.

FSSA also administers the Children's Health Insurance Program (CHIP). The Office of CHIP is located in the Office of the Secretary of FSSA. The Children's Health Policy Board, comprised of the Secretary of FSSA, the state health commissioner, the insurance commissioner, the state personnel director, the budget director, the state superintendent of public instruction, and the director of the division of mental health, directs policy coordination for Indiana's children's health programs, including CHIP.

ISDH is responsible for most of Indiana's health programs. The Executive Board of ISDH, the agency's ultimate authority, and the State Health Commissioner are appointed by the governor. The State Health commissioner is the secretary of the Executive Board and the chief executive of ISDH. By law, the commissioner must be licensed to practice medicine in Indiana.

The fact that ISDH has a physician head has made legislators and other policymakers reluctant to locate major responsibilities for the Medicaid program in ISDH. The concern is that the Commissioner will have conflicted interests when setting payment policy for physicians and other providers. Nevertheless, ISDH maintains great interest in the Medicaid program.

The Secretary of FSSA and the Commissioner of ISDH are required by statute to coordinate related programs, including the Medicaid program. The Secretary of FSSA is accountable for formulating overall policy for family, health, and social services in Indiana, including the resolution of administrative, jurisdictional, or policy conflicts between a division of FSSA and ISDH. By statute, FSSA must advise the Commissioner of ISDH of proposed rules affecting common areas of interest, including Medicaid, and obtain comments from ISDH on the proposed rule.

1.2.2 The Indiana State Budget Process

Indiana has a biennial budget which begins July 1st of odd numbered years. In each biennium, Indiana's part-time legislature has a "long" session in odd numbered years, in which the budget for the biennium is considered and adopted, and a "short" session the following year. The State's fiscal year runs from July 1st to June 30th. The Indiana Economic Forum, an independent body, and the Revenue Forecast Technical Committee of the legislature make revenue forecasts annually in the fall, prior to the convening of legislative sessions, and again in April, prior to final legislative approval and enactment of appropriations.

Agencies begin preparing the budget for the next biennium in the spring of odd numbered years and submit the departmental budget request to the State Budget Agency the following fall. The State Budget Agency submits the proposed budget to the State Budget Committee. This committee is comprised of the State Budget Director and the chair and ranking members of the budget committees in the Indiana House and Senate. This uniquely structured committee provides continued oversight and management of the budget when Indiana's part-time legislature is not in session.

The State Budget Committee prepares a budget report that is submitted to the Indiana

legislature for approval. Then the State Budget Committee submits the report to the legislature for adoption where it is considered by the relevant legislative committees and enacted, with amendments, by both houses. After consideration by a conference committee and final passage by both houses, the budget legislation goes to the governor for signature. A gubernatorial veto may be overridden by a majority vote in both houses of the legislature. Indiana's constitution requires the legislature to pass a budget each biennium.

The legislature can modify the budget in its "short" session in even numbered years. It generally does so for the Medicaid program, particularly in response to new federal mandates. Further, once eligibility and benefits for the Medicaid program are established, the Medicaid program receives so-called "open-ended" appropriations. By statute, the governor and budget director, upon the unanimous recommendation of the State Budget Committee, are authorized to augment the biennial appropriation when Medicaid program expenditures exceed prior appropriations. Generally, there is a supplemental appropriation for the Medicaid program.

Agencies implement the budget, although the State Budget Committee provides continuing legislative oversight of the budget's implementation. The State Board of Accounts, headed by a director directly elected in statewide elections, audits the budget annually.

2. **Indiana's Medicaid Program**

Indiana's Medicaid program provides health and/or long-term care coverage to low-income people. In SFY 2000, the program had 652,000 recipients and expended \$2.92 billion. Like other state Medicaid programs, Indiana's program is financed by the state and the federal government. In SFY 2000, the federal financial share was 61.7% (\$1.81 billion) while the state's share was 38.3% (\$1.11 billion). Indiana's Medicaid expenditures constituted 13% of the state's general fund budget in SFY 2000. At Figure 1 are displayed how Indiana's Medicaid program compares to other state programs.

Figure 1 Characteristics of the Indiana Medicaid Program with Other State Programs, 1998			
Characteristic	Indiana Rank	Indiana Data	US Data
Medicaid Recipients as a % of Total State Population	39 th	10.29%	15.04%
Total Medicaid Per Capita Expenditures	34 th	\$434.64	\$525.52
Total Medicaid Expenditures per Recipient for all Categories	16 th	\$4,222.02	\$3,501.10
Source: FSSA, SFY 2000 Annual Report (2002).			

Historically, Indiana’s program has been strict on eligibility, but generous on benefits and coverage as well as provider payment levels. The resulting program design was a very generous program for the minimally- required number of recipients. The theory behind this health design was that the Medicaid program should provide benefits at the same levels as private insurance. However, to do so, eligibility had to be limited to make the program affordable. This extraordinary program design reflected the effective advocacy of Indiana’s strong and respected provider community. However, in recent years, this program design has fundamentally changed with numerous federal mandates since the 1980s which have rationalized Medicaid eligibility and expanded coverage for poor children, among others. At Table 1 are presented the major data on Indiana’s Medicaid program, including the number of recipients, expenditures and the expenditures per recipient by aid category.

Category of Recipient	Recipients N (thousands) (%)	Expenditures by Aid Group N (millions) (%)	Expenditures per Recipient by Aid Group N
Adult	66 (11%)	\$130 (5%)	\$1,981
Aged	72 (12%)	\$891 (33%)	\$12,318
Blind & Disabled	83 (14%)	\$1,032 (38%)	\$12,439
Pregnant Woman	45 (7%)	\$ 80 (3%)	\$1,807
Child	315 (51%)	\$463 (17%)	\$1,523
CHIP	22 (4%)	\$16 (1%)	\$ 714
Unknown	7 (1%)	\$2,707	\$6,881
Disproportionate Share Hospital Expenditures	NA	\$47 (2%)	
TOTAL	609	\$2,707	\$4,367
Source: FSSA, SFY 2000 Annual Report (2002).			

Currently, Indiana's Medicaid program has three major components: (1) Hoosier Healthwise, a managed-care program for children, pregnant women and low income families enrolled in either Medicaid or CHIP, (2) a long-term care program, which finances institutional and community-based long term care for the elderly and disabled, and (3) "Hoosier Rx Benefit" for low-income elderly. It should be emphasized that the HoosierRx benefit is not yet a Medicaid program although it may become one if the state obtains a Medicaid waiver to fund the program. (Currently, this program is funded from tobacco settlement funds.) The Hoosier Healthwise program serves primarily children, pregnant women and low income families, and the latter two programs serve primarily the elderly and disabled.

2.1 The Impact of the Federal Government

In the last five years, major legislative changes at the federal level have had a major impact on the Medicaid programs of all states, including Indiana. The major change in the 1990s was the Balanced Budget Amendments of 1997 (Pub. L. No. 105-33) which enacted several reforms in federal Medicaid program requirements.

Most importantly, the Balanced Budget Act of 1997 established CHIP to expand health coverage for children with substantial federal support. CHIP provides federal grants to states to expand health coverage to children less than 19 years of age with family incomes at or below 200% of the federal poverty level. Federal funds may be used to expand Medicaid, create a new program, or implement a combination of these programs. CHIP is really a funding source, rather than a program per se. As described below, CHIP enabled Indiana's Medicaid program to enroll more children, which did much to increase Medicaid expenditures in recent years.

In addition, the Balanced Budget Act of 1997 permitted states to implement capitated managed care for Medicaid populations without obtaining a waiver of federal program requirements. This change does not have a major fiscal impact as it simply changes administrative requirements for establishing prepaid managed care plans. Indiana has had capitated managed care with the Hoosier Healthwise program, described below, since 1994 pursuant to a Medicaid waiver.

Also, in the Balanced Budget Act of 1997, Congress repealed the Boren Amendment, which required that Medicaid payments to nursing homes be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards" (Social Security Act, § 1902(a)(13)). The Boren Amendment greatly constrained states in their cost containment efforts regarding the Medicaid nursing home benefit. The repeal of the Boren Amendment gives states greater flexibility to reform nursing home payment and lower rates -- a step adopted by many states, including Indiana.

Finally, in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. No. 104-193), Congress fundamentally changed the cash assistance program for low-income mothers and children and their access to the Medicaid program. The Temporary Assistance to Needy Families (TANF) program requires recipients to work after two years of benefits. Many TANF recipients are eligible for Medicaid because they otherwise meet Medicaid eligibility requirements. They are not automatically eligible as they had been under

the former Aid to Families with Dependent Children (AFDC) program. In general, TANF recipients are protected by the federal requirement that states provide Medicaid coverage to children and parents who would otherwise be eligible for the former AFDC program – those with incomes under 133% of poverty.

2.2 Eligibility

To be eligible for Indiana’s Medicaid program, a person must meet certain financial requirements and belong to one of the following groups: (1) members of families with children; (2) pregnant women and children; (3) aged, (4) blind, or (5) disabled. They must also meet certain financial requirements in terms of income and resources. At Table 2 is displayed the trends in the numbers of Medicaid recipients since 1990.

	1994 N (% Change)	1995 N (% Change)	1996 N (% Change)	1997 N (% Change)	1998 N (% Change)	1999 N (% Change)	2000 N (% Change)
Adult	92	94 (2%)	91 (-3%)	72 (-21%)	63 (-13%)	66 (5%)	70 (6%)
Aged	58	67 (16%)	73 (9%)	73 (0%)	71 (-3%)	72 (1%)	71 (-1%)
Blind & Disabled	68	71 (4%)	75 (6%)	76 (1%)	77 (1%)	83 (8%)	79 (15%)
CHIP	0	0	0	0	0	22	34 (65%)
Child	315	324 (3%)	329 (2%)	295 (-10%)	304 (3%)	315 (4%)	348 (10%)
Pregnant Women	32	36 (13%)	45 (25%)	45 (0%)	48 (7%)	45 (-6%)	37 (/-18%)
Unknown	31	9 (-71%)	6 (-33%)	15 (150%)	20 (33%)	7 (-65%)	14 (100%)
Total	596	601 (1%)	619 (3%)	576 (-7%)	584 (1%)	609 (4%)	652 (7%)
FSSA, SFY 2000 Annual Report (2002).							

Until the 1980s, Indiana extended Medicaid eligibility only to those recipients of AFDC and Supplemental Security Income (SSI) whom federal law required be eligible. Indiana never

adopted a Medically Needy program that would cover the poor that met the characteristics of the categorically eligible, but for income. Historically, Indiana has had among the most restrictive financial requirements for eligibility in the nation. Also, because Indiana elected to be a “Section 209(b)” state, eligibility was not extended to all SSI recipients, but only those eligible for predecessor programs in place in the state before 1972. As a result of all of these eligibility restrictions, Indiana ranked 45th in the nation in terms of the percentage of the state’s population enrolled in Medicaid in FY 1990. Yet, that same year, Indiana ranked 7th on spending per recipient due to the generous benefits and provider payment levels.

Since the 1980s, Indiana’s Medicaid program has expanded eligibility primarily in response to federal mandates. Specifically, eligibility was extended to new groups of children and pregnant women pursuant to a series of federal mandates enacted in the 1980s. Also, the first phase of CHIP, initiated in July 1998, implemented as a Medicaid expansion in Indiana, made all children and pregnant women with family incomes of 150% of poverty and below Medicaid eligible. CHIP’s second phase, implemented in January 2001, covered all children with family incomes of between 150% and 200% of poverty. Implementation of the CHIP program is described further below.

In addition, eligibility for the aged and disabled also expanded in response to federal mandates enacted in the 1980s as well as the state’s adoption of new waiver programs. Also, a recent court decision, *Sullivan v. Day*, 661 N.E. 2d 848 (Ind. App. 1997), *appeal denied*, 681 N.E. 2d 713 (Ind. 2001), has effectively expanded eligibility for the disabled as well. Previously, only individuals with permanent, untreatable disabilities were Medicaid eligible. However, the Indiana Court of Appeals ruled that this criterion was more restrictive than the criterion in place on January 1, 1972, which clearly contemplated eligibility for applicants with treatable conditions. The judicially mandated criterion extends eligibility to applicants with disabilities expected to last at least four years if left untreated. Consequently, Indiana will serve 60,000 more elderly, low-income and disabled individuals by mid-2003, costing the state an estimated \$108 million (Cincinnati Courier Journal, Dec. 24, 2001).

2.3 Benefits and Coverage

From its inception, Indiana’s Medicaid program has provided generous benefits to eligible beneficiaries and has imposed few limits on the amount, duration and scope of benefits. The Indiana Medicaid statute specifies most of the optional benefits under federal law as required benefits. This statutory specification of required benefits has made it politically difficult for Indiana policymakers to eliminate or reduce expenditures for optional services deemed to be less beneficial or cost effective. In SFY 2000, Indiana provided 31 of 34 possible optional programs, making the Indiana Medicaid program one of the most comprehensive in the country. Program benefits are listed at Figure 2.

Figure 2 Optional Services in the Indiana Medicaid Program
Case management services
Chiropractic services
Christian Science nurse services
Christian Science sanitariums
Clinical services
Dental services
Diagnosis services
Emergency hospital services
Eyeglasses
Hospice care
Inpatient mental hospital services for the elderly
Inpatient psychiatric services for age 21 and below
Intermediate care for the mentally retarded
Medical social worker services
Nurse anesthetists’ services
Nursing facility services for age 21 and below
Occupational therapy
Optometry services
Physical therapy
Podiatry services
Prescribed drugs
Preventive services
Private duty nursing services
Prosthetic devices
Psychological services
Rehabilitative services
Respiratory care services
Screening services
Smoking cessation
Speech, hearing and language disorder services
Transportation services

2.4 Provider Payment

Also, historically, provider payment levels in Indiana were quite high compared to other

states. In FY 1990, Indiana ranked seventh in the nation for per-recipient spending. Further, Indiana’s Medicaid program paid most institutional providers on a cost reimbursement basis. Indiana was behind other states in adopting payment methodology that would encourage efficiencies in the delivery of care.

In the early 1990s, Indiana’s Medicaid program experienced a fiscal crisis. With implementation of federal mandates for expanded eligibility enacted in the 1980s, Indiana’s generous program for the few had expanded to include more people. Program expenditures exploded. Medicaid expenditures were rising 20% per year. The cost of Medicaid services more than doubled from SFY 1989 (\$1.13 billion) to SFY 1993 (\$2.32 billion). In SFY 1992, state Medicaid expenditures constituted 13% of the total state government spending, up from 9% in FY 1990.

Then Governor Evan Bayh made Medicaid payment reform a major policy initiative of his administration. Major cost containment initiatives were implemented beginning in SFY 1993. One major reform was the establishment of the innovative Hoosier Healthwise program for children and pregnant women in 1994 that continues to this day. This program is described below.

The major thrust of the payment reforms for institutional providers was to move from generous payment methods, which paid providers at some of the highest levels in the nation. For hospitals, the Medicaid program moved to a prospective payment methodology based on diagnosis related groups (DRGs). For nursing homes, the Medicaid program adopted a new case-mix reimbursement formula which was implemented in 1998. Nevertheless, as displayed in

Hospitals	\$498 (17%)
Pharmacies	\$454 (16%)
ICF-MRs	\$289 (10%)
Physicians	\$130 (5%)
Mental Health and Rehabilitation	\$164 (6%)
Capitation for Managed Care	\$145 (5%)
Waiver	\$101 (3%)
Dental	\$88 (3%)
Other	\$256 (9%)
TOTAL	\$2,924
Source: FSSA, SFY 2000, Annual Report (2002).	

Figure 3, nursing homes still receive more funds than any other category of provider under Indiana's Medicaid program.

	1994 Amount (% Change)	1995 Amount (% Change)	1996 Amount (% Change)	1997 Amount (% Change)	1998 Amount (% Change)	1999 Amount (% Change)	2000 Amount (% Change)
Adult	208	145 (-30%)	157 (8%)	127 (-19%)	106 (-17%)	130 (23%)	174 (34%)
Aged	784	714 (-9%)	804 (13%)	790 (-2%)	805 (2%)	891 (11%)	923 (4%)
CHIP	-	-	-	-	-	16	24 (50%)
Child	409	309 (-24%)	379 (23%)	352 (-7%)	380 (8%)	463 (22%)	549 (19%)
Blind & Disabled	929	737 (-21%)	919 (25%)	925 (1%)	970 (5%)	1,032 (6%)	1,110 (8%)
Pregnant Women	84	59 (-30%)	98 (66%)	88 (-10%)	85 (-3%)	80 (-6%)	82 (3%)
Unknown	75	40 (-47%)	46 (15%)	50 (9%)	49 (-2%)	48 (-2%)	62 (29%)
Total	2,488	2,004 (-19%)	2,403 (20%)	2,332 (-3%)	2,395 (3%)	2,660 (11%)	2,924 (10%)

Source: FSSA SFY 2000 Annual Report (2002).

The nursing home reimbursement rate is based on four components: direct care, indirect care, administrative, and capital. Each facility's "case mix index" is an index number determined quarterly on the basis of the level of resources used by the facility's patients. A facility's payment rate is equal to its direct care component adjusted for its case mix plus the sum of a percentage of the medians of the other three components. If a facility's costs are lower than the median of any of the components, the facility keeps a percentage of the difference as a profit-add-on "share" percentage. In addition, the case mix system imposes an overall rate limitation or "rate cap." Thus, for each rate component, the nursing facility's rate is capped at a specified percent of median case mix-adjusted costs.

The payment reform initiatives, combined with enrollment decreases resulting from welfare reform efforts, substantially reduced the growth in Medicaid services expenditures from SFY 1994 through SFY 1998. By 1998, Indiana's Medicaid program looked more like programs

of other states in its use of prepaid managed care and prospective payment methods for institutional providers. Of note, acute care services (including capitation payments to managed care organizations) accounted for 65.8% of Medicaid expenditures and long-term care services accounted for 41.1%. The trends in Medicaid expenditures since 1994 are presented at Table 3.

2.5 The Hoosier Healthwise Program

Hoosier Healthwise is a managed care program for children, pregnant women and low income families. FSSA has gone to great lengths to make this program look like a traditional health insurance program with a six-month advertising campaign and very user friendly enrollment and other procedures. Indeed, many enrollees are unaware that they are Medicaid recipients. Of note, empirical surveys show that recipients are very satisfied with the Hoosier Healthwise program and that satisfaction, as well as participation among providers, is steadily improving.

In Hoosier Healthwise, recipients are linked to a primary medical provider (PMP), a physician who provides all basic medical services and makes referrals for specialty care. Hoosier Healthwise has two delivery systems: (1) Primary Care Case Management (PCCM); and (2) Risk-Based Managed Care (RBMC). In the PCCM option, Medicaid pays PMPs and other providers on a fee-for-service basis. In the RBMC option, the Medicaid program contracts with Managed Care Organizations (MCOs) which in turn contract with providers for their Medicaid health plan(s). Medicaid pays the MCO a capitated rate per enrolled member and the MCO pays the participating providers.

Currently, the RBMC option is generally available in major metropolitan areas while the PCCM option predominates in rural areas. Since 1994, the Medicaid program has sought to extend the RBMC option for the Hoosier Healthwise program throughout the state. To achieve savings, the state is now mandating RBMC in eight urban counties pursuant to a Medicaid waiver and will eliminate PCCM for these counties. The mandate will be completely implemented in Indiana's three largest counties by October 2002.

Hoosier Healthwise offers three benefit packages. Package A is for low-income families

and children who are Medicaid recipients and includes all Medicaid services. Package B is for pregnant women with family incomes up to 133% of poverty. Package C is for children enrolled in the state-funded CHIP expansion with family incomes between 150% and 200% poverty. Package C excludes nursing home care and charges premiums as well as small co-pays for some services.

Indiana has implemented the CHIP program through expansion of Hoosier Healthwise. Beginning July 1, 1998, Indiana implemented the first phase of CHIP as a Medicaid expansion. Medicaid eligibility was extended to children below the age of 19 with family incomes of no more than 150% of the federal poverty level. These CHIP recipients receive Benefit Package A. In January 2000, Indiana implemented a second phase of CHIP as a non-Medicaid program to provide coverage to uninsured children with annual family incomes between 150% and 200% of poverty. Similarly, these children were enrolled in Hoosier Healthwise, but with Benefit Package C (described above). Indiana has been very successful in enrolling children into Hoosier Healthwise. Since July 1998, an additional 175,000 children have Hoosier Healthwise as a result of CHIP. The increase in the number of children included in the Medicaid program due to the CHIP expansion is a major reason for the growth in Medicaid expenditures in the late 1990s.

Further, in 2001, the Indiana General Assembly passed an additional coverage expansion under CHIP for parents of CHIP covered kids with family incomes between 25% and 100% of poverty – an estimated 43,000 adults. The program was to have started in 2002. The state had intended to finance this expansion with funds from the upper payment limit (UPL) funding sources as well as a reallocation of locally-generated funds to provide hospital care for the indigent as well as to cover financial “shortfalls” for municipal hospitals. However, the Centers for Medicare and Medicaid Services announced in November 2001 that it will end the use of the UPL loophole for 14 states, including Indiana, in 2001. Thus, given the fiscal crisis in the Medicaid program, the Indiana legislature and FSSA have postponed implementation of this CHIP coverage expansion until 2004.

2.6 Long Term Care for the Aged and Disabled

In SFY 1999, long term care services, which include institutional care, care under community-based waivers, home health care and hospice care, accounted for 44.7% (\$1.2 billion) of Medicaid expenditures. Despite obtaining and expanding waivers for home and community-based services, Indiana relies heavily on institutional long-term care. Of Medicaid long-term care recipients, 73.6% received care in a nursing home, ICF/MR or group home in SFY 1999, while only 8.1% received care through waiver programs for community-based, long-term care. Yet, Indiana has an over supply of nursing home beds with one of the lowest occupancy rates for nursing homes in the nation. Specifically, Indiana's nursing home occupancy rate is 75% versus the U.S. national average of 90%. Of note, Indiana does not have a certificate-of-need program.

Nevertheless, there is great pressure in the state to move toward the popular community-based, long-term care services. Long waiting lists exist for these services when provided through Indiana's CHOICE program which funds community-based, long-term care services for the aged and disabled over and above the Medicaid programs for these services. There has been much debate in the state about the future directions for long-term care in Indiana. On the one hand, fervent home care and consumer advocates have lobbied vigorously with some success for expanding community-based, long-term care services in Indiana. Still the nursing home industry also lobbies effectively to maintain Medicaid coverage of and reimbursement for institutional care.

Furthermore, Indiana is one of four states with an innovative long term care program which provide incentives for the purchase of private long term care insurance through a partnership between the Medicaid program and private insurance companies. Under this program, there is an asset protection feature including both dollar-for-dollar and total asset protection for participants in this program whom eventually need Medicaid-funded long-term care. There is also a state tax deduction for premiums paid. The purpose of this program is to encourage the purchase of long-term care insurance with a view towards reducing Medicaid

expenditures for long term care in the future.

2.7 Prescription Drug Program for Low Income Seniors -- Hoosier Rx

This new program assists low-income seniors pay the costs of their prescription drugs. Starting January 2001, those age 65 and over may receive refund certificates to reimburse them for half the costs of their prescription drug costs for each quarter, with an annual cap of \$1,000. To be eligible, Indiana seniors must have no other prescription drug insurance coverage, and a family income below 135% of federal poverty guidelines. Presently, the state has applied for a Medicaid waiver to incorporate this program into its Medicaid program. In its first year, "HoosierRx" was funded with \$20 million from the national tobacco settlement. By the end of 2001, 15,000 seniors were enrolled and \$4.5 million had been paid in benefits.

3. The Current Fiscal Crisis

The fiscal history of Indiana over the last five years (since 1996) has been characterized by flush times followed by crisis with the economic downturn in 2001. Now the state is facing a major fiscal crisis due to an antiquated and inadequate public funding system that needs reform.

3.1 The Fiscal History of Indiana over the Last Five Years

During the 1990s, Indiana's economy grew faster than the nation's with a growth rate of 47.6% from 1990 to 1997, compared to 41.1% for the nation during the same period. With an estimated 1997 Gross State Product of more than \$161.7 billion, Indiana's economy ranked as the 18th largest in the country in terms of the value of goods and services produced.

Further, in 1998, Indiana ranked 29th nationally with per capita income of \$24,219, or 91.7% of the U.S. average. Indiana ranked 17th in the nation, with household income of \$39,613, or 104.9% of the U.S. median. Between 1988 and 1999, Indiana experienced strong gains in non-farm employment, adding 572,800 new jobs, for a growth rate of 23.9%. Since 1995, employment growth has slowed to 4.2% – well below the national growth rate of 8.2%.

With the economic boom of the 1990s, Indiana enjoyed budget surpluses which supported expansions in public health insurance programs, such as the inauguration of CHIP in the late 1990s. In SFY 1999, the budget surplus was \$2 billion – one of the largest state budget

surpluses in the nation (CBPB 2001). The legislature and the governor agreed to spend \$800 million of that surplus for one-time, targeted purposes -- a \$290 million investment in the teachers' retirement fund, \$200 million for road construction, \$155 million for state infrastructure investments, \$80 million for new university buildings, and \$82 million for university technology. The budget for the SFY 2000-2001 biennium, which contained significant tax cuts, produced an imbalance of expenses over revenues of \$400 million per year.

Then, in 2001, the economy in Indiana took a downward turn. Growth slowed significantly and Indiana entered a recession. This economic downturn worked to reduce state tax receipts and precipitated the current fiscal and budgetary crisis. After remarkable performance with respect to tax receipts in the late 1990s, there were sharp declines in tax receipts in SFY 2001. For the first time in 20 years, Indiana experienced "negative revenue growth" in SFY 2001. In July 2001, the budget surplus had decreased by \$729 million from the previous year.

For the two years of the biennial budget beginning in July 2001, the State Budget Committee estimated that the revenue loss would be over \$250 million per year. As Indiana's constitution requires a balanced budget, the State Budget Committee estimated that the appropriations in the upcoming biennium should be reduced by \$800 million. The State Auditor announced that the state would be "virtually broke" once money was set aside for schools and emergencies (USA Today, Jul. 12, 2001).

Indiana's budgetary problems are due in large part to a tax system that is unable to generate the requisite revenues to meet the State of Indiana's basic commitments. Quite simply, the state's revenue stream is not sufficient to meet the expanding needs of public programs, such as Medicaid. Indiana has engaged in a number of short-term fixes to address the problems, such as borrowing from rainy day funds and deferring expenditures to future years. For example, Indiana delayed a \$556 million payment in FY 2002-2003 for schools, universities and local governments until after the end of the biennium (CPBP 2001). Further the state drew \$104 million from the Medicaid reserve fund to balance the SFY 2002-2003 biennium budget (CPBP

2001).

Governor Frank O'Bannon has proposed a balanced budget plan that called for some temporary measures to meet upcoming budget shortfalls. Temporary measures included drawing on the state's reserve funds, including the tobacco settlement trust fund, increasing the cigarette tax and the admissions tax on river boat gambling casinos, suspending the homeowner income-tax deduction, freezing university spending, and reallocating gaming revenue. However, these are really stop-gap measures and do not address the underlying structural problems in Indiana's public finance system. The governor has also reduced spending for several state programs, including Medicaid. To address the more structural problems, Governor O'Bannon announced his proposal for the "21st Century Tax Plan" in October 2001 in Indiana's public finance system, which calls for legislative reform of Indiana's tax system. There is real question whether the Republican Senate can come together with the Democratic governor and the Democratic House to forge and enact fiscal and revenue reforms that Indiana so desperately needs. Perhaps, the fact that the ratings on Indiana's bonds are threatened may inspire bipartisan action.

3.2 Current Challenges for Medicaid

With the downturn in Indiana's economy and the severe fiscal crisis that the state is experiencing, Indiana's Medicaid program is also in crisis. The Medicaid program is an important issue in the state's fiscal crisis because of its relative size in the state's budget (13% in SFY 2000) and, in particular, its escalating costs.

From SFY 1999 to SFY 2000, Medicaid program expenditures rose 11%. One major reason for the escalating costs was the 13% increase in Medicaid recipients due to the eligibility expansions described above. By summer 2001, Indiana's Medicaid program was \$410 million in the red. This crisis was exacerbated by the fact that the state underfunded its Medicaid budget by \$140 million in the FY 2003-2003 biennium budget.

Figure 4			
Adopted and Proposed Strategies to Achieve Medicaid Program Savings, 2001-2002			
Phase I Strategies and Savings * (July 2001)		Phase II Strategies and Savings (January 2002)	
Prescription drug payment cuts:	\$98.4 M	Medicaid as payer of last resort:	\$18.5 M
Nursing home care payment cuts:	\$79.5 M	Close eligibility loopholes:	\$ 5.5 M
Hospital care payment cuts:	\$57.4 M	Enhance system integrity and program effectiveness:	\$30.0 M
Make it tougher to shelter assets for nursing home care:	\$28.7 M	Promote appropriate and cost effective drug utilization:	\$40.6 M
Increase tax on group homes to draw more federal funding:	\$12.1 M	Reform reimbursement methodologies for nursing homes:	\$18.2 M
Enroll Marion County recipients in HMOs:	\$ 7.4 M	Modify optional services, such as dental and chiropractic, through caps and limits:	\$10.6 M
		Maximize federal revenue funding through use of UPLs:	\$ 8.0 M
		Adjust disproportionate share funding:	\$15.0 M
		Implement temporary nursing facility provider fee on nursing home patients:	\$21.0 M
		Total Program Savings	\$167.4 M
		LTC Transition Fund*	(\$12.0 M)
STATE SAVINGS (revised):	\$95.7 M	TOTAL STATE SAVINGS:	\$155.4 M
*Savings subsequently reduced due to delays in implementation, including court-ordered delays.		*LTC Transition Fund (from 25% of savings from Phase 2) to help nursing home patients transition into community and home-based care and other long term care options.	
Source: Indianapolis Star, Aug. 26, 2001; FSSA, Medicaid Balanced Budget Plan (2002).			

To close the Medicaid funding gap and encourage efficiencies in the delivery of care, the Medicaid program proposed major spending cuts in several areas of the program to achieve savings. The Medicaid program just proposed a new set of strategies in January 2002. These two phases of proposed savings are presented at Figure 4.

With respect to nursing home payment, the Medicaid program reduced nursing home reimbursement by modifying the payment formula. Included in the reforms were a marked reduction in the profit-add-on “share” percentage and modifications to formulas for calculating various rate components. These changes accounted for 2.5% of the reduction in nursing home reimbursement. The remaining 2.5% reduction came from a change in payment policy for facilities holding beds for individuals who are hospitalized or take therapeutic leave, among other measures. The Indiana Health Care Association and several nursing homes are suing the

Indiana Medicaid program to prevent implementation of these changes on grounds that FSSA did not comply with statutory rulemaking procedures.

The other cut that has generated great concern in Indiana are reduced payments for the ingredient costs and professional fees of pharmacists. Several national drugstore chains, statewide associations representing pharmacies and pharmacists and other affected parties obtained a temporary restraining order against the emergency rule establishing the fee reduction on several procedural grounds. Currently, FSSA followed proper procedures to issue a non-emergency rule to implement these same cuts.

4. Conclusion

Over the last five years, Indiana's Medicaid program has experienced a period of growth and reform buoyed by the extraordinary economic prosperity and growth of the 1990s. In that period, the Medicaid solidified its successful Hoosier Healthwise program, including the incorporation of coverage expansions for children under CHIP. But the program's growth has also exacerbated its fiscal crisis.

The economic downturn of 2001 also revealed profound structural weakness in the Indiana's public finance system. This structural weakness has crucial implications for the state's ability to manage the increasingly pressing demands of the Medicaid program. The tax structure needs reform, and taxes probably raised to address these problems. However, Indiana's General Assembly has historically been reluctant to raise taxes for social welfare program and to date has not exhibited the political will to make the tough choices needed to solve Indiana's greater public finance problems. Until then, or unless there is another economic boom to generate more revenue, Indiana's Medicaid program will be under great pressure to reduce costs and/or minimize program eligibility and benefits.

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