

medicaid
and the **uninsured**

State Case Study:

**Medicaid and the 2003-05 Budget Crisis—
A Look At How Alabama Responded**

Prepared by

Teresa A. Coughlin
The Urban Institute

August 2005

kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

James R. Tallon
Chairman

Diane Rowland, Sc.D.
Executive Director

kaiser
commission on
medicaid
and the **uninsured**

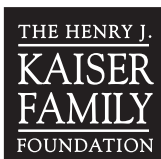
State Case Study:

**Medicaid and the 2003-05 Budget Crisis—
A Look At How Alabama Responded**

Prepared by

Teresa A. Coughlin
The Urban Institute

August 2005



Preface and Acknowledgments

This report is part of a Kaiser Commission on Medicaid and the Uninsured project that examined how eight states from around the nation responded to their budget crises during the 2003-05 time period, with a special focus on Medicaid and the State Children's Health Insurance Program. The state case studies review budget decisions made by state policymakers in Alabama, California, Colorado, Massachusetts, Michigan, New York, Texas, and Washington. An Overview that summarizes these eight states' experiences was published in *Health Affairs* as a web exclusive in August 2005.

This study would not have been possible without the many state officials and representatives of provider and consumer groups in the study state who gave so freely of their time and insights. We also wish to thank Erin Barringer who did a terrific job doing background research. Finally, we thank Barbara Lyons, Molly O'Malley, David Rousseau and Robin Rudowitz of the Kaiser Commission on Medicaid and the Uninsured for their help throughout the project.

Medicaid and the 2003-05 Budget Crisis: A Look at How Alabama Responded

Abstract

Alabama faced severe budget shortfalls over the 2003-05 period but Medicaid was mostly spared. By fiscal 2005, Alabama faced nearly a 25 percent gap between projected revenues and spending. The state cut spending on programs, but Medicaid was largely spared. Alabama also used a range of revenue measures to close its budget gaps, from accounting gimmicks to one-time strategies to increasing fees and provider taxes. Although the state tried to increase general taxes as part of a 2003 tax reform proposal (which was resoundingly defeated by voters), Alabama did not raise-broad based taxes over the 2003-05 time period.

Alabama is one of the poorest states in the nation, ranking 44th in median family income in 2000-2001. It is a small state geographically with a large minority population, principally African-Americans. Politically the state has a long history of being socially and fiscally conservative. Republican Bob Riley currently serves as the governor, while the legislature is solidly Democratic.

Alabama's budgetary environment is greatly constrained by a strong anti-tax sentiment among residents. In September 2003, a major tax reform initiative—which, among other things, called for raising taxes and redistributing the burden of taxes across groups--was put to Alabama voters and defeated by a 2 to 1 margin. Another factor influencing the state's budget situation is that Alabama earmarks nearly 90 percent of its revenue so that specific funds are dedicated to specific purposes. Such a high degree of earmarking severely restricts policymakers' ability to transfer monies between funds when revenue shortfalls occur in a particular spending account, making budgets for Alabama's state agencies highly variable and volatile.

Health programs in the state tend to be limited in their eligibility and benefits, mostly adhering to federal minimum requirements. For example, the Alabama Medicaid program currently covers 16 inpatient hospital days and 14 physician visits for adults per year whereas many states place far less restrictive limits on these basic health services. Reflecting the narrow

benefit package, Alabama's spending per Medicaid enrollee is well below the national average.¹ Even so, Medicaid is an important program in the state providing health insurance for more than 850,000 Alabamians, and financing nearly half of the all births in the state.²

In this brief we examine key budget decisions made by Alabama policymakers over the last three fiscal years—specifically fiscal 2003 to 2005. With a special focus on Medicaid and on the State Children's Health Insurance Program (SCHIP), we highlight proposals by the governor and what was ultimately adopted. We also discuss some of the major policy debates that developed in crafting the budgets over the 2003-05 study period. We collected information on Alabama's budget activities from state websites, newspapers and public documents. We then conducted interviews at various intervals over the three-year study period with state government officials and representatives of consumer organizations using an open ended structured protocol.

The Structure of Alabama's Budget. To appreciate Alabama's budget process and lawmakers' decisions over the last few years, it is critical to understand the structure of the state's budget. Alabama's budget is characterized by a high degree of earmarking where revenues are generally placed in the education trust fund or the general fund. The state also collects revenues (for example, intergovernmental transfers) that support discrete accounts, which we refer to as the "other state fund."³ For policymaking purposes, these accounts are viewed as being completely separate with limited ability to transfer monies among the funds.

Sources of revenue for the funds varies greatly. The education trust fund or ETF (appropriated at \$4.24 billion in fiscal 2004) is supported largely by taxes that typically increase when the economy expands, such as income and sales taxes.⁴ About 90 percent of ETF spending goes to cover K-12 education and higher education; the balance supports other educational programs and activities.

The second largest account is the other state fund (appropriations totaling \$2.25 billion in fiscal 2004), which encompasses a wide range of revenue sources, including intergovernmental transfers (*e.g.*, transfers of monies from public hospitals to the state Medicaid agency), transfers within state agencies (*e.g.*, transfer of monies from the department of mental health to the state Medicaid agency), revenues from provider taxes and tobacco settlement funds. The other state fund is an extremely important financing source for Medicaid, providing nearly 75 percent of the state share for Alabama's program in fiscal 2004.

The smallest of Alabama's major budget funds is the general fund or GF (appropriations totaling \$1.2 billion in fiscal 2004), which depends primarily on relatively small revenue streams that tend to have limited growth such as interest income from state investments, insurance premium taxes and estate taxes. The GF finances a host of state activities, including Medicaid, corrections, human resources, public health and the court system, among others. Unlike most other states, though, the GF accounts for only a small part of Alabama's Medicaid share, roughly 20 percent in fiscal 2003. The rest of state share is financed through the other state fund account, which for Medicaid relies primarily on intergovernmental transfers from public hospitals.

After enjoying some economic growth in the late 1990s, a huge issue for Alabama is that GF revenues have dropped dramatically in recent years. For example, owing to a general decline in interest rates, revenues from interest income (which accounted for nearly 20 percent of GF revenues in 2000) dropped by 50 percent between fiscal 2001 and 2003. Similarly, reflecting changes in federal and state policies, income from estate taxes has also significantly declined over the last few years.⁵ As a result, the GF has been significantly under-funded in recent years, creating considerable budget and policy problems for Alabama.

The other state fund also has had financial troubles, in part because of changes in federal policies governing Medicaid upper payment limits (UPL) for providers and inter governmental transfers (IGTs), which are exchanges of funds among or between different levels of government. Alabama has relied heavily on UPL and IGTs to finance a substantial part of its Medicaid program expenditures. The recent federal clampdown on state use of these mechanisms has put considerable pressure on the Alabama budget process over the last few years. Over the last few years the federal government has tightened state use of intergovernmental transfers and passed legislation in 2001 to limit use of UPL payment mechanisms.⁶

In contrast with the GF and other state fund account, revenues supporting the ETF have been comparatively strong, particularly in fiscal 2004 and 2005. So, while Alabama has seen growth in taxes that support education programs, revenues for non-education programs (including Medicaid) have not kept pace with spending needs. Since Alabama budget protocol permits only very limited money transfers across the ETF, GF and the other state fund, the financial strength of the ETF has little to no bearing on the GF or the other state fund.

Key Budget Debates and Decisions in Fiscal 2003 and 2004⁷

Fiscal 2003. Following a period of relative prosperity between 1998 and 2002, Alabama found itself in a tight budgetary position in fiscal 2003. The projected GF budget shortfall going into fiscal 2003 was \$123 million, or about a 10 percent gap between expected spending and revenues. The state used several one-time revenue strategies to fill the deficit, including funds from a tax escrow account that had been built up over several years, settlement funds from

litigation over off-shore drilling royalties, monies from an abandoned property reserve account, and monies in an informal rainy day fund.

In addition, federal funds provided through the Jobs and Growth Tax Relief Reconciliation Act of 2003, which temporarily increased the federal matching rate of Medicaid expenditures and gave states general financial support, were used.⁸ The state Medicaid agency had expected a \$30 to \$40 million funding gap during 2003, but because of federal fiscal relief Alabama was able to get through the year without making major program cuts. State officials reported that that the federal fiscal relief helped “immensely and could not have imagined what they would have done without the additional funds.”

The ETF also had some funding problems but not as severe as those of the GF. With the help of monies from the rainy day fund, Alabama, on balance, was able to maintain spending for education in fiscal 2003.

Fiscal 2004. Alabama’s fiscal picture worsened in fiscal 2004. When Governor Riley took office in January 2003, he found a budget gap of \$675 million projected for fiscal 2004 for the combined GF and ETF budgets, \$198 million of which was attributable to the GF. The gap represented about 16.5 percent of the GF and about 11.4 percent of the ETF. In his State of the State address in March 2003, Riley announced an ambitious plan to reduce unnecessary government expenditures and to reform state tax policy to address the problems inherent in stop-gap and deficit funding of public expenditures. A tax reform referendum that would have added \$1-1.2 billion in new revenues was put to the voters in September 2003, but failed by a large margin, just three weeks before the beginning of fiscal 2004.

A budget for fiscal 2004 reflecting the level of revenues projected without the tax reform had been proposed in March 2003 and, following the defeat of the referendum, passed the

legislature in September 2003 with little controversy. Described as a “bare bones budget,” K-12 and higher education received no funding increases. Teachers’ jobs were maintained but their health insurance co-payments for prescription drugs were increased.

The GF sustained much larger cuts, with overall fiscal 2004 appropriations reduced by about 5.25 percent from the previous year’s level. Many programs funded from the GF saw cuts of about 18 percent with some losing half or more of their funding. For example, expenditures for government operations were cut by 26 percent in the legislative branch and about 10 percent in the judicial branch. Funding for non-state agencies (such as local parks, museums and privately run medical and social services programs) were cut by 25 percent or more.

In contrast with most GF budget items, Medicaid was largely spared. Appropriations for Medicaid from the GF declined by less than 1 percent, going from \$222 million in fiscal 2003 to \$220 million in fiscal 2004. However, available Medicaid funds in the other state fund account declined substantially, dropping from roughly \$600 million in fiscal 2003 to \$550 million in fiscal 2004. This decline occurred because of the phase in of federal regulations limiting state use of the UPL payment mechanism, which affected Alabama’s ability to raise some of its state Medicaid share.

So, although fiscal 2004 GF appropriations were comparable to that of fiscal 2003, the amount of state funds available for Medicaid declined by more than \$50 million because of the drop in the other state fund account. Unless the state replaced these funds, spending for Medicaid stood to decline by about \$170 million, after including forfeited federal matching dollars.

The state Medicaid agency requested \$330 million in GF appropriations (an increase of \$110 million over fiscal 2003) to compensate for the loss in monies from the other state fund

account, as well as to cover general program growth and inflation. However, the increase was not approved and only \$220 million in the GF were appropriated to Medicaid. To compound the problem, because of general program growth and rising medical costs, fiscal 2003 spending for Medicaid came in higher than expected, adding to the shortfall. The total Medicaid budget gap Alabama faced in fiscal 2004 was estimated at \$145 million, about 18 percent of total (GF and the other state fund) state expenditures for Medicaid.

To fill the Medicaid funding gap, Alabama used a variety of strategies, including increasing revenues and making program cutbacks. As for revenue measures, in April 2004--about half way through fiscal 2004 and after delaying reimbursing providers for services--the legislature made a supplemental Medicaid GF appropriation of about \$40 million. To finance the additional Medicaid funding, the legislature approved an increase on a nursing home bed tax, as well as a tax increase on cigarettes and other tobacco products. The Medicaid supplemental appropriation was described by respondents as being a bipartisan legislative effort that was undertaken with the full support of the governor.

Though not a legislature initiated measure, the state also arranged with public hospitals to increase their intergovernmental transfers to help raise funds for Medicaid. Finally, \$70 million of the shortfall was filled by the enhanced federal match provided as part of the federal fiscal relief package. Between the tax increases, the new intergovernmental transfers and the federal fiscal relief dollars, Alabama was able to close about \$120 million of the projected \$145 Medicaid shortfall for fiscal 2004.

To fill the balance of the 2004 spending gap, Alabama implemented several changes to their Medicaid program. Soon after the fiscal year started, the state began phasing in a preferred drug list program, which was expected to save about \$13 million in fiscal 2004. Medicaid

officials also considered the possibility of several other administrative changes as well as eligibility and service cutbacks, including decreasing the number of covered hospital days from 16 to 14 per year, decreasing the number of covered physician visits from 14 to 12 per year and lowering nursing home income eligibility standards.

State officials acknowledged that they have very little room to cut program benefits and eligibility and remain in compliance with minimum standards set out by federal Medicaid statute. Alabama covers few optional services and few optional eligibility categories. Further, officials determined that cutting back on benefits either did not save much money (*e.g.*, reducing the number of covered physician visits) or did not make sense (*e.g.*, dropping prescription drug coverage, one of the few optional services covered by Alabama's program). Reductions in provider reimbursement were also considered.

In the end, Alabama adopted the following Medicaid cost saving measures:

- Tightened the nursing home asset transfer penalty so that individuals who transfer assets to qualify for Medicaid have a longer waiting period for benefits;
- Limited drug coverage for adults to 4 brand name prescription drugs per month; no limits placed on generic prescriptions;
- Implemented a therapeutic duplication edit for pharmacy claims which prevents a beneficiary from inappropriately receiving two drugs from the same class of drugs at the same time without a prior approval;
- Suspended the state's primary care case management program⁹;
- Contracted with private firms to check for availability of third-party liability and for fraud.

In contrast with Medicaid, the state's SCHIP program—All Kids—did not fare as well. In September 2003, just after the tax reform plan was voted down, Alabama froze enrollment in All-Kids and established a waiting list. The state also reduced outreach for the program.

According to Alabama officials, the capping of enrollment was in response to the state's general budget problems. It was also done to help the state get a handle on the costs of the new program, especially prescription drug costs, which had been increasing at a rapid rate. Beginning in March 2004 the state gradually took children off the waiting list and re-implemented a media campaign to promote program enrollment. Then, in August 2004, near the end of the fiscal year, the enrollment cap was officially lifted.

Budget Debates and Decisions in Fiscal 2005

As the state began its fiscal 2005 budget deliberations in January 2004, Alabama saw revenue growth in funds that support the ETF but not in revenues that support the GF. Reflecting this fiscal picture, Governor Riley proposed increasing education spending by \$111.6 million to \$4.29 billion. Under the budget plan, virtually all parts of the state's public education would have received a boost, including K-12 education, two-year colleges and public universities. The governor also proposed funding a large statewide reading initiative.

In contrast with the ETF, the outlook for the GF was much less positive. When Governor Riley introduced his fiscal 2005 in March 2004, GF revenues were running behind the same period in the previous year, and were well below state projections.¹⁰ Governor Riley proposed a mixture of revenue measures and program cuts to balance the GF. Overall the governor proposed to increase GF spending by 4.7 percent to \$1.33 billion. While Riley's plan called for several revenue measures, it avoided raising general, broad-based taxes on individuals or corporations. According to press reports, with the defeat of the tax reform measure in 2003, the governor felt that Alabamians had made it clear that they did not want their taxes increased and designed his budget accordingly.¹¹

Among other things, Riley proposed raising the nursing home bed tax, which, as discussed above, passed in May 2004 and was used to fund the fiscal 2004 Medicaid shortfall. He also called for increasing a number of fees (such as advertisers fees on billboards and court fees), as well as raising cigarette taxes. Proposed revenue actions also entailed the use of one-time strategies (such as windfalls from lawsuit settlements), transferring surpluses from other funds to the GF, and shifting the last fiscal 2005 pay period for state workers to the 2006 fiscal year.

For cost-cutting measures, the governor's GF plan called for several measures to limit spending on state workers, including eliminating merit and pension increases and raising health insurance premiums for state employees. In addition, Riley proposed cutting many state programs 7 percent below their fiscal 2004 appropriations. Agencies slated for cuts included the legislature, the agriculture department and the governor's office. Following significant cutbacks in fiscal 2004, Riley proposed eliminating funding for non-state organizations such as privately sponsored or owned museums or parks.

On the other hand, modest increases were proposed for some agencies, including prisons (a 1 percent increase was proposed) and the court system (a 7 percent increase proposed). Importantly, increases (sometimes substantial ones) were proposed for the state's major health and welfare programs, including human resources, the department of mental health and the department of public health, which is the agency responsible for administering All Kids, Alabama's SCHIP. By far, Governor Riley proposed the largest spending increase for Medicaid. Specifically, the governor's proposal called for increasing Medicaid GF spending by 60 percent to \$347 million, up from \$220 million in fiscal 2004.

According to state officials, there was a strong sense within the executive staff that Medicaid should be protected to the greatest extent possible. Medicaid faced an estimated GF shortfall of \$182 million in fiscal 2005, which was attributed to several factors—the loss of federal fiscal relief Medicaid funds, the loss of federal funds that had been obtained through UPL payment mechanisms, a drop in the state’s FMAP rate for fiscal 2005, as well as general program growth due to enrollment increases and inflation.

While Governor Riley proposed giving Medicaid a \$127 million increase, it did not cover the entire \$182 million spending gap. The balance of the shortfall was to be made up by program cuts (not specified in the governor’s budget) and revenue from a proposed increase in the nursing home bed tax.

Study informants stated that the legislature also had a strong desire to protect Medicaid in 2005 budget session. Indeed, in the midst of the budget debate, the chairman of the House of Representatives General Fund committee, John Knight (D-Montgomery) was quoted as saying if a spending measure, “is not earmarked for Medicaid, it doesn’t stand a chance of passing.”¹² The GF budget was approved at \$1.4 billion up 16 percent (or \$196 million) from the 2004 budget. The bulk of the new funds (\$144 million) were appropriated to Medicaid.

Most of the budget cuts the governor proposed were approved. There were some exceptions with an important one being benefits for state employees: While the budget did not contain cost-of-living raises for state agency employees, it did fully fund state employees health benefits, which was a contentious issue during the budget debates. Many of the governor’s proposed revenue measures were also approved, although sometimes with adjustments. For example, the governor had proposed increasing the nursing home bed tax by \$1400 whereas the legislature approved only a \$700 tax increase.

For Medicaid, the legislature increased the governor's proposed budget by \$16 million so that GF appropriations totaled \$364 million, an increase of \$144 million compared to fiscal 2004. After accounting for the other state funds, total state appropriations for Medicaid increased from \$771 million in fiscal 2004 to \$991 million in fiscal 2005, or a 28 percent increase. The rest of the Medicaid shortfall was filled by continued cost savings from programmatic changes enacted in fiscal 2004. So, the vast majority of Alabama's 2005 Medicaid budget gap was filled by new revenue rather than program cutbacks.

Some changes were made to Alabama's SCHIP program. Among others, the program received full year funding for a media campaign and the state developed a new online application system. As a cost saving measure, enrollee cost-sharing was increased.

Conclusions and Outlook for Fiscal 2006

Over the time period encompassing fiscal 2003 to 2005, Alabama experienced major budget problems, especially in balancing its GF account. In each of the three study years, the GF shortfall increased so that by fiscal 2005 the state faced nearly a 25 percent gap between projected revenues and spending. To fill the budget deficits, the state cut program spending and implemented a wide range of revenue strategies, from accounting strategies (which maximized federal Medicaid funds) to one-time revenues to increasing fees and provider taxes. Importantly, although the state had tried to increase general taxes as part of 2003 tax reform proposal (which was resoundingly defeated by voters), Alabama did not raise broad-based consumer or corporate taxes during fiscal 2003-05.

Over the study period, the mix of the strategies used to balance revenues and spending demands changed. In fiscal 2003, the state relied heavily on one-time revenue strategies (*e.g.*,

using settlement funds received from litigation and rainy day funds as well as federal fiscal relief) to fill the GF deficit while largely avoiding making significant program cuts.

In fiscal 2004 Alabama's fiscal picture declined yet further and to balance the GF the state relied primarily on program cuts. Many programs saw substantial cuts with some losing half or more of their funding. Medicaid's GF appropriations, however, remained largely intact in part because of the federal fiscal relief package that provided a temporary increase in federal spending on Medicaid. Even with the broad and significant program cutbacks, Alabama had to make a supplemental appropriation about half way through fiscal 2004. The mid-year adjustment was targeted at Medicaid, and was funded by a dedicated increase in provider taxes and partly by an increase in cigarette taxes. In addition, the state implemented some cost saving measures in Medicaid but major eligibility or benefit cuts were avoided.

In fiscal 2005 Alabama had to contend with another budget deficit, particularly in funding for Medicaid. In contrast with the previous two years, lawmakers enacted a mix of revenue strategies and program cutbacks to balance the fund. For revenue actions, the state used several, including raising a number of fees, increasing provider taxes, as well as one-time revenue strategies and accounting gimmicks. For program cuts, many agencies saw steep decreases in their GF appropriations, with some organizations (non-state ones) completely losing their state funding. General funding for Medicaid, however, was not only preserved but was increased substantially in the fiscal 2005 budget. Combined Medicaid appropriations from the GF and the other state fund increased by nearly 30 percent between fiscal 2004 and 2005.

In sum, over the 2003-05 period Alabama lawmakers made Medicaid a fiscal priority. Although some cutbacks were implemented during the period, Alabama substantially increased state funding for Medicaid substantially. However, the spending increase did not expand

Medicaid but was done to avoid major program reductions. Respondents acknowledge that Alabama does not have a "Cadillac" Medicaid program and that little can be cut from it without the state falling out of compliance with federal Medicaid rules. Nevertheless, the state did consider making some major changes (*e.g.*, eliminating drug coverage and reducing nursing home eligibility) but, in the end elected to raise new revenues to maintain the program.

Current state projections indicate that Medicaid will face another shortfall in fiscal 2006 estimated at about \$127 million. Among other things, the deficit is attributed to continued loss of UPL funding, another decline in the state's federal match rate, as well as general program growth and inflation. How Medicaid will fare in the 2006 budget is unclear.

Although Alabama officials report that the state has seen some economic growth in the last year, it has been in revenue sources that primarily support the ETF, which is expected to have a surplus in fiscal 2006. By contrast, the GF is expected to revenue less revenue in fiscal 2006 than the previous year. To maintain current program levels, the GF has a projected 2006 deficit of over \$255 million.¹³ In addition respondents noted that they have nearly exhausted many budget closing strategies used in recent years, such as one-time revenues and raising fees. Respondents also noted that raising broad-based consumer or corporate taxes is unlikely given the defeat of the 2003 tax reform measure. Without doubt, Alabama will face many difficult and complex budget and policy choices in 2006.

Endnotes

¹ State Health Facts. 2004a. “Alabama: Total (federal and state) Medicaid Spending per Enrollee, FFY 2000.” www.statehealthfacts.org (13 November 2004).

² State Health Facts. 2004b. “Alabama: Births Financed by Medicaid as a Percent of Total Births, 2000.” www.statehealthfacts.org (13 November 2004); Alabama Medicaid Agency. 2003. *Annual Report of the Alabama Medicaid Agency, FY 2003*. Alabama Medicaid Agency, Montgomery Alabama.

³ In addition, the state receives federal funds, which are appropriated across the education trust fund, the general fund and the other state fund. Among state agencies, Medicaid is the largest recipient of federal funds.

⁴ Alabama’s fiscal year runs from October 1 to September 30.

⁵ Moreover, the state portion of the estate taxes is to be phased out by fiscal 2005; the federal portion by fiscal 2010 (Alabama Legislative Fiscal Office. 2004. “Presentation for 2004 Regular Legislative Session.” 5 February). www.lfo.state.al/us/special-reports.html

⁶ Specifically, for IGTs, the Centers for Medicare and Medicaid Services have begun to question state use of transfer payments in Medicaid to ensure that states are fully contributing their share of Medicaid expenditures. For UPL, the 2001 Benefits Improvement and Protection Act called for changes in how states calculate UPLs for hospitals, nursing homes and other facilities. BIPA also set out various transition times for states to ensure that provider payments conform to the new UPL regulations.

⁷ Material presented in this section draws from Ormond 2004. (Ormond BA. 2004. “Alabama.” in *State Responses to Budget Crisis in 2004: An Overview of Ten States*, Holahan J. et al., Kaiser Commission on Medicaid and Uninsured, Washington D.C., January.)

⁸ Specifically, the act raised the federal Medicaid assistance percentage (FMAP) during the period of April 1, 2003 to June 30, 2004. For Alabama, the FMAP increase brought in an estimated \$47.5 million in fiscal 2003 and \$70.9 million in fiscal 2004. In addition to temporarily increasing states’ FMAP, the federal relief package granted \$10 billion (\$5 billion in federal fiscal year 2003 and \$5 billion in federal fiscal year 2004) to states for general budgetary relief.

⁹ Subsequently, Alabama’s PCCM program, called Patient First, was redesigned and is currently being reinstated with full implementation scheduled for February 2005.

¹⁰ Rawls P. 2004. “Riley Unveils Budgets to Negative Democratic Response.” *Associated Press State and Local Wire*, 5 February; White D. 2004. “Riley Eyes State Workers’ Insurance Plan Could Mean Higher Cost or Cut in Benefits.” *The Birmingham News*, 5 February.

¹¹ White D. 2004. “Riley Eyes State Workers’ Insurance Plan Could Mean Higher Cost or Cut in Benefits.” *The Birmingham News*, 5 February.

¹² Chandler K. 2004. “Panel OKs \$93 Million in Tax, Fee Increases.” *The Birmingham News*, 5 April.

¹³ Alabama Legislative Fiscal Office. 2005. “Presentation for 2005-06 Legislative Budget Hearings.” 6 January, www.lfo.state.al/us/special-reports.html.

Appendix A

List of Study Respondents

Alabama

Mary Finch, Alabama Medicaid Agency
Frank Gitschier, Alabama Legislative Fiscal Office
Carol Herrmann, Alabama Medicaid Agency
Mary Lawrence, Alabama Legislative Fiscal Office
Mike Lewis, Alabama Medicaid Agency
Drayton Nabers, Office of the Governor
James Tucker, Alabama Disability Advocacy Program
Mary Weidler, Arise Citizens' Policy Project

The Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG/KCMU

Additional copies of the full report (#7324) are available
on the Kaiser Family Foundation's website at www.kff.org.

