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Medicaid Budgets Under Stress: Survey Findings for State Fiscal Year 2000, 2001 and 2002

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

Medicaid, a joint federal-state program, provides health and long-term care coverage for over 40 million Americans. Medicaid is often the only source of health coverage available for low-income children, a critical support for people with disabilities in the community and the sole source of financial assistance for nursing home care. Federal Medicaid payments are projected to be $130 billion in fiscal year 2001, while state spending is estimated to be about $94 billion. Medicaid is the largest source of federal funds to the states accounting for 44 percent of all federal grants-in-aid in 1999.

Attention has focused on recent Medicaid spending growth. Although the growth in Medicaid spending has been substantially below the levels experienced a decade ago, it has stood out because it comes on the heels of historically low spending increases and revenues are beginning to decline is some states. The purpose of this study is to provide current information on Medicaid spending, identify the factors that states report are contributing to spending increases and describe the actions states are taking to limit spending growth. A survey of state Medicaid directors was conducted during May and June 2001 to examine details of each states' budget for the years 2000, 2001, and 2002.

This study finds that Medicaid expenditures are growing due to a number of factors, including medical inflation facing the health system generally, increased costs due to prescription drugs, "catch up" increases in provider payment rates, expansion of community-based long-term care, increased enrollment, and state efforts to refinance current state spending with more federal dollars. To meet Medicaid spending obligations in state FY 2001, 37 states provided supplemental funding beyond original legislative appropriations, typically drawing from a Medicaid trust or reserve fund or transfer of funds from other programs. The picture for FY 2002 looks bleaker because state revenues are declining and many states have been dipping into their year-end balances to address budget shortfalls. Twenty states are starting off FY 2002 anticipating that they have underfunded Medicaid. As of Summer 2001, states were not planning to cut back on eligibility or services, but were particularly concerned about the growth in pharmacy costs for elderly and disabled beneficiaries. However, the economic picture in many states is rapidly deteriorating and state Medicaid programs are headed toward a difficult period that could be exacerbated by an economic downturn.

Medicaid's Role in the States

Medicaid is a joint federal and state program that is administered by the states within federal guidelines. Each Medicaid program is different reflecting state priorities in coverage and benefits. Within the federal structure, states enroll beneficiaries using their own eligibility criteria, decide which services are covered, and set payment rates for providers. States also decide other key policies, such as which eligibility groups receive care within a managed care system, how the state will use Medicaid to finance a range of other medical services such as those provided through the mental health or public health systems, and special payments to hospitals that serve a disproportionate share of indigent patients.

State Medicaid programs currently provide health coverage to over 40 million Americans annually, or more than 12% of the U.S. population.[1] Medicaid provides health coverage for over 20% of all children in the U.S. Medicaid pays for the births of over one-third of all U.S. children. Almost three-fourths of all Medicaid beneficiaries are low-income children and their parents. Among the remaining one-fourth, about 10% are elderly, and about 15% are persons with disabilities. Medicaid is the single largest payer for long-term care, accounting for half of all nursing home spending and nearly 40% of home and community-based spending. While children and their parents comprise the majority of Medicaid beneficiaries, elderly and disabled beneficiaries account for 70% of Medicaid spending on benefits reflecting their greater health and long-term care needs.

Medicaid Provides Substantial Federal Funds to the States

The federal and state governments share in the financing of Medicaid expenditures. In fiscal year 2000, Medicaid spending totaled about $207 billion. This amount includes all State, local and Federal funds. Altogether, Medicaid helped to finance 73% of all State health spending. The federal share is determined annually based on a formula (known as the Federal Medical Assistance Percentage or FMAP) that adjusts for per capita personal income. The federal share currently ranges from 50 to 77% and averages 57%. Because of the matching formula, state spending on Medicaid brings increased federal dollars to the state. At a 50% matching rate, a state draws down one federal dollar for each state dollar it spends. At a 70% matching rate, a state draws down $2.33 in federal funds for every $1 it spends. Medicaid's matching formula provides an important vehicle for states to leverage federal dollars to increase funding for health and long-term care services.

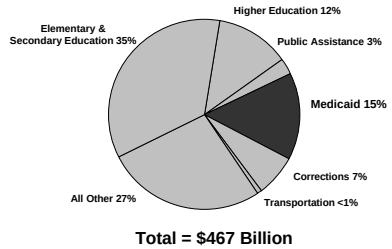
From a State fiscal perspective, Medicaid is a large program relative to the overall State budget. Federal Medicaid spending represents, on average, 15% of state general fund expenditures in FY 2000 and about 20% of all State spending, including general fund, and Federal funds (Figure 1).[2] Medicaid is the largest share of total federal grants to

[1] Data are for the most recent year for which HCFA data are available, Federal fiscal year 1998, and reflect the number of persons enrolled for one or more months during the fiscal year. Cited in: Christie Provost and Paul Hughes, "Medicaid: 35 Years of Service," Health *Care Financing Review,* Fall 2000 / Volume 22, Number 1. 141-174.

[2] National Association of State Budget Officers / Reforming States Group, *1998-1999 State Health Care Expenditure Report,* Milbank Memorial Fund, 2001.

states, comprising 44% of $222 billion in total federal grants in 1999 up from 26% in 1987 (Figure 2).[3]

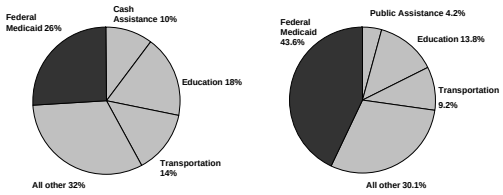
Figure 1: Medicaid Spending as a Percentage of State General Fund Expenditures, FY 2000



Total = $467 Billion

SOURCE: National Association of State Budget Officers, Fiscal Survey of States, June 2001.

Figure 2: Medicaid as a Share of Total Federal Grants to States, 1987 and 1999



Total = $108 billion 1987

Total = $222 billion 1999

SOURCE: National Association of State Budget Officers, 1999 State Expenditure Report, June 2000.

Medicaid expenditure growth can have an important impact on the overall fiscal condition of a State. If the growth in Medicaid general fund expenditures exceeds the growth in State revenues, less money may be available for other State programs. As shown in Table 1, the share of State budgets allocated to Medicaid increased during the early 1990s, but has actually remained fairly stable since 1995. However, as state revenue growth declines and Medicaid expenditures increase, this picture could change.

Table 1
Medicaid as a Share of State General Fund and Total
1987-2001

State Fiscal Year	Medicaid General Fund Spending as % of State General Fund Expenditures	Medicaid Total Spending as % of Total State Expenditures, all Fund Sources
1987	8.1%	10.2%
1989	9.0%	11.3%
1991	10.5%	14.2%
1993	13.3%	18.8%
1995	14.4%	19.8%
1997	14.6%	20.0%
1999	14.4%	19.5%
2001	14.7%	19.6%

Source: NASBO, *State Expenditure Report*, various years.

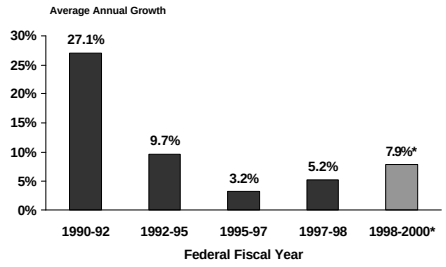
Recent Medicaid Spending Growth Reflects Program Priorities, Health Care Inflation, and State Financing Strategies

The current rise in Medicaid expenditures follows a period of unprecedented low growth in the Medicaid program due primarily to enrollment declines and restrictions on disproportionate share hospital payments. The period from 1995 to 1998 was characterized by a robust economy, rapidly dropping welfare rolls and a decline in the number of people enrolled in Medicaid. In addition, low health care inflation, state limits

[3] National Association of State Budget Officers, *1999 State Expenditure Report*, 2000.

on provider payments, and increased use of managed care resulted contributed to the slow growth in spending.[4] Between 1995 and 1997, the average annual growth rate in Medicaid expenditures averaged 3.2%, the lowest rates in the history of the program (Figure 3). [5]

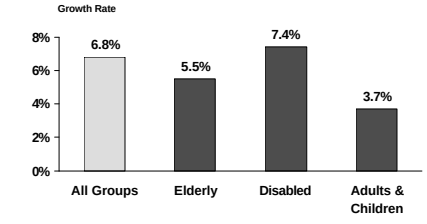
Figure 3: Average Annual Growth Rates of Total Medicaid Expenditures, 1990-2000



* Based on unedited HCFA-64 financial management reports.
SOURCE: Urban Institute estimates, 2001.

However, beginning in 1997, Medicaid expenditures began to grow again, averaging 5.2% from 1997 to 1998 and 5.5% from 1998 to 1999, with signs that spending was likely headed upward. [6] [7] Expenditures per enrollee increased by 6.8% between 1997 and 1998, with the growth greatest for the disabled (7.4%) and elderly (5.5%) and lowest for the adults and children (3.7%) (Figure 4).

Figure 4: Growth of Expenditures per Enrollee by Eligibility Group, 1997-1998



Note: Expenditures do not include DSH payments, accounting adjustments, or administrative costs.
SOURCE: Urban Institute estimates, 2000.

Since 1998, a number of factors have come together to generate higher rates of growth in Medicaid spending (Figure 5). Among the significant factors are:

[4] Bruen and Holahan, 2001. Also see: U.S. General Accounting Office, "Medicaid: Sustainability of Low Spending Growth is Uncertain," GAO Report No. HEHS-97-128 (Washington, DC: GAO, June 27, 1997).
[5] Brian Bruen and John Holahan, *Medicaid Spending Growth Remained Modest in 1998, But Likely Headed Upward*, Kaiser Commission on Medicaid and the Uninsured, February 2001.
[6] Brian Bruen and John Holahan, *Medicaid Spending Growth Remained Modest in 1998, But Likely Headed Upward*, Kaiser Commission on Medicaid and the Uninsured, February 2001. Publication 2230.
[7] National Association of State Budget Officers / The Reforming States Group, *1998-1999 State Health Expenditure Report*, Milbank Memorial Fund, 2001.

Figure 5: Converging Trends Are Causing Medicaid Expenditure Growth

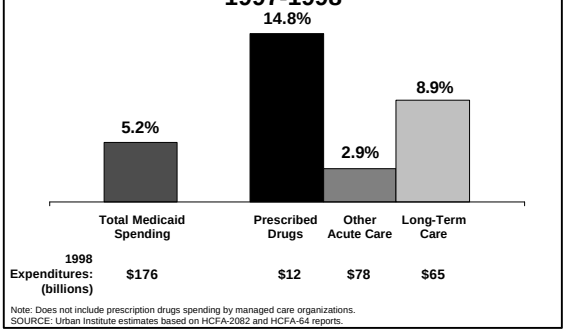
- **Increasing inflation in health care market**
  - Pressure to increase provider payments
  - Higher costs for brand and generic prescription drugs
- **Changing health care utilization**
  - Reliance on home- and community-based services
  - Greater use of prescription drugs, new technology
- **Expanding enrollment**
  - Eligibility expansions
  - Growth of the disabled population in Medicaid
- **Use of upper payment limit (UPL) arrangements**

SOURCE: The Kaiser Commission on Medicaid and the Uninsured, 2001.

- Health care price inflation in the general health care market place began to increase in 1999. At the same time annual increases in private health insurance premiums increased substantially. Medicaid must operate in the same health care market place as other health care purchasers. The forces that placed pressure on the private health insurance rates also placed pressure on Medicaid to increase provider payment rates, particularly in States that had not increased rates in several years.[8]

- An additional factor, however, was the substantial increase in spending for prescription drugs. Medicaid programs spent $11.7 billion for prescription drugs in 1998, a 14.8% increase over 1997 spending levels (Figure 6). Again, rising drug costs are not limited to the Medicaid program. However, because Medicaid covers a population in poorer health than the population in general, the program is particularly vulnerable to rising drug costs.

Figure 6: Average Annual Growth of Medicaid Spending for Selected Services, 1997-1998



Note: Does not include prescription drugs spending by managed care organizations.
SOURCE: Urban Institute estimates based on HCFA-2082 and HCFA-64 reports.

- There was a net decrease in the number of managed care organizations serving the Medicaid market. Those that exited the Medicaid market often cited lowMedicaid payment rates. Managed care organizations continuing to participate in Medicaid were able to secure significant increases in payment rates.[9]

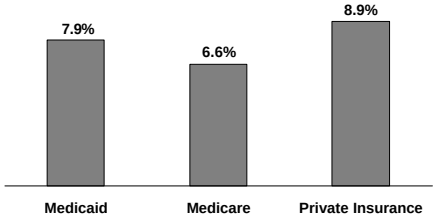
[8] Christopher Hogan, Paul B. Ginsburg, and Jon R. Gabel, "Tracking Health Care Costs: Inflation Returns," *Health Affairs*, Vol. 19, Number 6 (November/December 2000).

- Medicaid enrollment began to increase in 1999, reversing a three-year downward trend. U.S. Medicaid enrollment decreased in 1996, 1997 and 1998, for a total three-year decrease of 3.1%.[10] Over the twelve months from December 1998 to December 1999 Medicaid enrollment increased by 3.9%.[11] The State Children's Health Insurance Program (SCHIP) was enacted in 1997 and implemented by the States beginning in 1998. For the first time ever, States organized efforts to find and enroll low-income uninsured children in their SCHIP programs. These outreach efforts for SCHIP had a case-finding effect for Medicaid.[12] In many states, increasing the enrollment of low-income children became a policy priority. In addition, enrollment of the disabled who have considerably higher per capita costs also grew.

- An additional factor leading to greater Medicaid expenditure growth is the increase in "upper payment level" or UPL financing programs. In these programs, states pay rates that are higher than regular Medicaid reimbursements to publicly-owned facilities who return some of the extra payments to the state. The states get federal matching funds based on the higher payments, so they collect additional federal money without a net contribution of state funds. The result is an "expenditure illusion" in the sense that expenditures for Medicaid services appear to be higher than they really are. The number of states using UPL arrangements grew rapidly in 2000, although the federal government has now limited the amount of federal money that states can obtain through this mechanism.

The expected increase in Medicaid expenditures has materialized. States have reported Medicaid expenditure growth rates of 8.9% for state FY 2000 and 9.8% for state FY 2001. Rising health care costs are an important factor behind expenditure growth rates in Medicaid. As a large third party payer, Medicaid is very much affected by changes in the health care market in general. Health care costs and premiums are increasing for private and public payers, although Medicaid growth rates are lower than those in the private sector (Figure 7).

Figure 7: Projected Average Annual Growth Rate in Medicaid, Medicare, and Private Health Insurance, 2000-2005



SOURCE: HCFA, National Health Expenditures Projections, 2001

For example, in Michigan, Medicaid rates for HMOs were reduced through a bid process in 1997. In FY2001 HMO rates increased over 11%. See the Michigan text box later in this document. Also see: Susan Felt-Lisk. 2000.

[10] Bruen and Holahan, 2001.

[11] Eileen Ellis, Vernon Smith and David Rousseau, "Medicaid Enrollment in 50 States: June 1997 to December 1999, Kaiser Commission on Medicaid and the Uninsured, October 2000. Publication 2210.

[12] *CHIP Program Enrollment: December 1998 to December 1999*, The Kaiser Commission on Medicaid and the Uninsured, July 2000. Publication #2195

In many States, the higher growth rates for Medicaid expenditures occurred at a time when the original Medicaid appropriations were based on lower rates of growth. At the time they were made, the lower rates of growth were easily justified on the experience over the 1995-1999 period, and a confidence that managed care would now control Medicaid expenditures. In September 2000, Medicaid budget shortfalls were reported in seven States.[13] In December 2000, the National Conference of State Legislatures polled all the States and found that Medicaid expenditures were occurring at a pace that would exceed appropriations for State fiscal year 2001 in 23 States.[14] As State legislatures convened early in 2001, a number of States reported slower revenue growth and higher expenditure levels than had been anticipated when their 2001 budgets were adopted. In some cases, the increasing rate of expenditure in Medicaid budgets was seen as a contributing factor to overall State budget problems because of the size of the Medicaid budget shortfalls,[15] although budget shortfalls were occurring in other programs as well, including corrections and K-12 education.[16]

State Medicaid Appropriations and Budgeting Procedures

By law, the Medicaid program, like any other state program, can only spend funds that are appropriated. Legislative appropriations at the start of the state fiscal year do not always match realized expenditure levels. Budget forecasting is subject to uncertainty and the actual budget need can fall within a wide range. In determining the state budget, policymakers weigh the consequences of over-budgeting versus under-budgeting Medicaid. An over-allocation of funds for Medicaid could mean fewer funds available for other programs. On the other hand, an under-allocation of funds toward Medicaid that becomes apparent later in the fiscal year could result in the need for additional appropriations, particularly if it is too late in the year to make policy changes that would reduce expenditure levels for that year. Because Medicaid is an entitlement program, the state is required to pay for covered services that are provide to persons who are enrolled.

In some cases, policymakers recognize the possibility that the initial appropriation for Medicaid may not be the final appropriation because of the difficulty of forecasting the exact amount needed for the budget year. The legislature and the executive branch will track Medicaid expenditures through the year, update their forecasts as data become available for actual monthly expenditures, and then near the end of the year when the actual need is more certain determine if a supplemental appropriation is necessary. In other cases, the legislature makes an appropriation based on the best forecast of need, expects that amount to be sufficient for the year, but actual expenditures exceed expectations. This creates an unexpected need to align expenditures with the authorized funding level.

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[13] Charles Ornstein, "New Cost Problems Plague Medicaid--Rising enrollment, drug costs among causes as Texas, other States face budget overruns." *Dallas Morning News*, September 23, 2000. 1A.

[14] National Conference of State Legislatures, *State Fiscal Outlook for 2001*, December 2000. The 23 States included: AZ, CO, CT, DE, FL, GA, ID, IL, IN, KY, ME, MD, MA, MO, MT, NM, NC, OH, OK, TX, VT, VA, WA.

[15] Pamela Belluck, "Free Spending in Flush Times Coming Back to Haunt States," New York Times, March 19, 2001, A14.

[16] As of February 2001, 31 States expected to make supplemental appropriations for fiscal year 2001 for various State programs, such as corrections or K-12 education. National Conference of State Legislatures, State Fiscal Outlook for 2001, February Update, as updated March 8, 2001.

A Medicaid budget shortfall is said to occur when Medicaid spending for the State's fiscal year exceeds the amount the legislature authorized in the Medicaid appropriation for that year. The entitlement nature of Medicaid makes it more difficult to interpret a budget shortfall. Policy makers know that ultimately the full obligations of Medicaid will be paid, even if they were not fully authorized in the original appropriation. In a given budget situation, a legislature might even intentionally underfund Medicaid, expecting to return later in the fiscal year to resolve an anticipated budget shortfall when the actual budget requirements for the year are more certain.

A more difficult situation occurs when a budget shortfall is entirely unanticipated. This would occur when actual expenditures exceed expectations even when policy makers were confident that the amount would be sufficient for the year because the legislature made its original appropriation for Medicaid based on what were regarded as reasonable assumptions about the future. This creates an unexpected need to adjust expenditures or the authorized funding level, or both. When the budget shortfall is identified well into the fiscal year, as often occurs, there is insufficient time to adjust the pace of spending. The only alternative may be to find a source of funds to cover the Medicaid obligations.

When expenditures exceed appropriations, policymakers can reduce expenditures, increase the budget, or (in some states) shift the costs to a future year. Reducing expenditures typically involves reductions to covered benefits, provider payment levels, or eligibility levels for beneficiaries. Implementation of any of these strategies takes time and may be politically infeasible during the course of a fiscal year. Similarly, shifting costs to a future year may not be an option. Most states use an accrual accounting method for Medicaid where the financial obligation is booked in the year in which the service was rendered, not year in which the payment occurs. However, in states that use a cash accounting method for Medicaid, provider payments may be deferred to the next fiscal year, when additional funds would be available. In states with a biennial budget, it may be possible to spend funds in the first year of the biennium that were otherwise intended for the second year.

If sufficient expenditure reductions or payment deferrals are not accomplished, it is necessary to secure additional funding. Usually this is accomplished by a legislative appropriation of supplemental funds (sometimes referred to as a "deficiency appropriation"), drawing from a special Medicaid reserve or trust fund or transferring funds to Medicaid from other programs. In some states, it is common practice for Medicaid officials to return to the legislature part way through the fiscal year to report on current expenditure trends and to request a supplemental appropriation of necessary (Exhibit 1). In a few states, the legislature and the executive branch have created a formal process to fund Medicaid. On prescribed dates, a special consensus meeting is held to reach agreement among budget forecasters on the amount needed to fully fund the program as it has been defined by law. The legislature then assures that the necessary funding is available.

Exhibit 1

Budgeting Procedures: Comments of State Medicaid Officials

"In our State, shortfalls are a standard procedure. (Legislature appropriated $38 million less than agency projected in 2000.)"

"Medicaid is the balancing act for the State budget. The legislature funds us to the extent they are able."

"We did not start off 2001 as a fully funded program."

"In our State, the legislature appropriates on the basis of available funds. Almost all the cuts have to be borne by education and Medicaid, because the rest of State government is statutorily protected."

"Most of our shortfall comes from deliberate underfunding. If you look at the growth rate, Medicaid is budgeted to grow 5% to 6% per year, but it has been growing every year 10% to 11%."

"Yes, [we expect a shortfall], it is the general way things are done. We just expect it every year. We budget Medicaid very tightly."

"The budget practice is to use a revenue and caseload estimating conference."

"Technically, we cannot have a shortfall because we use a "consensus process for estimating Medicaid and TANF. However, actual expenditures are coming in above the original consensus estimates."

According to the National Conference of State Legislatures, the original legislative appropriations for Medicaid for State fiscal year 1999 reflected average annual increases of 3.7%. However, the actual rate of growth in total Medicaid spending for 1999 turned out to be 5.5%[17], after the necessary mid-year supplemental appropriations. For State fiscal year 2000, the average Medicaid budgeted increase was 4.2%.[18] State budget officers reported actual Medicaid spending growth in State fiscal year 2000 of 8.9%.[19] These percentage differences between the original legislative appropriation and realized expenditure levels can be very large dollar amounts that are of major significance to State budgets.

Methodology

This study is based on a survey of all Medicaid programs to examine current state Medicaid expenditure trends, factors contributing to higher Medicaid spending, and steps states are taking to deal with them for three specific years: last year (state FY 2000); the current year (State FY 2001, that was closing as this study was conducted); and next year (state FY 2002, for which budgets were being developed as this study was conducted). [20]

[17] NASBO / Reforming States Group, 2001.
[18] "Medicaid Spending on the Rise Again," *State Budget & Tax News*, National Conference of State Legislatures, Volume 19, Number 24, December 15, 2000.
[19] National Association of State Budget Officers, The Fiscal Survey of the States, June 2001. Table 9.
[20] State fiscal years run from July 1 to June 30 for all States except four: Fiscal years begin on April 1 in NY, September 1 in TX and October 1 in AL and MI.

A five-page survey was designed and sent to all Medicaid directors in late April 2001. The survey instrument is attached in Appendix A. Each Medicaid director was then contacted to schedule a structured telephone discussion, using the survey instrument as a discussion guide. The telephone interviews were conducted during the months of May and June 2001. Medicaid agencies completed the surveys during May and June 2001. In about two-thirds of the states, the survey was completed in the course of the scheduled interview with the Medicaid director. In other states, the interview was conducted with a person designated by the Medicaid director, usually the person responsible for the Medicaid budget. In ten states, the Medicaid agency submitted the completed survey and did not participate in a telephone interview to discuss the responses. Fifty states completed the survey. Results were compiled in June and July 2001.

Conducting this survey provided insight into the variations among States in how Medicaid is defined, budgeted and appropriated at the State level. The term "Medicaid budget" was found to vary in its meaning among States. Some Medicaid officials were able to provide information about all services financed with Medicaid funds. Others would have found that very difficult or impossible, but they were able to provide information about the portion for which they were responsible. Some had budget data for vendor payments for medical services, while others included payments for services provided through the public health or mental health systems. Because States budget Medicaid differently the same definition could not be applied to all States. For this study, the focus was on annual rates of change so it was sufficient to ensure that same definition was used for all three survey years. Because the definitions varied from State to State, no attempt was made to add the budget totals for all States. The definition used by Medicaid officials for this survey may also not be the same definition used by the State budget agency or legislative fiscal offices.

Survey Results

State Budget Appropriations for State Fiscal Year 2000 and 2001

When forecasting expenditure trends and developing budgets, state policymakers tend to give greater weight to recent experience. The low spending growth rates of the late 1990's may have resulted in initial appropriations that were below actual spending in state FY 2000 and 2001. A number of states reported that they did not start off state FY 2000 or 2001 with Medicaid as a fully funded program and, therefore, the need to appropriate additional money for Medicaid later in the year was not unexpected. In both state FY 2000 and FY 2001, the original legislative appropriations for Medicaid were below the actual rate of growth in total Medicaid appropriations and supplemental appropriations were made (Table 2).

Table 2

States Reporting Medicaid Shortfalls: FY 2000 and FY 2001			
State	Was there a Medicaid budget shortfall in SFY 2000?	SFY 2001 Medicaid Shortfall in State General Fund (in millions of dollars)	SFY 2001 Medicaid State Shortfall as % of State General Fund Medicaid Budget
Alabama	No	66.0	15.6%
Alaska	Yes	9.3	6.5%
Arizona	No	20.1	4.1%
Arkansas	No	No	---
California	Yes	No	---
Colorado	Yes	17.0	1.8%
Connecticut	No	71.6	6.3%
Delaware	Yes	17.8	8.3%
Florida	Yes	260.0	7.0%
Georgia	Yes	71.3	5.8%
Hawaii	No	No	---
Idaho	Yes	33.4	19.7%
Illinois	Yes	200.0	NA
Indiana	Yes	73.3	7.2%
Iowa	Yes	19.9	4.5%
Kansas	Yes	13.6	5.5%
Kentucky	No	No	---
Louisiana	Yes	21.6	2.5%
Maine	Yes	9.0	2.7%
Maryland	Yes	196.8	18.2%
Massachusetts	Yes	118.5	5.3%
Michigan	No	No	---
Minnesota	No	12.0	0.7%
Mississippi	No	No	---
Missouri	No	No	---
Montana	Yes	6.8	6.2%
Nebraska	Yes	3.2	0.9%
Nevada	No	No	---
New Hampshire	No	NA	NA
New Jersey	No	No	---
New Mexico	Yes	38.8	16.2%
New York	No	No	---
North Carolina	Yes	113.0	6.8%
North Dakota	No	1.8	2.4%
Ohio	Yes	237.0	9.7%
Oklahoma	Yes	9.7	2.0%
Oregon*	NA	12.0	1.9%
Pennsylvania	Yes	30.2	0.9%
Rhode Island	Yes	20.0	5.3%
South Carolina	Yes	2.0	0.5%
South Dakota	Yes	2.4	2.5%
Tennessee	No	2.4	0.1%
Texas	Yes	400.0	10.0%
Utah	No	No	---
Vermont	No	1.1	0.8%
Virginia	Yes	46.2	3.3%
Washington	Yes	170.0	15.9%
West Virginia	No	No	---
Wisconsin	Yes	17.7	1.7%
Wyoming	Yes	9.2	11.8%

Notes to Table 2: For SFY 2000 NA indicates State response was that specific information was not available because this was the second year of biennium and. For SFY 2001 NA indicates no response to this question; States reported original appropriations and final expenditures in both general funds and total amounts. These values were used to calculate shortfall amounts.

Legislative Appropriations and Medicaid Expenditures

For state FY 2000, 20 out of 50 states reported that actual expenditures were in line with original legislative appropriations. In the remaining 30 states, however, expenditures exceeded original legislative allocations. Oftentimes, these shortfalls were anticipated (Exhibit 2). In every case, states covered the additional expenditures through a supplemental appropriation or by drawing from a special Medicaid reserve fund. In at least two states (Kansas and Rhode Island), a formal consensus process assured adequate funding for Medicaid. The amount established through this consensus process is automatically authorized for Medicaid.

Exhibit 2

FY 2000: Comments of Medicaid and Budget Officials.

"In State FY 2000, pharmacy costs again increased far faster than any other service type and was the single most significant factor influencing Medicaid costs."

"In FY 2000, we made budget adjustments, transfers from other programs, used $60 million from the Medicaid Trust Fund and delayed the last check in 2000 into 2001."

"The budget shortfall was partly expected. Enrollments increased, and the appropriation was not what was requested. Certain cuts were not implemented. A drug manufacturer lawsuit prevented some pharmacy cost containment initiatives."

"From 1992 to 2000 the budget was flat due to State revenue issues. In 2000 Medicaid had to borrow from other health programs for increased nursing home rates, the costs of pharmacy, and to improve community services."

For state FY 2001, 13 out of 50 states reported that original legislative appropriations were in line with actual expenditures. In the remaining 37 states, actual expenditures exceeded original legislative appropriations. On average, expenditures that exceeded original appropriations comprised 6.1% of the Medicaid general fund budget and ranged from .1% to 19.7%.

State Medicaid officials reported the rates of growth in Medicaid general fund spending and general fund spending for the entire state (Table 3). Based on information provided by state Medicaid officials, Medicaid program expenditures, on average, increased faster than overall state expenditures in state FY 2000 and 2001. In state FY 2000, Medicaid general fund expenditures growth was 7.7%, compared to 5.6% for all state general fund expenditures. In state FY 2001, Medicaid general fund expenditure growth was 9.9% compared to 7.1% for overall general fund expenditures.

Table 3: Average Increases in Total Spending vs. Medicaid Spending, FY2000-2002

State Fiscal Year	Number of States Reporting	Average Increase in Medicaid Spending (General Fund Dollars)	Average Increase in Total State Spending (General Fund Dollars)
2000	32	7.7%	5.6%
2001	34	9.9%	7.1%
2002 Proposed	29	11.1%	7.4%

Source: Health Management Associates State Survey May/June 2001

Medicaid grew faster than the overall State general fund budget in about two-thirds of the States in State FY 2000 (67%) and in FY 2001 (68%). Medicaid general fund spending was projected to grow faster than the overall State general fund budget in three-fourths of the States in State FY 2002 (76%). Exhibits 3 and 4 describe the budget experience in Illinois and Michigan.

Exhibit 3

Illinois Case Study: Budget Expansions and Cost Containment

"In State FY 2000, Illinois was forced to contend with a Medicaid program that was expanding eligibility to aged and disabled populations, enrolling more children through SCHIP, and yet still ensuring adequate reimbursement rates to hospitals, long term care facilities, and physician providers. The FY 2001 Budget Agreement reached by the Governor and legislature provided additional reimbursements to hospitals for tertiary care, cost-of-living adjustments for long term care and non-institutional providers while staying committed to AABD [Aged, Blind and Disabled] and children's health enrollment growth. Yet, while addressing new budget initiatives, Illinois had to deal with ever-escalating pharmacy costs that in FY 2000 had grown by more than 22%. The combination of increased caseloads, especially AABD caseloads, relatively modest provider reimbursement increases, and large annual drug liability increases, drove the FY 2001 budget beyond manageable levels."

"In December 2000, Illinois enacted a number of cost containment measures necessary to bring the Medicaid program back to more manageable levels. These measures included reductions in prescription drug dispensing fees, changes in prescription drug pricing, expanded drug prior approval and utilization review, delayed implementation of the hospital tertiary care reimbursement initiative, and limitations of hospital reimbursements to the lesser of charges or allowable payments. Combined with other control measures, the estimated savings to the Medicaid program were projected to total $100 million in FY 2001." --Excerpted from written survey response.

Exhibit 4

Every Budget Year Is Different– A Michigan Example:

Medicaid budget situations change so quickly that a very different picture can emerge from one year to the next. Michigan provides a good example, looking at the three fiscal years 2000, 2001 and 2002.

In fiscal year 2000, Michigan increased payments to HMOs, physicians and hospitals by an average of 4%. For physicians, this was the first rate increase since 1991. For HMOs the increase was a significant change from the 1997-1999 period, because Michigan had decreased HMO rates through competitively bid prices and curtailment of rate increases.

In fiscal year 2001, physician payments were increased by an average of 7% and most hospital rates increased by 4%. HMO rate increases averaged more than 11% as a result of a "re-bid" of managed care rates. These were some of the largest provider rate increases ever granted by Michigan Medicaid. They were justified by the fact that most Michigan HMOs were losing money, higher pharmacy costs and their need to cover higher rates paid to providers. While not every HMO bid was accepted, the average accepted bid reflected an increase of 11.8%.

In fiscal year 2002 the Executive budget originally included 2% rate increases for providers. During the legislative session, State revenue estimates declined and this recommendation was revised to freeze provider rates at 2001 levels. The legislature adopted the provider rate freeze.

Each of these years -- the reductions in the 1997 – 1999 period, the 4% increase in fiscal year 2000, the 11.8% HMO rate increase in fiscal year 2001 and the 0% increase in fiscal year 2002 – reflects the continuous change that occurs in the State budget and Medicaid situations.

Factors contributing to the growth in Medicaid expenditures in 2001

Medicaid officials were asked to identify the key factors contributing to the growth of Medicaid expenditures in SFY 2001. State officials listed many factors that were contributing to increasing Medicaid expenditures (Table 4). The following four were listed most frequently by State officials when asked specifically to list the top two or three factors causing the increases in Medicaid costs in their State:

- Prescription drug cost increases
- Provider rate increases
- Enrollment increases
- Long-term care cost increases

Table 4: Factors Contributing to Increases in Medicaid Expenditures for FY 2001

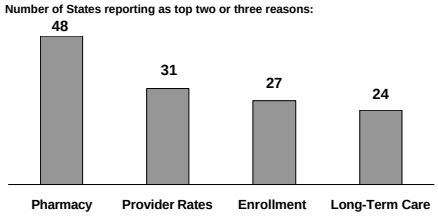
Alabama	Pharmacy (19.9% increase), managed care enrollment (3.7% increase), some physician rate increases. Other increases are due to better claims processing (claims up 55%).
Alaska	Home & community-based services (HCBS) waiver and other non-institutional LTC programs (43% cost increase), pharmacy (19% cost increase), and hospital payments (14% cost increase).
Arizona	Pharmacy (18% increase), inpatient hospitalization (3.4% increase), enrollment increases (enrolling state-only members in Medicaid and an increase in 1931 enrollment), home and community-based services waiver (8.8% -12% inflation), transportation (3.2% inflation).
Arkansas	Pharmacy (17% growth), nursing homes, upper payment limits for state teaching hospitals.
California	Pharmacy (18% increase per unit), outpatient hospital (14% increase), nursing homes, physician rates (6% increase), enrollment (3.5% increase).
Colorado	Pharmacy (18% increase) increased home health utilization.
Connecticut	Pharmacy (20% increase), nursing home and home health care (labor shortage and subsequent wage inflation), increased utilization of services (both Fee-for-service and managed care), increase in hospital rates.
Delaware	Pharmacy (21.9% increase), nursing homes (16.4% increase), enrollment increases (mainly due to SCHIP outreach and expanded coverage for pregnant women).
Florida	Inpatient and outpatient hospital (32-34% increase), pharmacy (12.9% increase), nursing homes (8.9% increase).
Georgia	Pharmacy (increased use of single source brands), increased enrollment (TANF add-backs, more disabled), LTC/institutional care (increased rates).
Hawaii	Pharmacy (25% increase).
Idaho	Enrollment (28.3% increase), surge in CHIP and children's programs, increased outreach for CHIP.
Illinois	Pharmacy (large annual drug liability increases), increase in caseloads (due to expanding eligibility (especially for Aid to the Aged, Blind, or Disabled (AABD) and children), increase in provider rates.
Indiana	Pharmacy (21% increase), nursing homes (6% increase), enrollee increase (10.8%).
Iowa	Pharmacy, outreach (40% of applicants to SCHIP are referred to Medical Assistance Division).
Kansas	Pharmacy, home health transportation, increased enrollment (about 50% of cost increase).
Kentucky	Pharmacy, inpatient hospitals (policy change for 0-stay days), increase in enrollment due to aging population, and increased outreach of TANF cases and children.
Louisiana	Pharmacy (16% increase), enrollment (11.7%).
Maine	Pharmacy, enrollment expansion for kids, non-institutional care (social services residential care, mental health services for kids, adults, ICF-MR, and private non-medical institutions).
Maryland	Pharmacy, enrollment.
Massachusetts	Pharmacy (14%), managed care rates (22%), long term care and nursing home rates (22%).
Michigan	Pharmacy, provider rate increases.
Minnesota	Home & community-based waiver and other non-institutional LTC programs (41.7% increase), pharmacy (11.2%), nursing homes (13.3%).
Mississippi	Pharmacy (31% increase), Poverty-level aged and disabled (PLAD) expansion (17% increase).
Missouri	Increases in pharmacy costs, enrollment, disabled caseloads.
Montana	Pharmacy (18.5% increase), mental health, enrollment increases (up 5,000 children and 500 disabled).
Nebraska	Pharmacy (16% increase), nursing homes (8.4% increase), sharp increases in enrollment.
Nevada	Pharmacy (14% increase), inpatient hospitalization (13% increase), outpatient hospitalization (12% increase).
New Hampshire	Pharmacy (increases in utilization and cost of product), outpatient hospital cost settlements, poverty level and CHIP increases.
New Jersey	Pharmacy (16% increase), managed care (30% increase), dental costs, home health costs.

New Mexico	Pharmacy (23.9% increase), enrollment changes including doubling of SCHIP participants, physicians' fee increases, home & community-based waiver (personal care costs increase of $45 million).
New York	Pharmacy, nursing homes and community-based services, rate increases (e.g. dental), and eligibility increases (Family Care Plus waiver will add eligibility for persons aged 19-64).
North Carolina	Increases in number of services (units) per eligible, increase in cost per unit especially for drugs, physicians, and hospital inpatient services.
North Dakota	Pharmacy (13% increase), nursing homes (8% increase), outreach for CHIP has increased enrollment.
Ohio	Pharmacy (22.5% increase), nursing homes (9% increase), enrollment (13% increase).
Oklahoma	Provider rate increases (12% payment increases for pharmacy and hospitalization, 36% increase for nursing homes) and caseload increases.
Oregon	Pharmacy (17-20% increase), enrollment increases, changes in composition of Medicaid enrollees including increases in higher cost groups.
Pennsylvania	Managed care (7.3% increase), pharmacy (16.1% increase), enrollment increases (due to welfare reform).
Rhode Island	Pharmacy (16% increase), behavioral health, enrollment increases for kids and disabled.
South Carolina	Pharmacy, hospital rate increases, higher utilization of services.
South Dakota	Pharmacy, inpatient hospitalization, increases in number of enrollees.
Tennessee	Changes in number of people enrolled (temporary restraining order on disenrollment of waiver population), and pharmacy (double-digit growth).
Texas	Pharmacy (increase in number and average cost of prescriptions), slight shift in caseload toward aged and disabled and medically needy.
Utah	Pharmacy (18-20% increase), inpatient hospitalization (utilization increase), managed care.
Vermont	Pharmacy (20% increase), nursing home ($5 million increase), enrollment (5% increase).
Virginia	Rate increases for providers.
Washington	Pharmacy (21.6% increase), caseload growth (6.2% increase in total eligibles), efforts to expand DSH and UPL programs.
West Virginia	Pharmacy (increase in utilization and 6% cost increase), increase in dental provider rates.
Wisconsin	Family-related caseload growth (majority of 4.6% Medicaid enrollment increase), pharmacy (9.7% increase), hospital payments (8.4% increase for inpatient and 5% increase for outpatient).
Wyoming	Pharmacy (15% increase), and mental health (almost 300% increase for inpatient psychiatric services and mental health under 21).

Note: This table is based on responses to the question: What are the two or three most significant contributors to the increase in Medicaid expenditures in State Fiscal Year 2001?

Prescription Drugs: The number one factor driving Medicaid budgets today is pharmacy costs. Pharmacy costs were mentioned as one of the top two or three key Medicaid cost drivers by 48 States, and 36 listed it first (Figure 8). Many Medicaid officials reported dramatic increases in prescription drug costs (Exhibit 5). States attributed pharmacy cost growth to increases in the number of prescriptions per enrollee and to inflation in the average cost of each prescription. States often mentioned annual rates of increase in their pharmacy costs of 15% to 20%, with thirteen States reporting annual increases between 20% and 31%. Several States mentioned that their Medicaid budget now spends more for prescription drugs than for inpatient hospital care.

Figure 8: Top Reasons Reported by State Medicaid Officials for Medicaid Expenditure Growth in FY 2001



SOURCE: Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured, June 2001.

Exhibit 5

State Medicaid Officials Report Substantial Increases in Pharmacy Costs

"Over half of our supplemental is due to pharmacy."

"Pharmacy – An increase in the number and average cost of prescriptions."

"Pharmacy was half of the increase the past two years, and still came in $25 million in general funds over budget."

"The largest impact has been pharmacy. It has been up 18% to 20% for each of the past three years. It has been about 10% price inflation and 8% to 9% in utilization per person, over the whole Medicaid program."

Provider payments: Almost two-thirds of the States (31) indicated that increases for inpatient or outpatient hospital services contributed to Medicaid expenditure growth in their States. 22 States mentioned managed care payment increases. In some States, physician and dental provider payment rates were increased for the first time in several years.

Long-term care: Nursing home rate increases and cost increases for home and community based services were mentioned as one of the top two or three factors in Medicaid cost growth in about half (24) of the States. Long-term care was listed a factor overall in about two-thirds of all States, particularly in States in the Northeast and upper Midwest. A number of States mentioned labor shortages as a contributing factor to cost pressures.

Number of persons enrolled: Over half of all States (27) listed increasing Medicaid enrollment as one of the top two or three top reasons for current Medicaid cost growth. Certainly, increasing enrollment is one of the most visible factors. Over eighty-five percent of States (43 out of 50) indicated that recent increases in Medicaid enrollment were contributing to current Medicaid cost increases. Most often States mentioned increasing enrollment of children associated with recent outreach initiatives for the State

Children's Health Insurance Program. States usually mentioned that children are relatively less costly than other groups, so the budget impact was proportionately less than the increase in their numbers. However some States also mentioned steady increases in the number of disabled adults as a cost driver. Increasing enrollment has been a goal of many state Medicaid programs reflecting the continuing on reaching low-income uninsured children, expanded coverage of the disabled, and reinstatement of low-income families who mistakenly lost coverage under welfare reform efforts (Exhibit 6).

Exhibit 6

State Medicaid Officials Report Gains in Medicaid Enrollment:

"Outreach is being done under the April 7 letter. We are paying their back bills and enrolling them."

"The average number of monthly eligibles exceeded the number budgeted by over 7,000."

"We think the percent of eligibles enrolled has increased from about 50% in the mid-1990s to about 80% now. We are getting people into these programs that were never in the program before. At the same time, the economy has taken many people off."

"We had expected a reduction in the number of TANF individuals, but we saw an increase. The disabled caseload is increasing, and they tend to be heavy users of prescribed drugs."

"We had steep increases in the number of enrollees. SCHIP brought in Medicaid enrollees also."

"Our Family Care Program is expanding rapidly. It just began in October 2000. In six months we have 101,000 enrollees now."

"We had a mandate from our legislature to be aggressive in getting eligibles enrolled. In 2001 we saw large increases in the number of enrollees. SCHIP participation doubled. In Medicaid we went from 305,000 to 325,000."

"It is not the entire cause of the Medicaid increase, but we have a whole lot more recipients than we thought we would."

Different Expenditure Growth by Caseload Component: About half of the States indicated that costs were increasing faster for some components of the Medicaid caseload than for others in fiscal year 2001.

Some states responded based on the fact that aggregate expenditures for a particular component of the caseload had increased faster than for other groups. Sometimes this was a group that includes heavier users of prescribed drugs, such as the disabled. The number of enrollees might not have increased substantially, but total costs were growing faster than for other groups. In other states large increases in the number of enrolled children resulted in a higher increase in aggregate costs for children than for other Medicaid groups, even though children are relatively less expensive on a per enrollee basis.

Other states responded based on the component of Medicaid with the greatest increase in per capita costs. These States indicated that per capita costs for the disabled were increasing at a faster rate than other groups of Medicaid enrollees (Exhibits 7 and 8).

Exhibit 7

State Medicaid Officials Report that Expenditures are Growing Fastest for Elderly and Disabled Beneficiaries

"For what eligibility group are expenditures growing fastest? Any group that uses prescription drugs, so that would be the disabled and the aged."

"The three most significant factors [in our State] in the increase in Medicaid spending in 2001: Prescription drugs, higher utilization and a slight shift in the caseload toward aged and disabled and medically needy."

Exhibit 8

Case Study: Ohio Medicaid Budget

"We were on target for the first nine months of the biennium. It just skyrocketed beginning in April 2000 and got progressively worse each month."

"Because Medicaid is such a large portion of the State's budget, OBM has traditionally asked [Medicaid] to update Medicaid projections during the budget deliberation process, so we can provide the most timely advice to the budget Conference Committee. As we review our Medicaid projections, we remain concerned that Medicaid caseload growth is strong and healthcare inflation continues to increase. For example, pharmacy costs are rising at a rate higher than assumed in the Executive Budget. Last week OBM Director Tom Johnson expressed to you his nervousness about our Medicaid figures. I want to echo his cautionary words to you once again today."

"The Medicaid caseload is exceeding budget projections for the biennium [ending June 30, 2001] at an estimated cost of $279.4 million…. The overall growth in Covered Families and Children reflects a previous reaction to welfare reform, when many families dropped their health coverage as they left cash assistance, even though their health coverage could have continued. This turnaround in enrollment has occurred in response to retraining county eligibility workers, to outreach efforts at the State and local levels to inform uninsured families about coverage options, and to legislatively – directed simplification of the eligibility process."

"Growth in nursing home costs is increasing at twice the rate of the original estimate from four percent to 8.5%. This translates into a budget shortfall of $105 million. Other ABD services are also experiencing higher cost and utilization. This increase includes hospitals, prescription drugs and community based services, including home care, durable medical equipment, private duty nursing and transportation"

--Excerpted from testimony of Barbara Coulter Edwards, Ohio Medicaid

Covered Services: Seventeen States indicated new or expanded coverage of services, including home and community-based services such as home health care and personal care. Coverage expansions generally were not regarded as a major driver of cost increases.

State Actions to Control Medicaid Cost Increases in 2001

States were asked to identify the policy actions they had undertaken in State FY 2001 to address the increases in Medicaid expenditures. State Medicaid programs are continuously seeking to obtain better value as purchasers in the health care market place. This involves a constant effort to adjust policies to contain and control costs, regardless of the State fiscal position.

However, State FY 2001 was not a year for aggressive cost containment actions by most State Medicaid programs, except for the focus on controlling pharmacy costs (Exhibit 9). Indeed, States seemed intent on protecting recent eligibility expansions for children, pregnant women and the working disabled. During FY 2001, 17 States indicated that they added or expanded coverage, including initiating the option for breast and cervical cancer. Several States indicated that they expanded eligibility of simplified the eligibility process. It is noteworthy that for FY 2001 no States mentioned reductions of covered benefits or eligibility levels to control costs.

Exhibit 9

State Medicaid Officials Maintained Coverage and Eligibility Expansions in FY 2001

"We are not interested in any service cuts at all."

"We will reduce the outreach for the SCHIP program to keep down the increases in enrollment, because we've been bringing in more Medicaid kids than we expected."

"There was no cost containment. We used tobacco dollars to increase dental rates and physician fees, to increase access."

"We saw an uptick at the end of 2000. That led us to a supplemental for 2001. With the supplemental that leaves us with enough to finish the year."

"Medicaid expenditures for 2001 slightly exceeded the appropriation, but this is not regarded as a shortfall because Medicaid had some funds left over from the first year of the biennium."

The common theme among States with a budget shortfall in FY2001 was that the Medicaid spending authorization was increased to reflect the increasing fiscal requirements of the program. The increased authorization was accomplished through a supplemental appropriation, drawing from a Medicaid trust or reserve fund or transfer of funds from other programs. Although not universally true, most States were in the fortunate position to have reserves and general fund balances that did not force Medicaid program reductions in 2001.

The following summarizes actions undertaken by States to control Medicaid costs in SFY 2001.

- Restrictions on prescription drug utilization and costs
- Limitations on provider rate increases (in some States)
- Increased use of managed care and other actions to contain costs or increase Federal revenues

Restrictions on prescription drug utilization and costs: Reflecting the priority on controlling prescription drug costs, the primary cost control measures were in this area. States moved to increase the number of brand name prescription drug products that would be subject to prior authorization, introduced new drug utilization edits, reduced pharmacy dispensing fees, limited the number of covered prescriptions per recipient per month, mandated use of generic products, instituted aggressive "Maximum Allowable Cost" (MAC) pricing, increased the discount from "average wholesale price" (AWP) and contracted with a Pharmacy Benefit Managers (PBM) to manage costs.

Limitations on provider rates: Provider fees were frozen in at least three States. Rates were cut 7% in one State. However, in most States provider reimbursement was increased during this period, including increases for hospitals, nursing homes, physicians and dentists.

Increased use of managed care: Most States are already using managed care extensively. At least one State mentioned expanded use of managed care as part of its approach to controlling Medicaid costs. Several States mentioned increases in managed care capitation payments as a factor in their increasing expenditure rate.

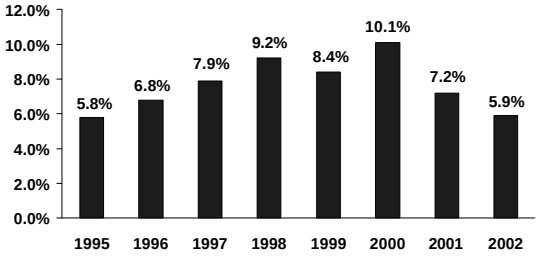
Other cost containment actions: Three States mentioned specific initiatives designed to improve program integrity and reduce fraud and abuse.

State actions to increase Federal revenue: In the past few years, a number of States have used Upper Payment Limit strategies to the State's financial advantage. The use of a UPL approach has an "expenditure illusion" effect as nominal Medicaid expenditures increase without an associated increase in State general fund expenditures or services provided. Congress and the Center for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) have placed limits on States' use of UPL approaches. Nevertheless, about a half dozen States specifically mentioned that they used a UPL approach as one way to help finance the increasing costs of Medicaid in 2001.

The Outlook for 2002

As States begin FY 2002, Medicaid is in a period of significant cost growth. This cost growth comes just at a time when State revenue growth is leveling or decreasing, State general fund balances are decreasing and other State programs are targeted to grow at rates much slower than is Medicaid (Figure 9 & Exhibit 10)

Figure 9: Average State Year-End Balances as a Percentage of Expenditures, FY 1995-2002



SOURCE: NASBO, June 2001

Legislative action was not complete on all Medicaid and State budgets for SFY 2002 at the time of this survey. However, an examination of the Governors' executive budget recommendations for SFY 2002 shows that many States are recognizing the upward trend in Medicaid spending, at least in part. According to the National Association of State Budget Officers, executive recommendations for SFY 2002 for Medicaid budgets reflected general fund increases that averaged 7.8%. The corresponding executive recommendations for the total State general fund budget averaged only 3.6%.[21] In other words, Governors' executive budget recommendations proposed that Medicaid expenditures grow at over twice the rate of other State expenditures in SFY 2002.

For State FY 2002, Medicaid officials were asked to indicate the expected percentage increase in Medicaid expenditures and also the expected percentage increase in the overall State budget. Officials in 29 States responded with estimated expenditure growth for both Medicaid and the entire State general fund budget. Among these 29 States, about three-fourths (22 of 29) indicated that the Medicaid growth rate would exceed that of the overall budget. The average expected increase in total State general fund spending for FY 2002 was 7.4%, and the expected increase for Medicaid general fund spending was 11.1%.

Medicaid officials were also asked if they expected actual Medicaid expenditures would exceed the amount that was authorized or was being proposed for authorization for FY 2002 at the time of the survey. A total 47 States responded. Officials in 20 of these 47 States indicated that they expected a Medicaid budget shortfall and a likely need for supplemental funding for SFY 2002 (Table 5 and Exhibit 11).

[21] National Association of State Budget Officers, *Fiscal Survey of the States*, June 2001.

Exhibit 10

State Medicaid Officials Report a Tightening Budget Outlook for FY 2002:

"We will have some real financial problems here in Medicaid in the year ahead of us."

"State revenues have been good so far. They are a little softer now, but it has not affected the Medicaid budget yet."

"We are having a hard time just sustaining the program. If we do not get new revenue it will not be enough to maintain the program. We are not looking forward to 2003 and 2004. We do not know what we are going to do."

"We are caught in the [statutory] limit in the growth of the overall State budget."

"Do we anticipate a budget shortfall in 2002? I wouldn't be surprised."

"We're suffering as the economy is slowing. We already declared a pro-ration on the school fund, so aid to schools is already being cut."

"The legislature appropriated $20 million less than the Executive Recommendation for 2002."

"We believe the Medicaid budget for 2002 is about 10% underfunded, but the legislature is still looking at this."

"The legislature is beginning to look at options, considering rate cuts or eliminating optional services."

"Everything we have done [in Medicaid] has been in the context of cuts, downsizing and shortage of funds."

"The economy is always a factor. But we are not budgeting for any kind of a downturn. [Actual budgeted increase was 5%.]"

"We are now in the middle of the budget process. There is a lot of pressure to increase rates. At the moment, there is no pressure to cut programs. But, we may be coming to a problem. Last year, the projections were too low, so the actual was a surprise."

"We expect it to be tight. We are expecting a slowdown in caseload and in pharmacy costs. If they continue at the recent pace, we will have a problem. If we are not thrown a curveball, I think we can get through the next two years."

'This will be tight. A limited reserve leaves us very little room for error. So it will force us to request a supplemental if expenditures increase."

"The Legislature appropriated less than the original executive recommendation and the re-projection is higher than the executive recommendation. Plus, the new FMAP for the last nine months of the biennium will add to the shortfall."

Table 5: States Anticipating Fiscal Year 2002 Medicaid Shortfalls as of May and June 2001

State	Without further action, do you anticipate a Medicaid shortfall in SFY 2002?	SFY 2002 Medicaid Shortfall in State General Fund (in millions of dollars)	SFY 2002 Medicaid State Shortfall as % of State General Fund Medicaid Budget
Alabama	No	---	---
Alaska	Yes	14.7	8.6%
Arizona	No	---	---
Arkansas	NA	NA	NA
California	No	---	---
Colorado	No	---	---
Connecticut	No	---	---
Delaware	Yes	6.2	2.3%
Florida	No	---	---
Georgia	Yes	141.0	9.7%
Hawaii	No	---	---
Idaho	Yes	5.6	2.4%
Illinois	No	---	---
Indiana	Yes	4.2	0.4%
Iowa	Yes	3.7	0.8%
Kansas	No	---	---
Kentucky	Yes	85.0	8.2%
Louisiana	Yes	104.0	11.1%
Maine	No	---	---
Maryland	Yes	96.2	6.6%
Massachusetts	No	---	---
Michigan	No	---	---
Minnesota	No	---	---
Mississippi	Yes	100.0	31.6%
Missouri	NA	NA	NA
Montana	NA	NA	NA
Nebraska	No	---	---
Nevada	No	---	---
New Hampshire	Yes	10.0	NA
New Jersey	No	---	---
New Mexico	Yes	5.0	1.6%
New York	No	---	---
North Carolina	Yes	388.0	15.9%
North Dakota	Yes	9.0	10.1%
Ohio	Yes	180.0	5.9%
Oklahoma	Yes	69.0	11.3%
Oregon	No	---	---
Pennsylvania	Yes	NA	NA
Rhode Island	No	---	---
South Carolina	No	---	---
South Dakota	No	---	---
Tennessee	No	---	---
Texas	No	---	---
Utah	No	---	---
Vermont	Yes	NA	NA
Virginia	No	---	---
Washington	No	---	---
West Virginia	No	---	---
Wisconsin	Yes	NA	NA
Wyoming	Yes	5.3	5.7%

* NA indicates no response to this question.

Exhibit 11

One State Budget Example for FY 2002: Ohio

The Biennial State budget for Ohio was adopted in June 2001. It reflected an annual increase of 2.4% for FY 2002 over FY 2001. Included in the 2.4% increase is an increase of 13.4% for Medicaid.

Factors Contributing to the Increase in the 2002 Medicaid Expenditures

For FY 2002 States identified the same cost drivers for Medicaid as they did for FY 2001 (Table 6).

- Prescription drug costs
- Provider rate increases
- Long term care
- Enrollment increases

Table 6: Factors Contributing to Increases in Medicaid Expenditures for FY 2002

Alabama	Pharmacy (increase is expected to continue so an 11% increase is budgeted).
Alaska	Pharmacy (21.5% cost increase), home & community-based services (HCBS) waiver and other non-institutional LTC programs (19.3% cost increase), enrollment (10% increase), continuing rise in disabled population, and potential reduction in FMAP due to CPI formula changes.
Arizona	Pharmacy (18% increase), enrollment (increase in 1931 population and expansion to 100% FPL which will result in more adults and SSI), home and community-based waiver and other non-institutional LTC programs (14.8% increase), nursing homes (5.6% increase).
Arkansas	Pharmacy, nursing homes, upper payment limits, and mental health. Other factors will be the increase of the federal poverty level, expansion of medical assistance for adults as well as children with limited benefits, implementing senior prescription program and an assisted living waiver.
California	No response.
Colorado	Pharmacy (18% increase), rate increases for home and community-based waiver and other non-institutional care programs (11.6-12.5% increase), welfare outreach may increase enrollment, and an HMO lawsuit.
Connecticut	Pharmacy (20% increase), nursing home and home health care (labor shortage and subsequent wage inflation), increased utilization of services (both FFS and managed care), increase in hospital rates.
Delaware	Pharmacy (18.8% increase), inpatient hospitalization (17 % increase), nursing homes (20.1% increase), MR waiver.
Florida	Pharmacy (27.6% increase), nursing homes (5.8% increase), enrollment and caseload (6% increase).
Georgia	Pharmacy (increase use of single source brands), enrollment increases (TANF add-backs, more disabled), federal poverty level increase.
Hawaii	Pharmacy (22.5% increase).
Idaho	Enrollment (16.2% increase), surge in CHIP and Medicaid kids.
Illinois	Increases expected for pharmacy, home and community-based waiver programs, and enrollment (ABD expansion).
Indiana	Pharmacy (22% increase), outpatient hospital (18% increase), managed care (8%), nursing homes (6% increase), increased enrollment due to change in disability definition, outreach programs (disease management & care management for aged, blind and disabled).
Iowa	No response.

Kansas	Pharmacy (17% increase) home health/transportation, increased enrollment including number of children and Transitional Medicaid for Temporary Assistance for Families (TAF) adults.
Kentucky	Pharmacy, inpatient hospitals (policy change for 0-stay days), increase in enrollment due to aging population, and increase in outreach of TANF cases and children.
Louisiana	Pharmacy (16%-18 % increase), inpatient hospital increases (due to outlier payments), significant impact due to Olmstead decision (currently in a negotiated settlement of a lawsuit), and enrollment increases (12,000 new Title XXI kids, large Title XIX increases, may cover adults of kids covered, and legislation to increase coverage for pregnant woman and kids).
Maine	Pharmacy, home and community-based services waiver and other non-institutional LTC programs as well as provider payments for mental health services.
Maryland	Pharmacy (15%-18% increase), managed care rates, and increase in enrollment (28,000 people).
Massachusetts	Pharmacy (14% increase), community long-term care (significant increases), managed care rates including behavioral health, and increase in enrollment (4% increase).
Michigan	Increase cost and utilization for: pharmacy, hospitalization, managed care, nursing homes, and home and community-based waiver and other non-institutional LTC programs.
Minnesota	Managed care (59% share of total budget increase), home and community-based waiver and other non-institutional LTC programs (16% share of total budget increase), nursing homes (10% share of total budget increase).
Mississippi	Pharmacy cost and utilization (27% increase), nursing homes (10% increase in allocated beds), home and community-based waiver programs (35% increase).
Missouri	Pharmacy (18-21% increase), managed care increases, enrollment (5.4% increase for TANF and 6% increase in disabled enrollees.)
Montana	Increases in provider payments for pharmacy and mental health.
Nebraska	Pharmacy, nursing homes (due to labor situation for professional and non-professional), sharp increases in enrollment (growth in number of kids and will enroll breast and cervical cancer patients to 225% FPL).
Nevada	Provider payment rates increase to make up for past rate freezes (totaling $40 million with majority going to LTC), caseload growth—especially TANF and children (7.6% increase projected).
New Hampshire	Provider payment increases for pharmacy and outpatient hospital services.
New Jersey	Managed care (17%-18% increase), practitioner fees, pharmacy costs, and personal care services.
New Mexico	Pharmacy (26.7% increase), inpatient hospitalization (25.6% increase), home and community-based waiver services, personal care program (10.8% increase).
New York	Pharmacy, nursing homes and community-based services, rate increases (e.g. dental), and eligibility increases (Family Care Plus waiver will add eligibility for persons aged 19-64).
North Carolina	Pharmacy (24% increase), hospital inpatient (17% increase), hospital ER (20% increase), physician services (15% increase), mental health clinics (18%).
North Dakota	Pharmacy (10% increase), nursing homes (legislature's budget shows 15.5% increase).
Ohio	Pharmacy, nursing homes, enrollment.
Oklahoma	Pharmacy (15% increase), managed care (5% increase), graduate medical education (GME) increasing $62 million (doubling in size and financed through IGT).
Oregon	Pharmacy (15-16% increase), managed care (20% increase), enrollment (6.4% increase), changes in composition of Medicaid enrollees including poverty level children, foster care, ABD.
Pennsylvania	Managed care (7.24% increase), pharmacy (16.1% increase), enrollment increases (due to welfare reform).
Rhode Island	Pharmacy (16.5% increase), nursing homes (4.8%), behavioral health, and enrollment increases (particularly disabled adults).
South Carolina	Pharmacy, physician rate increases, utilization trends.
South Dakota	Pharmacy, inpatient hospitalization, increase in number of enrollees.
Tennessee	Pharmacy (double digit increase in costs), managed care (4% overall increase in MCO capitation payments), changes in number of people enrolled.
Texas	Pharmacy (increase in number and average cost of prescriptions), higher utilization, slight shift in caseload toward aged and disabled and medically needy.
Utah	Pharmacy (18% increase), inpatient hospitalization (utilization increase), managed care. Inflation and utilization are higher than in previous years.

Vermont	Pharmacy (36.5% of increase in total expenditures), nursing home (30% of increase of total expenditures).
Virginia	No response.
Washington	Pharmacy (15% increase due to increased cost and higher utilization), hospital payments (8.7% increase for inpatient and 9.9% increase for outpatient), enrollment (3% total increase), efforts to expand nursing home, DSH and UPL programs.
West Virginia	Pharmacy, inflation, utilization.
Wisconsin	Pharmacy (15.3% increase), hospital payments (4.6% increase for inpatient and 4.2% increase for outpatient), nursing.
Wyoming	Pharmacy (15% increase), three new waivers (for elderly, acquired brain injury, assisted living), potential rate increases for inpatient and outpatient hospital payments due to previous underfunding.

Source: State Medicaid officials response to survey by Health Management Associates, May and June 2001.

Prescription drug costs: Pharmacy cost increases was listed as the number one cost driver (Exhibit 12). Many State officials were quick to describe how the pharmacy line in their budget was increasing at rates of 10% to 28% per year. Of the 26 States that indicated a specific expected increase in pharmacy costs for SFY 2002, the average was 18%. In addition to these rates, States mentioned increasing pharmacy costs as a cost driver in other areas of the Medicaid budget, especially in mental health services and managed care rates.

Exhibit 12

State Medicaid Officials Note Pharmacy and Nursing Home Costs in FY 2002:

"I wish we could do something about prescribed drugs. I don't know what can be done."

"Again, pharmacy costs are expected to be the largest single item influencing the FY 2002 Medicaid budget."

"The pharmacy prior authorization is the only reason we've been able to control costs."

"The biggest issue in the upper Midwest is how to control nursing home costs. We need to move people to home and community-based settings."

"The 2002 budget depends on the economy staying good and caseload growth occurring at the budgeted rate…. Caseload is budgeted at 6%. It quite likely will be higher and cause a budget problem."

"The managed care rate increase doesn't begin to account for the 20% increase in pharmacy costs."

Nursing home costs account for one-quarter of the Medicaid budget, and nursing homes will receive a 4.8% increase for inflation."

"The executive recommendation was for an increase of 4% for [nursing homes], but the Legislature granted 15.5%."

Provider rate increases: Inpatient and outpatient hospital costs are expected to be significant cost drivers. About half the responding States indicated that hospitals would receive rate increases in SFY 2002.

Managed care rate increases are significant in States with large numbers of enrollees in health plans. Reported rate increases ranged from 3.4% to 8%, although States with increasing managed care enrollment indicated their overall managed care expenditures might increase by 17% to 18%.

Long term care: Half of respondents indicated that nursing home rate increases would be significant (Exhibit 13). Eighteen States indicated home and community-based programs were a factor in Medicaid cost growth, due both to rate increases for personal care and other home-based services and due to expansions in coverage. The Olmstead decision is a factor in these expansions. One State specifically indicated that their policy changes were related to a lawsuit settlement process. Another States' response summarized a prevalent view regarding the impact of the Olmstead decision: "We expect a significant impact but it has yet to be reflected in actual expenditures."

Enrollment increases: States expect continued increases in the number of persons enrolled in Medicaid. Half of respondents listed enrollment increases as a key factor in expected Medicaid cost growth in FY 2002. States indicated expectations for increases in the 2% to 6% range, with a few States indicating increases in the range of 6% to 10% and one State indicating an expected increase of 16%. Reasons for the increases include expected increases in TANF caseloads, TANF-related Medicaid outreach[22], new efforts to enroll children in State Children's Health Insurance Programs, recent eligibility expansions for children and families. As in FY 2001, increasing enrollment of low-income uninsured families remained a policy priority for many states.

Notably, States also expect increases in enrollment in the aged and disabled categories, due to the aging population, a new definition of disability and coverage for the working disabled. States indicated this would likely change the composition of the caseload and impact program costs.

Other factors: Benefit coverage expansions are a minor factor for FY 2002. States mentioned limited benefit expansions targeted for family planning waivers and added coverage for persons with breast and cervical cancer.

State strategies to control expected Medicaid expenditure growth in SFY 2002
Recent Medicaid cost increases have forced Medicaid officials to focus on strategies for controlling expenditure growth. Many states have already begun to implement approaches as directed by their legislature. Other States are forming special task forces to identify possible options.

For SFY 2002, the dominant Medicaid cost containment strategies are those that target cost increases for prescription drugs. However, states are not limiting their attention just

[22] During 2002, many States plan to contact individuals whose Medicaid cases were closed at the time that their TANF cash assistance cases were closed. The outreach will seek to find individuals and families that still qualify for Medicaid coverage.

to drugs. Medicaid officials described the following Medicaid cost control strategies being considered in FY 2002:

- Controls on prescription drug costs and utilization
- Freezes or reductions in provider payments
- Increased use of managed care, care coordination, disease management and other utilization management approaches
- Using home and community-based services in place of nursing home care
- Competitively bidding for medical equipment, supplies or other services
- Increased efforts on control of fraud and abuse

Controls on prescription drug costs and utilization: States indicated multiple strategies to control the escalating costs of prescription drugs. The three most prevalent strategies mentioned include:

(a) prior authorization of selected brand name products to encourage use of generics,
(b) reduced payment for pharmacy products by applying a greater discount from average wholesale price (e.g., going from AWP less 10% to AWP less 15%), and
(c) contracting for a pharmacy benefit manager (PBM).

Other pharmacy strategies are also proposed. At least three States have proposed reducing the pharmacy dispensing fee. At least two States have proposed increasing copayments for prescription drugs. Other strategies include "brand necessary" or "dispense as written" policies for brand name products where a generic is available, a mail order pharmacy option, supplemental rebates for selected therapeutic categories of drugs, use of a drug formulary and initiation of disease management programs.

Freezes or reductions in provider payments: About one-third of the States adopted or proposed freezes or actual reductions in provider payments. Several of these reductions were to result from rebasing inpatient or outpatient hospital rates, or through the replacement of a cost-based reimbursement methodology. Nine States specifically mentioned rate freezes for hospitals or other providers. For example, in one State the legislature froze all discretionary provider rates at FY 2001 levels. Another State expected savings from selective contracting for inpatient hospital services.

Increased use of managed care, care coordination, disease management and other utilization management approaches: Most States have some form of managed care. For FY 2002 many States expect to expand their use of managed care, or to adopt case management strategies for populations that may not be in managed care. A number of States have experienced a decrease in the number of managed care organizations willing to serve Medicaid. Several of these States are considering the adoption of a Primary Care Case Management (PCCM) system. Another primary focus is on care coordination for the disabled populations. States describe their strategies in various ways, such as "case management for high utilizers" or "disease management for the disabled and aged" or "care coordination for complex cases." In each case the objective is to ensure that appropriate care is provided, with the expectation that the result will be higher quality care and lower costs.

Using home and community-based services in place of nursing home care: In some States, efforts to control long-term care costs are as significant as the pharmacy cost issue is in other States. States are looking at ways to control payment rate increases. However, labor shortages have created great pressure to increase rates for nursing homes and for home and community-based services. Several states are increasing the number of individuals authorized to receive home and community-based services. Some of these States also are adopting prior authorization policies to prevent overuse of home and community-based services such as personal care and home health.

Competitively bidding for medical equipment, supplies or other services: A few States indicated they are planning to competitively bid for durable medical equipment and medical supplies and other services such as vision care.

Increased efforts on fraud and abuse control and coordination of benefits: A number of States are dedicating more staff for audits and anti-fraud activities, more data matches with other State agencies including Treasury, high-cost claim analysis and additional efforts to recover third party liability payments.

Other Strategies: A number of other strategies were listed, including new information technology to enable better program management and premium subsidies to continue employer sponsored health coverage.

Eligibility and Coverage Strategies: Significantly, no State mentioned a proposed reduction in eligibility. Indeed, several States indicated they were considering or planning to adopt eligibility expansions, such as a Section 1931 expansion for uninsured adults. Similarly, few States indicated they were considering benefit reductions. Two States did indicate they were considering a proposal to eliminate coverage for adult dental or denture services, but these had not been adopted. Many states, however, were adding coverage such as limited benefits under a waiver for family planning or for breast and cervical cancer.

Revenue Strategies: Several States indicated that they continue to look for opportunities to use UPL or other strategies that might advantage the financing of the Medicaid budget. Even before SFY 2002 had begun, State Medicaid officials were looking at the possible need for supplemental appropriations in the future. Even before the year began, twenty States indicated a likely need for a supplemental appropriation for Medicaid in SFY 2002.

Summary and Conclusion

States are emerging from a period during which State revenues increased at near record rates at the same time that cost pressure from Medicaid, one of the largest programs in the budget, was at historic lows.

That favorable situation has changed rapidly. In early 2001, growth rates in State revenues declined, dramatically in some States, forcing some States to adjust their budgets for SFY 2002 downward even before they were adopted. State year-end fund balances were above 10%, the highest levels in twenty years in FY 2000, but dropped by half in FY 2001. In many States, Medicaid Upper Payment Limit and Inter-Governmental Transfer strategies that have assisted States in financing Medicaid are now limited and are being phased out.

At the same time that revenue is becoming more limited, Medicaid expenditure growth has accelerated to a pace that exceeds the growth in State revenues in most States. The reasons for the recent Medicaid cost growth increases are several. Among the key reasons are dramatic increases in Medicaid costs for prescribed drugs, "catch-up" increases in provider payment rates after several years of low or no increases, increases in rates paid to managed care organizations and for long-term care, increasing numbers of persons enrolled, and increased use of state financing strategies (i.e., UPL arrangements) to bring in more federal dollars.

As these trends converge, the immediate prospect is for a difficult and contentious period for Medicaid budgets. Medicaid cost pressures are already conflicting with a diminishing ability of States to finance the program. Without doubt, these forces will intensify and provide a difficult challenge for State health policy and budget decision-makers in the immediate future. Notwithstanding the state budget issues, the Medicaid program is an important factor in the local economy, bringing in at least $2 in federal dollars for each state dollar spent.

Facing these challenges, several major questions arise for public officials and policy makers.

- Will States be able to find ways to contain Medicaid cost growth within what is affordable?
- Will the new fiscal realities cause States to re-think the recent expansions of Medicaid and SCHIP coverage for children, families, the working disabled, persons qualifying for family planning coverage and women's treatment breast and cervical cancer; or will there be a slow down or reversal of this policy direction?
- Will states continue to use Medicaid as a vehicle to finance health coverage for low-income uninsured workers, and to assure coverage for the low-income families and children, the elderly and disabled populations served by the program?
- How will the safety net be affected, and will budget constraints at the State and Federal levels force communities to face additional challenges?
- Will states take action to shore up state revenues in order to preserve Medicaid and other state programs?

- As states seek to balance their budgets, will they try to preserve the federal dollars flowing to states through the Medicaid program?
- Does Medicaid's matching formula adequately protect states in times of fiscal crisis?

Fiscal realities are a powerful driver of public policy at all times, and this period of budget pressure will force the States to deal with difficult fiscal questions and tradeoffs for the first time in nearly a decade. Following years of program stability and expansion, potential program constraints and significant budget reductions will be especially challenging for policy makers and public officials, and will make this an especially significant time for the Medicaid program.

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