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Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003

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States continue to confront the most daunting fiscal situations they have faced in decades. In real terms, state revenues have been falling for five straight quarters. State spending is increasing, and spending on Medicaid, a joint federal-state program that covers more than 42 million low-income individuals, is increasing rapidly. Nearly every state now faces a budget shortfall this fiscal year, according to the National Conference of State Legislatures, and recent data indicate that these shortfalls are likely to grow in the upcoming fiscal year.

Many states are focusing on Medicaid as a key part of their efforts to balance their state budgets. Medicaid constitutes about 15 percent of state general fund spending, and is the second largest program in most states' budgets after elementary and secondary education.

To identify state Medicaid spending trends and states' plans to reduce the growth in their Medicaid spending as they began fiscal year 2003, the Kaiser Commission on Medicaid and the Uninsured (KCMU) sponsored a survey by Health Management Associates (HMA) of state officials in June 2002. This information was presented in the September 2002 report, *Medicaid Spending Growth: Results from a 2002 Survey* and is based on interviews with Medicaid officials in all 50 states and the District of Columbia (D.C.) that were completed in June.[1]

This fall it became clear that states' fiscal situation had deteriorated further as a number of states provided new estimates of their fiscal year 2003 revenue and spending that indicated that their budget gaps were widening. To address these budget shortfalls, some states held special legislative sessions or undertook executive action late in calendar year 2002. To reflect the most current information on state Medicaid spending and cost control strategies, the Kaiser Commission had HMA resurvey Medicaid officials in all 50 states and D.C. during December 2002. States were surveyed about plans state executives have made with regard to their Medicaid program since the beginning of FY 2003, which for most states was July 1, 2002.[2] Many of these plans were approved by state legislatures or implemented through executive action. A few are still awaiting legislative review.

The brief December survey update, which is reprinted in Appendix A, focused on five main questions:

1. What are your state's current FY 2003 estimates of Medicaid spending and enrollment?

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[1] Vernon Smith, Eileen Ellis, Kathy Gifford, Rekha Ramesh and Victoria Wachino, Medicaid Spending Growth: Results from a 2002 Survey, Kaiser Commission on Medicaid and the Uninsured, September 2002. Publication #4064.

[2] State fiscal years run from July 1 to June 30 for 46 states. The fiscal year begins on April 1 for New York, on September 1 in Texas and on October 1 for Alabama, Michigan and the District of Columbia.

2. Is the state projecting a shortfall in its Medicaid budget for FY 2003? How large is the most recent projection and is it larger or smaller than the projections that were made in June 2002?
3. Is the state making additional mid-year changes to its Medicaid spending to reduce the rate of spending growth?
4. Is your state developing or implementing new ways to gain additional federal financing through "Medicaid maximization" strategies, such as provider taxes, in FY 2003?
5. What is the outlook for the Medicaid budget in your state in FY 2004?

A survey form was sent to Medicaid officials in all 50 states and the District of Columbia at the end of November 2002. HMA conducted follow-up telephone interviews to discuss the results of the survey with each state. Surveys and telephone conversations were completed by early January 2003 and responses were received from all 50 states and the District of Columbia.

These interviews confirmed that as state fiscal situations have continued to deteriorate, states are expanding their efforts to reduce Medicaid spending growth. The survey found:

- **States now expect Medicaid spending to increase nine percent in FY 2003 on average.** This is significantly higher than the 4.8 percent average growth rate that state legislatures appropriated for FY 2003 earlier this year. These most recent projections reflect more realistic estimates of Medicaid spending growth, which was almost 13 percent in FY 2002. Medicaid officials also indicate that they expect Medicaid enrollment to grow 7.7 percent this fiscal year, which is higher than the 6.2 percent enrollment growth states reported in June. These new projections are also more in line with recent trends.

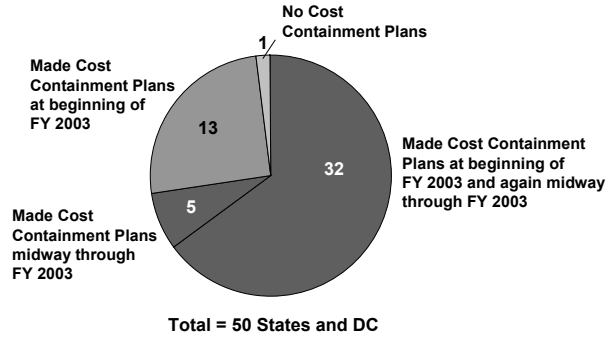
- **Forty states reported they are now facing a shortfall in their FY 2003 Medicaid budgets as of December, and in 27 states the expected shortfall had grown since the last KCMU/HMA survey in June.** Given that the average increase in FY 2003 appropriations was significantly lower than FY 2003 spending growth, the fact that most states now face a shortfall in their Medicaid budgets is not a surprise.

- **Since the beginning of the fiscal year, a total of 49 states have either made plans or already acted to reduce their Medicaid spending growth** (Figure 1). In the June survey, 45 states reported that they were making Medicaid cost containment plans as the fiscal year began. In the December survey update, 37

Figure 1

49 States and DC Report Medicaid Cost Containment Plans for FY 2003

Over Two-Thirds (37 states) Have Taken Mid-Year Action



Total = 50 States and DC

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, July 2002 and December 2002.

states reported that they were making Medicaid cost containment plans midway through the fiscal year. In total, 49 states reported that they were making Medicaid cost containment plans at either the beginning or midway through fiscal year 2003. Of the 37 states that reported in December that they were making cost containment plans, five had not planned to take cost containment action at the beginning of FY 2003. The remaining 32 states not only had plans to reduce their Medicaid spending growth when state fiscal years began in July, they also found it necessary to make additional cost containment plans midway through the fiscal year.

Despite the fact that most states have been taking actions to cut their Medicaid spending growth for at least the past two fiscal years, increasing numbers of states now report that they plan to place new controls on their pharmacy costs, increase beneficiary copayments, restrict eligibility, and reduce benefits.

- **To relieve their fiscal pressures, states are also trying to increase the federal share of Medicaid funding by drawing down additional federal funds.** Many states are turning to available "Medicaid maximization" strategies, which are limited by law and regulation, to draw down additional federal Medicaid matching funds or reconfigure state-funded programs to qualify for federal Medicaid matching payments.

- **State Medicaid officials expressed serious concern about the Medicaid budget outlook for fiscal year 2004.** Despite having undertaken significant cuts this fiscal year and last, they believed states will have to resort to even more stringent cost-containment measures in the year ahead.

Medicaid is caught in a crossfire between the rapid deterioration of state revenues, on the one hand, and increased health care spending, on the other. By design, Medicaid is counter-cyclical: as unemployment rises and incomes drop in an economic downturn, more people become eligible for Medicaid. As result of this dynamic, Medicaid's importance has grown even as pressure has mounted to contain its spending. These survey findings indicate that as the state fiscal crisis has deepened, increasing numbers of states have put plans in place to reduce their Medicaid spending growth, and most of the states that had already made such efforts are expanding them. These planned actions come on the heels of many previous cost containment actions states adopted in 2002 and, in some cases, 2001 as well.

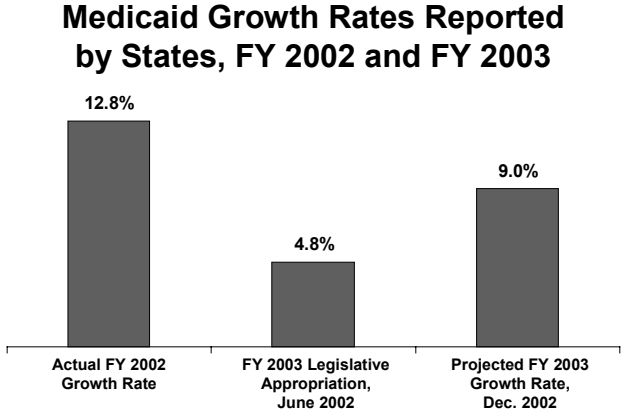
The fiscal outlook for states does not yet appear to be improving. Prospects for economic growth are uncertain, and any improvement in the nation's economy is unlikely to translate into increased state revenues for some time. One-time, temporary revenue measures like tobacco settlement funds and rainy day funds that states have used to forestall deeper cuts or tax increases are no longer available in many states. Unless Medicaid spending growth suddenly and unexpectedly abates, or unless state revenue collections rebound, Medicaid is destined to remain in a precarious position.

Results of the 50-State Update for FY 2003

1. Current Forecasts for Medicaid Enrollment and Spending Growth are Increasing and More Consistent with Recent Trends

At the outset of FY 2003 states reported that, on average, legislatures had appropriated increases in Medicaid funding of 4.8 percent.[3] This increase seemed unrealistically low given that Medicaid spending increased by nearly 13 percent in FY 2002 (Figure 2). The cost pressures that underlay that increase, namely a deteriorating economy and increases in spending on key services such as prescription drugs, were unlikely to abate. Many states assumed that their economies would grow, thereby slowing the rate of growth in Medicaid. They also assumed lower growth in per beneficiary spending as specific Medicaid cost control measures were implemented. In the September KCMU report, we noted that this level of funding was unlikely to be sufficient to meet actual program expenditures.[4]

Figure 2



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, July 2002 and December 2002.

When HMA interviewed Medicaid officials in December 2002, many reported they had significantly increased projections of Medicaid spending for FY 2003. States now expect total Medicaid spending to increase nine percent this fiscal year on average. [5] This means that Medicaid officials now believe total Medicaid spending in FY 2003 will increase

[3] For FY 2003, state legislatures adopted overall budgets providing total spending increases that averaged just 1.4 percent, according to the National Association of Budget Officers' Fiscal Survey of States, November 2002.

[4] Vernon Smith, Eileen Ellis, Kathy Gifford, Rekha Ramesh and Victoria Wachino, Medicaid Spending Growth: Results from a 2002 Survey, Kaiser Commission on Medicaid and the Uninsured, September 2002. Publication #4064.

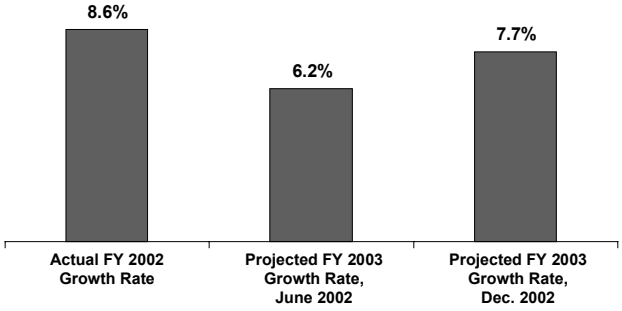
[5] One state declined to answer this question. All indicated averages are calculated as the unweighted mean over all states.

almost twice as fast as the average 4.8 percent increase that was provided in original legislative appropriations.

One key component of increasing Medicaid spending is Medicaid enrollment. Largely as a result of the economic downturn, enrollment in Medicaid is increasing. Medicaid officials indicate that they currently expect Medicaid enrollment to increase by 7.7 percent in FY 2003 (Figure 3). This is a significant increase over their June 2002 projections of a 6.2 percent increase in Medicaid enrollment for FY 2003, but still falls short of the 8.6 percent increase in Medicaid enrollment that states realized in FY 2002. Medicaid officials now indicate that the continued economic slowdown prevented the expected slowing in the rate of Medicaid enrollment growth in most states.

Figure 3

Medicaid Enrollment Increase Projected by States, FY 2002 and FY 2003



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, July 2002 and December 2002.

"What we have is not exactly a Medicaid problem. What we have is a problem of an economic downturn, higher health care costs and declining state revenues. "
--State Medicaid official, December 2002

2. Most States Still Face Medicaid Budget "Shortfalls," and in a Majority of States These Shortfalls are Growing

The December survey update asked Medicaid officials whether they expected the state to experience a Medicaid budget shortfall during FY 2003, and if so, whether the shortfall was now expected to be larger or smaller than it was when the fiscal year began. A "shortfall" occurs when a state's actual Medicaid expenditures are projected to exceed the Medicaid funding level the legislature has appropriated for the fiscal year.

Of the 49 states and the District of Columbia who responded to this question, Medicaid officials in 40 states indicated that they anticipate a Medicaid budget "shortfall."[6] This is

[6] One state declined to respond to this question.

roughly consistent with the 41 states that reported at the beginning of the fiscal year in June that they expected a shortfall in their FY 2003 Medicaid budgets. Given that the 4.8 percent average increase appropriated by state legislatures for FY 2003 was less than half of the 12.8 percent average increase state Medicaid programs experienced in FY 2002, it is not a surprise that most states are projecting budget shortfalls. It is noteworthy that among the 40 states now expecting a shortfall, six states had indicated in June that a shortfall was unlikely. And, among the ten states now not expecting a shortfall, seven said they had taken actions they now believe will resolve a previously expected shortfall.

> *"Our trend has not leveled. You'd think it would have by now, but it hasn't."*
> *--State Medicaid official*

Twenty-seven of the responding states reported that they expect their state's Medicaid budget shortfall to be larger than they predicted when the fiscal year began. Officials in 13 states (including the District of Columbia) said their state's Medicaid shortfall was now expected to be the same or smaller. For most states, Medicaid budget problems are becoming more severe than they were anticipated to be six months ago, at the beginning of the fiscal year, even with the cost containment actions states planned at that time.

> *"To cover our shortfall we will use the very last of our reserves. That will use up everything we had accumulated. Going into '04 we will be bled dry."*
> *--State Medicaid director*

3. Forty-Nine States and D.C. Plan to Reduce Their Medicaid Spending Growth in FY 2003, and Nearly Two-Thirds of States are Planning Midyear Cost Containment Strategies (Figure 4).

In the December survey update, Medicaid officials were asked if they had taken action, or had specific plans to implement, additional cost reduction strategies above and beyond those strategies they had planned to implement at the outset of FY 2003. States were surveyed about plans state officials have made or plan to make with regard to their Medicaid program since the beginning of FY 2003, which for most states was July 1, 2002. Many of these plans were approved by state legislatures or implemented through executive action. A few are still awaiting legislative review.

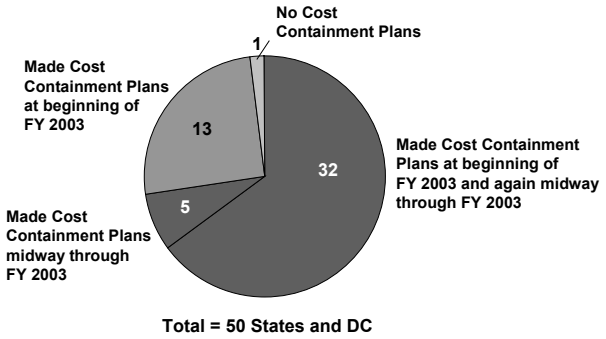
Reflecting the deepening budget shortfalls, a total of 49 states and D.C. reported that they have planned or taken action to implement Medicaid cost containment measures at some

time in FY 2003.[7] In June, as states prepared to begin the fiscal year, 45 states reported that they planned to undertake some kind of Medicaid cost containment measure.[8]

Figure 4

49 States and DC Report Medicaid Cost Containment Plans for FY 2003

Over Two-Thirds (37 states) Have Taken Mid-Year Action



Total = 50 States and DC

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002 and December 2002.

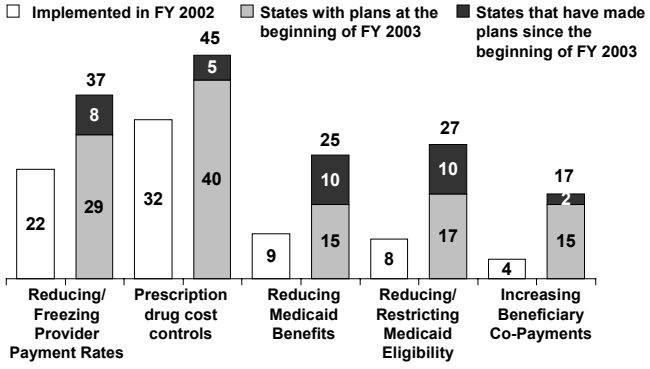
In responding to the December survey, 37 states told HMA that they had undertaken Medicaid cost containment measures since the beginning of the fiscal year. Five of these 37 states had not planned specific measures to reduce their Medicaid spending growth at the beginning of the fiscal year in July. Thirty two of the 37 states had not only planned to reduce their Medicaid spending growth in June, but have taken additional Medicaid cost containment action since then. Three quarters of all states who began FY 2003 with a Medicaid cost containment strategy in place went back after the fiscal year began to put additional cost control measures in place.

[7] As of December 2002, only Alabama had not reported any Medicaid cost containment plans.

[8] Forty-five states reported in June that they had plans at the beginning of FY 2003 to implement cost containment strategies to reduce their Medicaid spending growth. This number was reported as 41 in the September report, *Medicaid Spending Growth: Results from a 2002 Survey*, but since that report was released the total has been recalculated. As of December 2002, only Alabama had not reported any Medicaid cost containment plans.

Figure 5

States' FY 2002 and FY 2003 Cost Containment Plans to Control Medicaid Spending Growth



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002.

> *"Because of the national recession, our revenues are down substantially. The Medicaid budget must be controlled to fit anticipated revenue. The state has attempted to control the budget by balancing provider reductions, administrative reductions and utilization controls."*
>
> *--State Medicaid official*

The additional cost containment strategies states plan to undertake in FY 2003 are described below and are shown in Figures 5 and 6. Additional information on the number of states undertaking different cost containment strategies is in Appendix B.

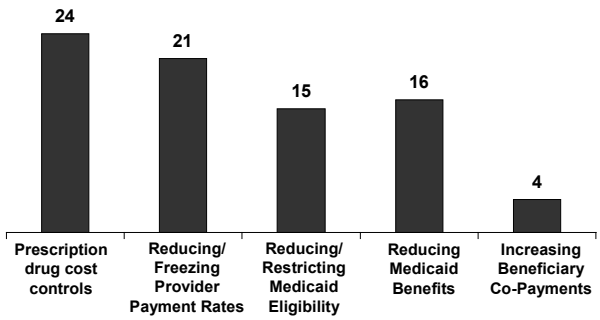
Provider rate reductions or freezes: In total, the number of states who reported in December or June that they plan to reduce or freeze provider rates at any point in FY 2003 is 37. In December, twenty-one states reported that they have taken action since FY 2003 began to reduce or freeze their payment rates to some types of providers who participate in Medicaid. Eight of these states had not previously taken action or planned to reduce or freeze their rates, but took midyear action to do so.

Eighteen of the 21 states reduced, or planned to reduce provider rates or reduce scheduled rate increases to make payment levels lower than they would have been otherwise. In addition, seven states froze provider rates (i.e., did not implement provider rate increases that were scheduled to occur). These rate freezes and reductions affected providers of all types, but focused on hospitals and nursing home providers. In some states provider rates

were selectively reduced to target specific procedures. Provider rate increases were still granted in some states, but the exact number was not recorded in this survey.

Figure 6

States Taking Additional Actions Since the Beginning of FY 2003 to Control Medicaid Spending Growth



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002.

Prescription drug actions: As has been the case in recent years, states continue to try to control growing spending on prescription drugs. In total, the number of states who reported in December or June that they plan to take action to reduce spending on prescription drugs at any point in FY 2003 is 45. Twenty-four states reported in December that they had taken action or developed plans to control drug costs since the beginning of FY 2003. Five of these 24 states had not reported that they planned to reduce prescription drug costs at the outset of the fiscal year, but took midyear action to do so.

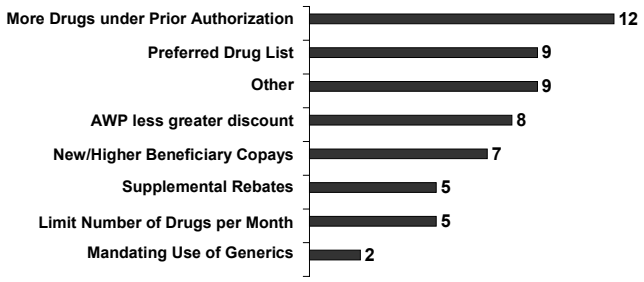
The midyear pharmacy actions the 24 states reported taking or planning included:

- Reducing payments for drug products, with a greater discount from average wholesale price (8 states);
- Subjecting more drugs to prior authorization, including new drug classes (12 states);
- Implementing or expanding a preferred drug list (9 states);
- Initiating supplemental rebates from manufacturers (5 states);
- Mandating the use of generics (2 states);
- Imposing new limits on the number of prescriptions per month (5 states);
- Imposing new or higher beneficiary prescription copayments (7 states), and
- Adopting other new policies to control drug cost per unit (such as new state maximum allowable cost schedules) or policies to control utilization (such as patient profiling, step therapy requirements, new quantity limits for number of days allowed) (9 states).

These changes are summarized in Figure 7.

Figure 7

Additional Medicaid Pharmacy Cost Containment Measures States Have Taken Since Beginning FY 2003



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002.

Benefit limits or eliminations: In total, twenty-five states reported in December or June that they planned to take or have taken action to reduce acute care benefits in FY 2003. In December, sixteen states reported that they have taken action or made plans since the beginning of FY 2003 to eliminate or limit covered benefits. Ten of these states had not taken previous FY 2003 action or made previous plans to limit or eliminate benefits, but took midyear action to do so.

Dental coverage for adults continues to be a primary focus of states' benefit limits, with two states eliminating coverage for adults, two other states eliminating coverage for dentures, one state eliminating all but basic restorative coverage, and one state imposing an annual per person limit of $600 on dental services. In addition, states planned or carried out new limits on vision, home oxygen, targeted case management, occupational therapy, speech therapy, physical therapy, private duty nursing, or a new limit on the number of days Medicaid would cover in an inpatient hospital.

Eligibility cuts and restrictions: A total of 27 states reported in December or June that they plan to take action to reduce or restrict eligibility in FY 2003. In December, 15 states reported that they have taken midyear action to cut or restrict eligibility, or announced new plans to do so. Ten of these states had not previously taken action or made plans in FY 2003 to reduce eligibility.

States' planned and implemented eligibility cuts include a range of actions. Three of the 15 states that took midyear action to reduce eligibility indicated plans to eliminate medically needy eligibility altogether, including one state that is moving up a previously planned implementation date for eliminating its medically needy program. Two other states plan to lower the eligibility level or restrict the medical bills that count toward medically needy eligibility.

Two states announced plans to cut eligibility for the 1931(b) groups that include adults with children (for example, in California, from 100 percent of the federal poverty level to 61 percent). Two states planned to restrict transitional Medicaid coverage to the federally required minimum of six months for persons who leave welfare due to their earnings, and another is reinstating the 100 hour rule, which will cause affected adults to lose welfare eligibility and become eligible for transitional Medicaid coverage. One state has scheduled the full elimination of eligibility for 40,000 caretaker adults on March 1, 2003. Another state has proposed decreasing eligibilty from 100 percent to 75 percent of the federal poverty level for seniors and disabled adults. If adopted, this change would affect approximately 6,000 Medicaid recipients.

Two states are re-instating previous policies on counting assets and unemployment insurance income in determining Medicaid eligibility. One state has eliminated presumptive eligibility and decreased income disregards to the minimums. Two states have reported reinstating verification procedures for beneficiary income.

Finally, three of these fifteen states that have or are planning to restrict eligibility are also deferring implementation of previously announced eligibility expansions.

Beneficiary Copayments: A total of 17 states reported in December or June that they planned or have taken action to increase or initiate beneficiary copayments in FY 2003. (These actions are in addition to any copayments for prescription drugs, and in addition to previously existing copayment policies.)

In December, four states reported that they have proposed or planned midyear action to impose new or higher copayments. Two of these four states had not previously taken action on or planned to implement copayments in FY 2003. In three of the four states, plans are being made (including the needed waiver applications) to impose a copayment on emergency room visits. One state adopted a new $1 copayment on non-emergency transportation, and one state will increase the copayment on physician services from $2 to $3 on February 1, 2003.

Long Term Care Reduction Strategies: In total, the number of states who reported in December or June that they plan to take actions or have already taken actions to reduce their long-term care spending in FY 2003 is 19. In December, nine states reported that they have proposed or planned midyear action change their long-term care policies. Six of the nine states had not planned to change their long-term care policies at the beginning of the fiscal year in June.

Four of the nine states that reported in December that they have changed or plan to change their long term care policies are revising their reimbursement policies for nursing homes. These changes include lower payments for reserve days or redefinitions of property, adoption of a payment system based on a Resource Utilization Group (RUG) classification system for nursing facility residents and a decision to move from a cost-based system to a price-based system.

For home-and community-based services (HCBS), two of the nine states have raised the minimum criteria for acceptance into their HCBS Medicaid waivers, and one state froze the number of HCBS waiver slots available. Another state imposed a limit on the dollar value of services the program would pay for under the HCBS Medicaid waiver for persons with developmental disabilities.

Although four states made their HCBS policies more restrictive, two states expanded HCBS waiver services as part of their overall long term care strategy.

Other cost control strategies: Several states listed a number of other new actions adopted or planned since the beginning of FY 2003 as part of their states' overall strategy to control the growth in Medicaid spending. These included:

- Adopting disease management or care management (6 states);
- Increasing fraud and abuse control for beneficiaries and providers (6 states);
- Increasing priority on third party liability collections (3 states); and
- Expanding Medicaid estate recovery efforts (1 state).

In addition, states continue to look to waivers as a potential means to reduce their Medicaid spending growth. Seven states reported that since the beginning of FY 2003 they have begun to evaluate opportunities to use a Section 1115 waiver, a Health Insurance Flexibility and Accountability (HIFA) waiver, or Pharmacy Plus waivers.

There are several reasons states may be considering waivers. States may consider a HIFA waiver or a Section 1115 waiver as a way to develop a less comprehensive benefit package for specific non-mandatory Medicaid populations. Some states see waivers as potentially allowing them to use unspent State Children's Health Insurance Program (SCHIP) allocations. States could also reap fiscal benefits from Pharmacy Plus waivers that allow them to use Medicaid funds to finance part of their state pharmacy assistance programs for the elderly and/or expand prescription drug coverage to the elderly. (However, these waivers frequently include provisions limiting a state's ability to secure federal Medicaid matching funds for the cost of serving their elderly Medicaid population in the long term.)

Comments Some State Medicaid Officials Made During Survey Interviews:

"You take all the cuts we have proposed and we are still projecting a shortfall, so there are significant new cuts being considered. We don't have any choice."

"Everything is quite fragile right now…we are told we will have another cut this year, and we don't yet know about '04. We have a new Governor and we are waiting to see what he proposes."

"Medicaid has a health outcomes impact, but it also has an economic impact. In these times of budget cuts, people are beginning to recognize that. By the time you consider all the economic impacts, you hardly save anything."

"All fall we have been looking for ways to save, and here we are in December looking at more requests for more savings."

"This is the start, not the end."

4. States Continue to Develop "Medicaid Maximization" Strategies to Increase Federal Funding of Medicaid Spending.

As states address their overall budget shortfalls, many are looking at available strategies to increase the amount of federal Medicaid revenue to the state. This can be achieved through a variety of different strategies. Collectively, these strategies are commonly referred to as "Medicaid maximization." Federal law and regulation limit the use of many of these strategies.

The survey update asked Medicaid officials if they had initiated new "Medicaid maximization" strategies since in FY 2003 began to increase federal Medicaid revenue coming into the state. Among the 50 responding states and D.C., a total of 31 states indicated in December 2002 that they had implemented or were developing plans for new Medicaid maximization strategies in the first six months of FY 2003.[9] The most prevalent methods were new strategies involving:

- Provider taxes (16 states):
- Upper Payment Limit (UPL) or Disproportionate Share Hospital (DSH) payments funded through inter-governmental transfers (IGTs) (15 states)
- School-based services (2 states).

The majority of states reporting that they are developing Medicaid maximization strategies are focusing on provider taxes, UPL, and DSH. There is some degree of overlap among states developing provider taxes and states are developing UPL and DSH strategies, because some states use these strategies in combination. Fifteen states are pursuing UPL strategies, which are limited by recent federal regulations. In some cases, provider tax, UPL, or DSH strategies are being used to help states maintain or increase existing payments to providers that otherwise would not have been possible, given state fiscal conditions. Two states have undertaken efforts to analyze current program expenditures to find new opportunities to claim Medicaid matching on current spending, including health care spending in other state run programs, such as education. States' use of Medicaid maximization strategies has and will continue to contribute to the recent rapid increase in total Medicaid costs.

Discussions with Medicaid directors left the clear impression that Medicaid maximization was a priority. Most of the states that did not report developing new Medicaid maximization initiatives since the beginning of FY 2003 said that they had previously focused on these strategies.

5. The Outlook for the Next Fiscal Year is for Continued, and Probably Growing, Budget Pressure on Medicaid.

[9] This question was not asked in the June survey.

Even as states are putting plans in place to close their budget gaps in FY 2003, they are facing the prospect of still larger total budget shortfalls in the coming fiscal year, FY 2004. Governors are releasing their budget proposals for FY 2004, and many are of these budgets are expected to contain proposals to reduce Medicaid spending growth still further.

In the survey update, Medicaid directors were asked to describe the outlook for the Medicaid budget in their state for FY 2004. Without exception, Medicaid directors painted a picture of great challenge and difficulty. Commonly used words were "bleak," "grim" and "tough." In the words of one Medicaid director: "Unless there is a revenue increase, it looks very grave. There will be serious reductions. I've been in government for 20 years. I've never seen the budget situation worse than it is right now." Another observed: "FY'04 for us is really about the whole state budget situation. We are such a large part, we have to figure out how we are going to contribute."

Medicaid officials looking toward FY 2004 foresaw no appealing options to control spending growth. Medicaid spending growth, like growth in private health insurance, is likely to continue next year. Medicaid directors see a likelihood of continued, deep and difficult cuts in the program, unless something unforeseen occurs. They are preparing themselves for the likelihood of very difficult choices in the immediate future.

Observations of Medicaid officials on the outlook for FY 2004:

"FY '04 is going to be a very tight budget. We are looking for additional cuts in eligibility and services right now."

"For Medicaid, it will depend on enrollment. If growth is above two percent, we're in trouble. I don't see any rate increases in '04 for the third year in a row. I would see further reductions in eligible groups and covered benefits."

"When you cut a rate you see savings right away. In '04 we are going to see the fruit of our efforts in case management and other initiatives that take longer. In '04 if we can hold to 6.5 percent increase in spending, it will be the lowest rate of growth in ten years. But if we get an influx of eligibles, all bets are off."

"Extremely bleak. Our recommended amount for '04 is the same as for '03, with no prospect for supplemental funds."

"It doesn't matter what I tell you about how our program looks right now, because it won't be the same in July."

"It's just grim. The official party line is zero growth. We are anticipating another 8 to 9 percent growth in enrollment. It is going to be tough."

"There is going to be a major fight over Medicaid. I can see us cutting a lot of people off before we are done, and we will be in court over it."

"The new biennium is a disaster. There is a showdown coming."

"It is going to be brutal, brutal, brutal—both on an operations and a program standpoint."

Conclusion

The fiscal outlook for states does not yet appear to be improving. State revenue collections remain weak. Some recent data indicates that state budget shortfalls, estimated at almost $50 billion in FY 2003, may grow to as much as $85 billion in the coming fiscal year.[10] Although these shortfalls vary by state, on average they are estimated to represent between 13 and 18 percent of state spending. Prospects for economic growth are uncertain, and any improvement in the nation's economy is unlikely to translate into increased state revenues for some time.

Medicaid's importance has grown even as pressure has grown to constrain its spending. By design, Medicaid is counter-cyclical: as unemployment rises and incomes drop in an economic downturn, more people become eligible for Medicaid. This, in combination with increasing health care costs that are affecting both the public and private sectors, is propelling Medicaid costs upward.

Medicaid is caught in a crossfire between the rapid deterioration of state revenues, on the one hand, and increased health care spending, on the other. States have been taking actions to cut their Medicaid spending growth for at least the past two consecutive years. As this survey indicates, even states with Medicaid cost containment actions in their original FY 2003 budget have planned actions to make further reductions. Although many states were able to forestall making deeper cuts this fiscal year by using one-time revenue measures like tobacco settlement funds and rainy day funds, those funds, for the most part, are no longer available. Unless Medicaid spending growth suddenly and unexpectedly abates, or unless state revenue collections rebound, Medicaid is destined to remain in a precarious position.

For more information, please contact the Kaiser Commission on Medicaid and the Uninsured at (202) 347-5270.

The September 2002 KCMU report on its June 50-state budget survey "Medicaid Spending Growth: Results from a 2002 Survey" can be accessed at http://www.kff.org/content/2002/4064/4064.pdf

[10] Iris Lav and Nicholas Johnson, State Budget Deficits for Fiscal Year 2004 are Huge and Growing," Center on Budget and Policy Priorities, December 23, 2002. When California's shortfall, which is estimated to be between $15 and $25 billion in FY 2004, is excluded, this total shrinks to between $60 and $70 billion.

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Appendix A

Medicaid Budget Survey Update for Fiscal Year 2003

State of: _____ Name: _____ Date:_____
Phone: _____ Email: _____

1. **SFY 2003 Medicaid Spending and Enrollment Growth**:
What is your current estimate, in percent, for projected Medicaid spending and total Medicaid enrollment growth in SFY 2003 (above SFY 2002)?

% Growth in Total funds _____%
% Growth in State funds _____%
% Change in enrollment _____%

2. **Medicaid Budget Shortfall**:
A. If you are projecting a budget shortfall for SFY 2003, is it larger or smaller than was expected when the fiscal year began? (*Please circle*)

Smaller About the same Larger No shortfall expected

B. If you are projecting a budget shortfall for SFY 2003, what is the *current* estimated size of that shortfall? …….$_____Millions

3. **New Medicaid Maximization Strategies:**
Are you developing or implementing any new Medicaid maximization strategies in your state in SFY 2003 (i.e., new or increased provider taxes, new or expanded IGT funded initiatives, or reconfiguration of state funded programs to leverage Medicaid FMAP)? Yes_____ No_____

If yes, can you briefly describe them:_____
_____
_____
_____
_____

4. **Mid-year Medicaid Budget Adjustments**:
A. Are you making mid-year changes in Medicaid to reduce the rate of spending growth?

Yes_____ No_____

B. If yes, are these changes in addition to those included in the original SFY 2003 appropriation?

Yes_____ No_____

5. If you answered **"yes"** to 4B above, can you briefly describe these mid-year SFY 2003 Medicaid cost containment initiatives:

Program/Policy Area	Description
Provider payments:	
a. Rate reductions	
b. Rate freezes	
Rx controls and limits:	
c. Payment @ AWP less a greater discount	
d. More drugs subject to prior authorization	
e. Preferred drug list	
f. Supplemental rebates	
g. Require use of generics	
h. Limits on the number of Rx per month	
i. New or higher copays	
Benefits:	
j. Other benefit or service reductions or limits (other than Rx)	
Eligibility:	
k. Eligibility cuts	
l. Expansion delays	
Copays:	
m. New or higher beneficiary copays (other than for Rx)	
Managed care and disease management:	
n. Expand managed care	
o. Disease management/case management	
Long term care:	
p. Changes to institutional LTC	
q. Changes to home and community-based care	
Other:	
r. Fraud and abuse controls	
s. Administration changes	
t. Other	

6. **Outlook for SFY 2004**: How would you describe the outlook for the Medicaid budget in your state for SFY 2004?

_____
_____
_____
_____
_____

If you have any questions, please feel free to contact any of us who are working on this survey:

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The report based on this survey update of all 50 states will be sent to you as soon as it is available.

Thank you very much

Appendix B

Number of States & DC That Have Taken Action or Planned Medicaid Cost Containment Strategies in FY 2002 and FY 2003

	FY 2002	FY 2003				
Cost Containment Actions	**States that Implemented in FY 2002**	**States with New Plans at Start of FY 2003**	**States with New Plans Midway Through FY 2003**	**States with New Plans at Start and Midway Through FY 2003**	**States with New Plans Only Midway Through FY 2003**	**Total States with New Plans at Some Time in FY 2003**
Provider Payment Rate Freezes or Decreases	22	29	21	13	8	37
Pharmacy Related Actions	32	40	24	19	5	45
Benefit Reductions	9	15	16	6	10	25
Eligibility Reductions	8	17	15	5	10	27
Implementation or Increase in Non-pharmacy copays	4	15	4	2	2	17
Expansion of Managed Care	10	12	0	1	0	12
Implementation of Disease/Case Management	11	21	6	3	3	24
Enhanced Fraud and Abuse	16	18	6	4	2	20
Long Term Care	7	13	9	3	6	19
Any Cost Containment Action	45	45	37	32	5	50

Source: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002.

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