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States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions

By Vernon Smith, Rekha Ramesh, Kathleen Gifford and Eileen Ellis, Health Management Associates
and
Victoria Wachino and Molly O'Malley, Kaiser Commission on Medicaid and the Uninsured

January 2004

THE HENRY J. KAISER FAMILY FOUNDATION

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

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Executive Summary

Since 2001, states have been responding to extremely difficult fiscal conditions. As revenues have fallen, spending on Medicaid has increased, and states have increasingly focused on Medicaid as a key component of their efforts to balance their budgets. Over the past three years, states have employed several different strategies to reduce the growth in their Medicaid spending, from reducing provider payments to restricting eligibility and benefits and increasing beneficiary co-payments.[1] While these actions have helped states balance their budgets, they have also had an impact on Medicaid beneficiaries, the providers who serve them, and the health care system.

As states concluded the third year of the fiscal crisis, and what was for many a third year of significant Medicaid cost containment, they received two pieces of positive budget news. First, Congress enacted $20 billion in temporary federal fiscal relief for the states in May 2003. The federal government supports Medicaid by sharing in the program's costs; in every state it pays at least half, and in some states far more, of state Medicaid spending. Part of the fiscal relief was provided through an increase in the federal share of total Medicaid program costs. Second, the falloff in state revenues began to ease. Across all states nominal state tax revenues increased on average in 2003, although when this figure is adjusted for inflation and the effect of legislative changes, there is still a slight decline.[2] At the same time, states significantly constrained overall state spending, which is expected to decline by two percent in real terms in FY 2004.[3]

Over the past three years, the Kaiser Commission on Medicaid and the Uninsured has worked with Health Management Associates to survey state Medicaid officials about their Medicaid spending growth and Medicaid cost containment plans. The results of the most recent of these surveys was published in September 2003 and reported states' plans as they began fiscal year 2004. [4] That survey found that Medicaid spending was increasing at a slower rate and that every state and the District of Columbia began fiscal year 2004 with new plans to reduce their Medicaid spending growth. In December, HMA conducted a brief survey update of these same officials to identify changes related to Medicaid spending growth and cost containment that have taken place since the beginning of Fiscal Year 2004. This report is based on the December survey update.

The survey update found:

- **The rate of total Medicaid spending growth declined slightly.** After growing at an average rate of 11.9 percent in 2000-2002, states estimate that total Medicaid spending growth will slow slightly to 8.2 percent in 2004. This modest slowdown in the rate of growth contrasts with trends in the cost of employer health premiums,

[1] Smith, Ramesh, Gifford, Ellis and Wachino, *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004*, The Kaiser Commission on Medicaid and the Uninsured, September 2003.
[2] See Boyd and Wachino, "Is the State Fiscal Crisis Over?" Kaiser Commission on Medicaid and the Uninsured, January 2004.
[3] National Governors Association/National Association of State Budget Officers, *Fiscal Survey of States, November 2003*, www.nasbo.org
[4] Smith, Ramesh, Gifford, Ellis and Wachino, September 2003.

for which the rate of growth continues to increase. This 8.2 percent growth rate applies to total (combined state and federal) Medicaid spending.

- **As a result of the federal fiscal relief, the growth rate of the state share of Medicaid spending is significantly lower –an increase of 3.3 percent in FY 2004.** At 3.3 percent, the growth rate in the state share of Medicaid spending in FY 2004 is significantly less than the 8.2 percent rate of increase in total Medicaid spending. Overall, state spending on all programs in their budgets is expected to be flat in FY 2004.
- **Medicaid enrollment growth is also slowing.** The number of people enrolled in Medicaid is now expected to increase by 5.5 percent on average in FY 2004, falling from an 8.8 percent growth rate in FY 2003 and an 8.5 percent rate of growth in FY 2002. This is the lowest rate of enrollment growth the Medicaid program has experienced since 2000, when the economy was still strong.
- **Almost every state is implementing Medicaid cost containment in FY 2004, including eighteen states now taking new, mid-year actions to further slow Medicaid spending growth**. In total, forty-nine states and the District of Columbia reported that they planned to undertake Medicaid cost containment in FY 2004. Eighteen states reported that they took additional action after the beginning of FY 2004 to pursue Medicaid cost containment policies. Although this is a substantial number of states taking new midyear cost containment action, it is a dramatic drop from a year ago, when 37 states indicated they were planning mid-year budget-driven actions to cut Medicaid spending growth.[5]
- **The temporary federal fiscal relief helped states ease their budget problems and avoid making additional and deeper changes to their Medicaid programs in FY 2004.** Forty-two states reported that the federal fiscal relief helped to meet the funding increases in their Medicaid programs by resolving budget shortfalls. Twenty-seven states, or just over half of all states, reported that they used the fiscal relief to avoid, minimize or postpone Medicaid cuts or freezes. No states made changes to Medicaid eligibility that would have disqualified the state from receiving federal fiscal relief. The fiscal relief also helped many states fill shortfalls in their overall general fund budgets.
- **States expect a significant adverse impact when the temporary fiscal relief expires in June.** When the fiscal relief expires in June 2004, few states will have the fiscal resources available to fill the gap that it creates. When the fiscal relief ends, the percentage increases in the state cost of Medicaid in FY 2005 likely will be the highest experienced in many years. Proportionately, the impact of the expiration will be greatest in states with the lowest per capita incomes and highest federal matching rates.

[5] Smith, Gifford, Ramesh and Wachino, *Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003*, The Kaiser Commission on Medicaid and the Uninsured, January 2003.

At the midpoint of fiscal year 2004, states are facing a budget outlook that has improved modestly, buttressed by temporary federal fiscal relief. Three years of state Medicaid cost containment actions have slowed the rate of growth of Medicaid spending and enrollment. The state revenue situation has also stabilized. The combination of these factors meant that fewer states were compelled to make mid-year Medicaid budget changes in FY 2004 compared to the same point in FY 2003.

However, this relative sense of stability in the Medicaid program is likely to be short-lived. The recent modest growth in state revenues has not been strong enough to fill the hole that was created in state budgets when state tax revenues fell more than 6 percent in real terms in 2002. This low level of revenue growth also is not sufficient to maintain Medicaid funding, even at the lower Medicaid growth rates that states are now experiencing. Spending pressures in other areas of state budgets will grow over the next year. And the federal fiscal relief to states will expire in June, leaving states with significant gaps in their state budgets that they will struggle to fill. Looking forward, the outlook remains extremely challenging for most state budgets and the Medicaid program in fiscal year 2005.

Methodology

Since 2001, the Kaiser Commission on Medicaid and the Uninsured (KCMU) has worked with Health Management Associates (HMA) to survey all 50 states and the District of Columbia to identify state Medicaid spending trends and state plans to reduce growth in their Medicaid spending. Typically, this survey occurs twice each year: once in June, as states are beginning their fiscal year, and once in December, as states are midway through their fiscal year. The June survey is an in-depth, comprehensive survey that is designed to capture detailed information on spending growth trends and cost containment plans at the outset of the fiscal year. The December survey is a short, mid-year update designed to capture changes that have taken place over the past six months. Our most recent comprehensive survey was published in September 2003, and was based on interviews with Medicaid officials in all 50 states and the District of Columbia (D.C.) that were completed in June 2003.[6] In December 2003, HMA conducted its midyear survey update. The update survey was sent to Medicaid officials in all 50 states and D.C. at the end of November 2003. HMA conducted follow-up telephone interviews to discuss the results of the survey for each state. Surveys and telephone interviews were completed by early January 2004.

In responding to the survey, state officials provide information that is complete and accurate as of the time they are surveyed, and this information is included in the report. However, the information reflects a specific point in time, and it may change after the state has completed the survey. State cost containment plans sometimes change as legislatures review policies, as new proposals are developed, as priorities or overall strategies evolve, as unforeseen impacts of proposed policies become known, as states evaluate, change or delay previous plans, as legal challenges arise, or as administrative plans are developed. For this reason, the information in this report is current as of the time states responded in December 2003 and January 2004.

[6] Smith, Ramesh, Gifford, Ellis and Wachino, September 2003.

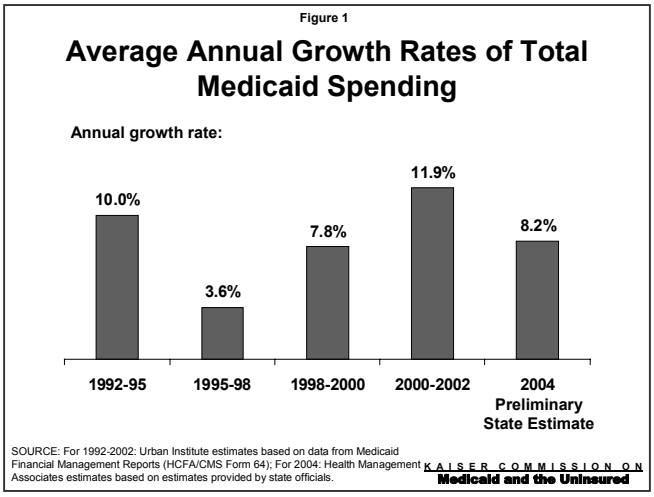
Results of the 50-State Update for FY 2004

Survey Results for Mid-Fiscal year 2004

1. The Rate of Medicaid Spending Growth Remains Substantial, Although it is Declining Slightly

Overall, total Medicaid spending is expected to grow on average by 8.2 percent for FY 2004, according to state officials' survey responses.[7] This rate of growth, which applies to total (state[8] and federal) Medicaid spending, is down slightly from the average 11.9 percent rate of growth that occurred in 2000-2002 (Figure 1).[9] The decline in the rate of growth in Medicaid spending is a departure from trends in the private insurance market, where the rate of growth in employer health premiums has continued to increase. However, the 8.2 percent mid-FY 2004 spending projection is significantly above the 5.3 percent growth authorized in original legislative appropriations for FY 2004. In other words, states' initial legislative appropriations for Medicaid were lower than currently expected expenditure levels in many states. [10] In those states, supplemental appropriations or other actions will be required to fully fund FY 2004 actual program expenditures.

Figure 1



[7] The average for FY 2004 was calculated across all 50 states on an weighted basis using total Medicaid spending by states as reported in: National Association of State Budget Officers, *State Expenditure Report*, November 2003. In previous reports, we have reported these averages on an unweighted basis.

[8] In some states, the non-federal share includes both state and local funds.

[9] It is also a decline from the estimated 9.3 percent growth rate for FY 2003 that states reported in June, before fiscal year 2003 had ended in most states. See Smith et al., September 2003.

[10] Appropriations made at the outset of the fiscal year for Medicaid frequently do not match what is required to fund the program during the course of the fiscal year. As a comparison to FY 2004, for example, original legislative appropriations for FY 2003 averaged 4.8 percent (unweighted average) above FY 2002 spending, and actual annual spending growth averaged 9.3 percent (unweighted average) above FY 2002 levels. For an additional discussion of this issue, see Smith, Ramesh, Gifford, Ellis and Wachino, September 2003, p. 36.

As a result of the fiscal relief to states that Congress provided in May 2003, the growth in the state share of Medicaid funding in FY 2004 is now projected to be 3.3 percent, significantly lower than the growth in total Medicaid spending. Because the federal government assumed a greater share of total Medicaid spending, state Medicaid spending growth declined dramatically in FY 2004. In FY 2003, the state share of Medicaid spending had increased eight percent.

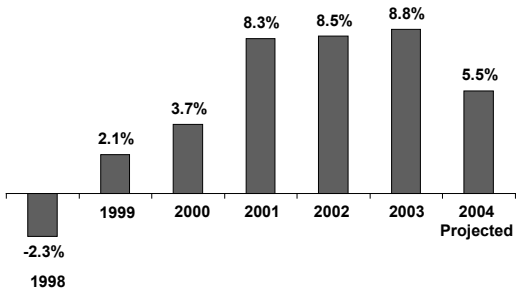
Partially as a result of this lower spending growth, fewer states expect to realize a "shortfall" in their Medicaid budgets in FY 2004. At the beginning of FY 2004, Medicaid officials in 32 states indicated the likelihood of a Medicaid budget shortfall was at least 50-50. In this survey, a total of 27 states indicated a FY 2004 Medicaid shortfall was expected. Moreover, for some states that still expect a shortfall, that shortfall is now believed to be smaller than previously projected.

2. Medicaid Enrollment Is Growing More Slowly in FY 2004

Medicaid enrollment growth, along with utilization and provider payment levels, is a key factor in current Medicaid spending growth. The most current projections for Medicaid enrollment show the number of persons enrolled in Medicaid is projected to increase on average by 5.5 percent in FY 2004 above FY 2003 levels (Figure 2).[11]

Figure 2

Percent Change in U.S. Medicaid Enrollment, FY 1998 – FY 2004



Source: For 1998-2002: Eileen Ellis, Vernon Smith and David Rousseau, *Medicaid Enrollment in 50 States: June 2002 Data Update*, Kaiser Commission on Medicaid and the Uninsured, July 2003. For 2003-2004: Smith, Ramesh, Gifford, Ellis and Wachino, September 2003 and January 2004.

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This rate of growth is a significant decline from previous years, and is the lowest rate of enrollment growth the program has realized since 2000, when it was 3.7 percent. In 2000, the nation's economy was still expanding and unemployment was at a 30-year low of less than four percent. In 2004, the nation's economy is still recovering from recession and employment presently stands at 5.7 percent. In FY 2002, Medicaid officials estimated an average enrollment growth of 8.5 percent, and an average growth rate of 8.8 percent in 2003.

[11] Percentage changes for enrollment growth in this report reflect weighted averages across states. Those averages are calculated on a weighted basis by total enrollment by state in December 2002, as reported in: Eileen Ellis, Vernon Smith and David Rousseau, *Medicaid Enrollment in 50 States: December 2002 Data Update*, Kaiser Commission on Medicaid and the Uninsured, December 2003.

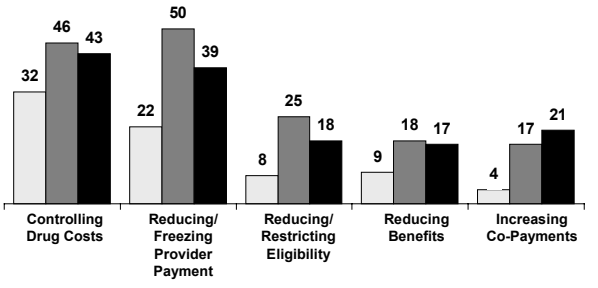
This mid-year projection for enrollment growth is also slightly higher than it was expected to be at the beginning of FY 2004, when Medicaid officials indicated in our previous survey that legislative appropriations were based on projected enrollment growth of 4.7 percent, on average. The mid-year projection for a growth rate of 5.5 percent on average for FY 2004 suggests that enrollment growth continues at a faster pace than previously expected, albeit at a far slower pace than in the past three years.

3. **Eighteen States Have Initiated New, Mid-year Actions to Further Slow Medicaid Spending Growth**.

In September, our most recent survey reported that all 50 states and the District of Columbia were undertaking new Medicaid cost containment plans at the outset of FY 2004. With nearly every state in the nation preparing to limit provider rates and put in place additional plans to reduce their prescription drug spending, some states were also turning to reducing Medicaid benefits and/or eligibility, and many states were also planning to increase beneficiary co-payments as well. Moreover, for many states, this marked the third straight year of Medicaid cost containment plans, with states layering on many different cost containment policies as the state fiscal crisis persisted. Considerable Medicaid cost containment activity is continuing to occur in FY 2004. A total of 49 states and the District of Columbia had implemented some or all of these strategies, or had definite plans to do so (Figure 3). One state reported that they no longer planned new Medicaid cost containment in FY 2004.

Figure 3

States Undertaking Medicaid Cost Containment Strategies FY 2002 - FY 2004



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002 and September and December 2003.

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At the same time, when our midyear survey update results from FY 2004 are compared to those from FY 2003, states are much less likely in FY 2004 to be initiating mid-year actions to slow the rate of growth in Medicaid spending. According to Medicaid officials in December 2003, new mid-year Medicaid cost-containment actions are being taken in just 18 states. This is significantly smaller than the 37 states that reported taking mid-year Medicaid cost containment actions in FY 2003.

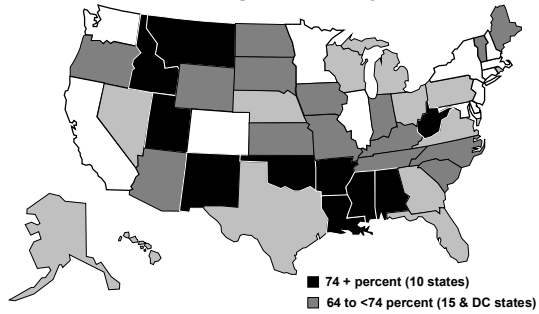
An Explanation of the Federal Fiscal Relief to States

In May 2003, Congress enacted and President Bush signed into law the Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27), which included a provision to give states $20 billion in temporary federal fiscal relief in FY 2003 and FY 2004. This $20 billion included two components: $10 billion in general fiscal relief through payments to states for unrestricted purposes, and an estimated $10 billion through a temporary increase in the federal share of Medicaid spending, known as the Federal Medical Assistance Percentage (FMAP). The Medicaid provision increased each state's matching rate by 2.95 percent, which is calculated on top of the higher of the state's FY 2002 or FY 2003 scheduled matching rate (Figure 4). As a condition of receiving this increase in the federal matching rate, states must maintain the eligibility levels in their Medicaid programs that were in effect as of September 2, 2003. States that reduce eligibility below that level cannot receive the increased FMAP.

The fiscal relief applied only for the last two quarters of federal fiscal year 2003 and the first three quarters of federal fiscal year 2004. The fiscal relief will expire on June 30, 2004.

Figure 4

Federal Medical Assistance Percentages (FMAP), FY 2004, Including Temporary Fiscal Relief



NOTE: The percentages listed reflect the temporary increase in federal Medicaid matching rates enacted in the Jobs and Growth Tax Relief Reconciliation Act of 2003, which is effective for the first 3 calendar quarters of FY 2004.
SOURCE: Federal Register, June 17, 2003.

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The mid-year actions planned in these 18 states are generally less severe than the cost-containment actions states had put in place previously in FY 2004 and in FY 2003. Reflecting the requirements of the federal fiscal relief (see box), additional eligibility reductions are nearly nonexistent. Significant cuts in benefits are less common, as are reductions in provider payment rates. The plans that states reported were more likely to include policy changes relating to prescription drugs (e.g., preferred drug lists or supplemental rebates) or enhanced fraud and abuse activities.

The midyear Medicaid cost containment plans that states report are:

Provider rate reductions or freezes: Eight states reported that they have made additional plans since the start of FY 2004 to reduce or freeze their payment rates to providers who participate in Medicaid. Two of these states had not previously taken action or planned to

reduce or freeze their rates, but took mid-year action to do so. Six of the eight 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, three of the eight states froze rates, including two that froze hospital rates (by eliminating an inflation adjustment that was otherwise scheduled to occur). The rate reductions affected providers of all types including behavioral health, HMO rates, transportation and reimbursement for personal care services. Provider rate increases were still granted in six states. In total, 39 states reported in the December survey update that they had taken any action in FY 2004 to reduce provider payments.[12]

Prescription drug actions: As has been the case in recent years, states continue to try to control growing spending on prescription drugs. Twelve states reported in December that they had taken action or developed new plans to control drug costs since the beginning of FY 2004. Four of these 12 states had not reported that they planned to reduce prescription drug costs at the outset of the fiscal year, but took mid-year action to do so. In total, 43 states reported in the December survey update that they had taken any action in FY 2004 to reduce spending growth on prescription drugs.

Comments of State Officials on Prescription Drug Cost Containment Actions:

"We have gone a long way down the road toward pharmacy cost control. We don't have a lot of opportunity to do more. Our cost increases are about as low as you can do."

The mid-year pharmacy actions the 12 states reported taking or planning mid-year included:

- Implementing or expanding a preferred drug list (seven states);
- Subjecting more drugs to prior authorization, including new drug classes (six states);
- Initiating supplemental rebates from manufacturers (four states);
- Implementing a long term care pharmacy initiative (three states);
- Adopting other new policies to control drug cost per unit (such as incentives to use generics) or policies to control utilization (such as provider and patient profiling and education) (three states);
- Imposing new limits on the number of prescriptions per month (two states);
- Contracting with a pharmacy benefit management vendor (two states); and
- Reducing payments for drug products, with a greater discount from average wholesale price (one state).

Benefit limits or eliminations: Three states reported that they have taken action or made plans since the beginning of FY 2004 to eliminate or limit covered benefits. None of

[12] In responding to the December survey update, state officials were asked to describe cost containment actions taken at the outset of the fiscal year and since the beginning of the fiscal year.

these three states had taken previous FY 2004 action to limit or eliminate benefits, but took mid-year action to do so. Georgia eliminated a number of optional services for adults, including dental and vision care, orthotics and prosthetics and in-home therapies. New Mexico restricted and imposed prior authorization requirements on dental and vision care, dialysis and transportation. Finally, Indiana imposed new limits on behavioral health services. In total, seventeen states reported in December that they have already or plan to limit benefits in FY 2004.

Eligibility cuts and restrictions: In December, only one state, Georgia, reported that it had taken or planned mid-year action to restrict eligibility, which did by imposing new premium requirements for disabled children eligible for Medicaid under the "Katie Beckett" option[13]. Georgia had previously not reduced or restricted eligibility in FY 2004. A total of 18 states reported in December that they plan to take action to reduce or restrict eligibility in FY 2004.

Beneficiary Copayments: Four states reported that they have proposed or planned mid-year action to impose new or higher copayments. Three of these four states had not previously taken action on or planned to implement copayments at the beginning of FY 2004. One of the four states, New Hampshire, instituted a copayment on emergency room visits.[14] New Mexico is instituting copayments on prescription drugs and another state, Indiana, is increasing the copayment for generics to $3.00. Finally, South Carolina is instituting new copayment requirements on a broad range of services including drugs, doctor visits, durable medical equipment, optometry, chiropractor, federally qualified health center visits, rural health center visits, ambulatory dental services, non-emergency outpatient hospital services and inpatient hospital services. At the same time that other states were planning new or additional copayments midyear, Illinois eliminated copays for generic drugs. A total of 21 states reported in December that they plan in FY 2004 to increase or initiate beneficiary copayments, including copayments for prescription drugs.

Managed Care and Disease Management: Three states reported that they had taken or planned mid-year action to expand managed care arrangements. One of these three states had not reported that they planned to expand managed care at the outset of the fiscal year, but took mid-year action to do so. Indiana increased the number of enrollees in risk-based managed care and Wisconsin implemented new managed care programs with a special emphasis on mental health services and care management. Oklahoma was eliminating its HMO contracts, but expanded its primary care case management program statewide. A

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[13] The "Katie Beckett" option (sometimes referred to as the "TEFRA" option) allows states to elect to extend Medicaid eligibility to children that meet the SSI standard for disability and would qualify for Medicaid eligibility if parental income were not attributed. In guidance to states on the fiscal relief, the Centers on Medicare and Medicaid Services has provided a detailed definition of what changes constitute an eligibility change, and has said that increased cost-sharing, including new or increased premiums, are not considered an eligibility change for the purposes of obtaining the FMAP increase. Consequently, Georgia's action does not disqualify it from receiving the fiscal relief.

[14] Federal Medicaid law permits states to impose beneficiary copayments in emergency room settlings only when the beneficiary receives non-emergency services, and these copayments are subject to the approval of a waiver of law from the Secretary. See section 1916 (a)(3) of Title XIX of the Social Security Act.

total of 13 states reported in December 2003 that they plan to take action to expand managed care arrangements in FY 2004.

Seven states reported that they had taken mid-year action to expand disease management programs. Five of these seven states had not reported that they planned to expand disease management programs at the outset of the fiscal year, but took mid-year action to do so. A total of 19 states reported in December 2003 that they plan to take action to implement or expand disease management programs in FY 2004.

Long Term Care Reduction Strategies: In December, three states reported that they have planned mid-year actions affecting long-term care. One of these three states had not previously taken action affecting long-term care in FY 2004. One state reported on a long-term care initiative to relocate nursing home residents into community settings and two states reported on changes in home and community-based services (HCBS) waiver programs that would slow the number of new individuals accessing the program or place limits and caps on services. Although two states made their HCBS policies more restrictive, one state expanded HCBS waiver services as part of their overall long-term care strategy. In total, the number of states who reported in December that they plan to take actions or have already taken actions that affect long-term care in FY 2004 is fourteen.

Other cost control strategies: Several states listed a number of other new actions adopted or planned since the beginning of FY 2004 as part of their states' overall strategy to control the growth in Medicaid spending. These included:

- Increasing fraud and abuse control for providers and beneficiaries (four states);
- Increasing coordination of benefits through identification of insurance from non-custodial parents (one state), and
- Implementing volume purchasing for hearing aids and batteries (one state).

Why have states decreased their emphasis on Medicaid cost containment in FY 2004?

Medicaid officials offered three primary explanations for the lower incidence of Medicaid actions taken after fiscal year 2004 began. The first and most significant reason was the federal fiscal relief to states, which included an increase in the federal share of Medicaid spending through an increase in the federal matching rate. The additional federal funding for Medicaid clearly has allowed many states to survive FY 2004 Medicaid fiscal pressures without resorting to severe cuts to program benefits, eligibility levels or provider payments.

The second reason was that states were already in the process of implementing a comprehensive array of Medicaid cost containment actions in response to the intense fiscal pressures of the past three years. In many states, legislatures adopted fairly comprehensive cost containment strategies in FY 2003 and again in the original legislative budget adopted for FY 2004, and this came on top of initial Medicaid cost

containment action in FY 2002 in many states. These initiatives have been successful in slowing the rate of Medicaid spending growth from a high of 10.0 percent in FY 2002 to a reported eight percent in FY 2004. At the same time, these cost containment actions have likely also contributed to the slowing in enrollment growth in the program to 5.5 percent in FY 2004.

A third probable reason behind the reduced incidence of Medicaid cost containment is the recent modest stabilization in the overall state budget picture. As state revenues have stopped falling and states have held spending pressures at bay, it is likely that states have felt less need to put midyear cost containment measures in place. In addition, Medicaid officials in several states indicated that policy makers increasingly were feeling pressure from provider groups and beneficiary advocates who had borne the brunt of previous cost-containment policies, and who were now advocating for catch-up increases in payment rates, or the restoration of previous cuts in benefits or eligibility.

Comments of State Officials on FY 2004 Cost Containment Actions:

"I recently counted. We have something like 35 separate policies underway to control Medicaid costs."

"We are working hard to implement the things in the original budget. There is nothing new [mid-year]."

"Many things were implemented late in '03, and we are seeing the savings now."

4. Federal Fiscal Relief to States Helped States Fill Budget Shortfalls, Avoid Additional Medicaid Spending Reductions, and Slowed the Rate of State Medicaid Spending Growth.

The December 2003 survey asked Medicaid officials to describe how their state used the enhanced federal funding provided through the temporary 2.95 percentage point FMAP increase provided as part of Congress' broader $20 billion fiscal relief package. The results clearly convey that the fiscal relief has helped stabilize states' budgets, resolve budget shortfalls, and forestall additional and more far-reaching Medicaid policies to reduce Medicaid spending growth.

Officials in 42 states reported that fiscal relief funds helped meet funding increases in the Medicaid program by helping to resolve an overall Medicaid budget shortfall. In 27 states, officials indicated the enhanced funding was used specifically to avoid, minimize or postpone proposed Medicaid program cuts or freezes. And, reflecting the requirements of the federal fiscal relief, no states made changes to eligibility that would have disqualified them from receiving the fiscal relief. In six states, Medicaid officials indicated that program increases, including increasing provider rates and restoring benefits, were made that would not otherwise have been made (Figure 4).

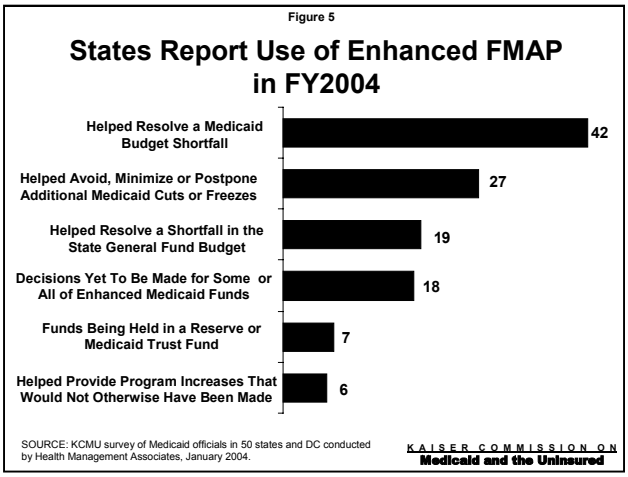
Comments of State Officials on the Use of the Enhanced FMAP:

"All of these cuts were smaller because of the temporary FMAP."

"We used the enhanced FMAP money to do expansions that we might not have been able to afford otherwise and to avert cuts that might have been necessary."

Because of the timing of the federal fiscal relief, some states had not yet determined how to spend it. Congress adopted the fiscal relief in May 2003. By that time, many legislatures had completed or nearly completed their decisions on the FY 2004 budget. In these states, their budget decisions had been made before the fiscal relief was adopted. This timing issue accounts in significant part for the fact that in eighteen states officials indicated that final decisions had not yet been made on how some or all of the funding will be used. It can be expected that legislatures in these states will finalize these decisions when they convene for their 2004 sessions this spring.

Figure 5



Beyond its effect on state budget shortfalls and Medicaid budget decisions, the fiscal relief also caused a significant reduction in the state share of Medicaid spending. Because the federal government is temporarily assuming a greater share of Medicaid expenditures, total Medicaid spending is projected to increase by 8.2 percent in FY 2004, while the cost of Medicaid in state general funds is expected to grow by 3.3 percent.

4. States Expect a Significant Fiscal Impact When Temporary Federal Fiscal Relief Ends

The expiration of the fiscal relief will have a strong and direct impact on the Medicaid program. On July 1, 2004 the cost of Medicaid in every state will increase dramatically as a result of the expiration of the temporary increase in the federal matching rate. Consequently, in many states, the percentage increases in the state cost of Medicaid in FY 2005 will likely be the highest experienced in many years. Proportionately, the impact will be greatest in those states with the lowest per capita incomes and highest

federal matching rates. Few states will have the fiscal resources at their disposal to meet the significant increase in the state share of Medicaid costs.

Comments of Medicaid Directors on the Impact on Medicaid When the Enhanced FMAP Ends:

"We approach a crisis when the FMAP ends. There is no additional money laying around to backfill."

"It [FY 2005] will be more problematic than '04, because we lose the benefit of the FMAP relief. I expect deficiencies to be three or four times the '04 level."

As shown in Tables A-1 and A-2, the enhanced FMAP had a significant impact on the state share of Medicaid costs in FY 2004. Indeed, in the December 2003 survey, five states reported actual reductions in state spending for Medicaid in FY 2004. It is clear that many states were able to survive the continuing increases in total Medicaid spending in FY 2004 because of the enhanced FMAP.

However, when the enhanced FMAP ends on June 30, 2004, states will have to adjust to dramatic percentage increases in the state cost of Medicaid for FY 2005 (Figure 5). The combination of underlying Medicaid spending growth and the decline in the federal share of the program mean that states will experience unusually high growth rates in FY 2005. For example, a state with a regular FMAP of 50 percent and annual growth of 8 percent in total Medicaid spending would see increases in the state general fund cost of Medicaid of at least 14.8 percent in FY 2005 (Table A-1). The higher the regular FMAP for that state, the higher will be the FY 2005 rate of growth in state cost of Medicaid. In some of the ten states with regular FMAP above 70 percent, the annual rate of growth in the state general fund share of Medicaid spending in FY 2005 might exceed 20 percent.

Table A-1: FMAP Impact Example: A State with 50% FMAP*

	FY 2003 (Prior to enhanced FMAP)	FY 2004	% Change in FY 2004	FY 2005	% Change in FY 2005
FMAP	50.0 %	52.95 %		50.0 %	
Total Medicaid Spending**	$100.0	$108.0	+ 8.0 %	$116.64	+ 8.0 %
Federal Share	$50.0	$ 57.186	+ 14.4 %	$ 58.32	+ 2.0 %
State Share***	$50.0	$ 50.814	**+ 1.6 %**	$ 58.32	**+ 14.8 %**

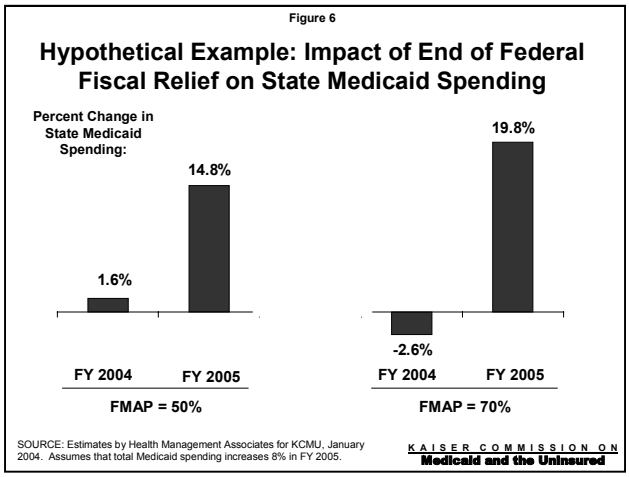
* A total of 12 states had FMAP rates of 50.0 percent in FY 2003.
**This example assumes 8% growth in total spending in FY 2004 and FY 2005
***In some states, state and local share.

Table A-2: FMAP Impact Example: A State with 70% FMAP*

	FY 2003 (Prior to enhanced FMAP)	FY 2004	% Change in FY 2004	FY 2005	% Change in FY 2005
FMAP	70.0 %	72.95 %		70.0 %	
Total Medicaid Spending**	$100.0	$108.0	+ 8.0 %	$116.64	+ 8.0 %
Federal Share	$70.0	$ 78.786	+ 12.6 %	$ 81.648	+ 3.6 %
State Share***	$30.0	$ 29.214	**- 2.6 %**	$ 34.992	**+ 19.8 %**

* A total of 10 states had FMAP rates of 70 percent or greater in FY 2003.
**This example assumes 8% growth in total spending in FY 2004 and FY 2005
***In some states, state and local share.

With these examples, it is easier to understand the concern expressed by Medicaid officials as they described the outlook for Medicaid in their state in FY 2005.



Comments of Medicaid Directors on the Impact on Medicaid When the Enhanced FMAP ends:

"We have a very large increase in our base. So it will be awful when the FMAP goes back."

"I dread "05, '06 and '07. The only reason we are getting along right now is the enhanced FMAP."

"It [the FMAP increase] really masked the underlying problem. It delayed the need to address the fundamental cost problem for the Medicaid program."

"Medicaid will still be the fastest growing program in the state budget. The legislature will be trying to find a way to have us live with the amount we had last year…It will be a challenge because the legislature will have to build the budget assuming no increase in the FMAP. It is going to be a tough session."

"We know it ends. Based on our preliminary estimates, we think we will be OK in '05."

"The state is going to have to make up the difference or cut services. So, we have some tough choices ahead."

"Our regular FMAP dropped, so it's a double drop off for us. We need a lot of new state funds. It is going to be bad. We'll have to reduce benefits or rates. We know we will have to do it. We have stopped outreach. We have done everything we could to get ready, but we are going to be hit in '05."

5. Outlook for FY 2005

As states looked toward fiscal year 2005, most expressed strong concern about prospects for the Medicaid program. Although the fiscal situation seemed to be improving in some states, the improvement varies by state. While some state officials described fewer demands for new Medicaid cost containment measures, and a few even described hopes for restoring previous reductions or making expansions, many others described continuing state budget shortfalls and pressure from legislatures, Governors and state budget directors to bring Medicaid spending under control. The ending of the temporary FMAP increase dominated Medicaid officials' comments relating to the outlook for FY 2005, with many states expressing strong concern about how they would fill the gaps that the expiration of the matching rate increase would create.

Moreover, even in those states where revenues seemed to be recovering, the mismatch between revenue growth and Medicaid spending growth remains a serious concern. Officials cited continuing pressure from Medicaid caseload increases, as the number of persons enrolled in Medicaid continues to increase. Some states specifically mentioned the impact of increasing numbers of seniors and people with disabilities, whose costs are high, enrolling in Medicaid. In addition, there was concern about medical inflation and the associated impact on Medicaid provider payment rates.

Comments of Medicaid Directors Expressing Concern About the Outlook for Medicaid in FY 2005:

"*The growth in the aged and disabled is putting more pressure on the program."*

"Our program continues to grow. Everyone is seeing cost inflation, and it is hitting us, too."

"The situation is improving. Receipts are starting to come up, and we are containing costs."

"We are not talking (any more) about cuts in eligibility or benefits. There will still be issues with long term care and pharmacy, but it will be a better year."

"'05 will be about as abysmal as '04. The Governor has asked us to take a huge cut for '05. We're cutting the whole gambit. No stone is being left unturned."

"Unless the economic recovery is dramatic and sustained, continuing structural adjustment to Medicaid payment methodologies, eligibility and benefits seems unavoidable."

"Expenditures continue to rise while revenues remain stagnant. We must find a way to reduce one or increase the other."

"We are looking at potential expansion areas, and where the funding would come from. There's been less talk about cuts."

"The Governor is looking at cuts. When revenue growth is 5 percent in a good economy, and health care is increasing in the teens, it just doesn't work for us."

"We have a status quo budget for '05. We have problems because of the FMAP and growth in enrollment…It is going to be a battle. Legislators have already told us they can't continue funding increases in Medicaid."

An additional change that lies on states' horizon is the new Medicare prescription drug benefit, which is scheduled to take effect in 2006. The Medicare Prescription Drug Improvement and Modernization Act of 2003 makes a fundamental policy change by moving financial responsibility for prescription drug coverage from Medicaid to Medicare for dual eligibles, who are enrolled in both programs. The survey asked state officials how they viewed the potential impact of this change, which is significant because dual eligibles account for about half of all Medicaid spending on prescription drugs.[15]

At the time of the survey, Medicaid officials were still assessing the impact of the new Medicare legislation on their programs. They indicated that on average, Medicaid spending for prescription drugs for dual eligibles accounted for 47 percent of the total Medicaid spending for prescription drugs.[16] When asked whether the new Medicare prescription drug benefit would affect future Medicaid strategies to control prescription drug spending, officials in 30 states said they expected it to have an impact. (Officials in 16 states indicated they expected no impact, and officials in 5 states said they did not know yet how to respond and declined to indicate an answer to this question.)

In particular, state officials were concerned that as Medicaid's market share was diminished by about half as responsibility for dual enrollees' drug spending was taken over by Medicare, Medicaid's leverage to negotiate rebates from manufacturers would also diminish. However, Medicaid officials did not immediately see a change in the strategies they expect to employ to control Medicaid spending for prescription drugs.

Comments of Medicaid Directors on the Impact of the Medicare Prescription Drug Benefit on Medicaid:

"It could hurt our buying process, but I don't think it will change our strategy."

[15] Bruen and Holahan, *Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government*, Kaiser Commission on Medicaid and the Uninsured, November 2003.

[16] A total of 33 states responded when asked what percentage of their total prescription drug expenditures were spent on dual eligibles.

"We could lose our leverage for supplemental rebates. Dual eligibles account for over 50 percent of Medicaid prescription costs."

"It makes it more difficult when this big chunk of dollars is being taken out. It will make it more difficult to negotiate rebates, for example."

"Over time, Medicaid program's ability to negotiate supplemental drug rebates will be reduced because of the loss in Medicaid drug volume, which will be transferred to Medicare Part D."

Conclusion

At the mid point of FY 2004, Medicaid officials continue to face difficult challenges in administering the program. Three years of Medicaid cost containment has slowed the rate of spending growth, and has helped to substantially slow enrollment growth. As a result of these trends, the temporary federal fiscal relief to states, and the relative stabliziation of the state revenue situation, fewer states took additional midyear cost containment action than had done so at this time one year ago. Medicaid officials who responded to the survey credited the temporary increase in the federal Medicaid matching rate (the FMAP) as the major reason they were able to avoid severe cuts in Medicaid in FY 2004.

But all signs point toward continued challenges for the Medicaid program in FY 2005. Not only does the rate of Medicaid spending growth, while slowing, continue to outpace growth in state budgets and state tax revenues, but the state share of Medicaid spending will increase dramatically in every state when the federal fiscal relief expires in June. Few states expect the spending and revenue pressues they face to subside by then, and fear that they will have no easy means of filling the gaps that the expiration of the fiscal relief will create. In most states, considerable concern remains that budget pressure to control Medicaid spending will continue at an intense level for FY 2005. It therefore seems likely that Medicaid policy makers will continue to face difficult challenges for some time to come.

Appendix A: Medicaid Cost Containment Actions Planned in 49 States and the District of Columbia in FY 2004

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts**	Copays	Managed Care Expansions	DM/ CM	Fraud and Abuse	LTC ***
Alabama									
Alaska*		X						X	X
Arizona*	X	X		X	X				
Arkansas	X	X					X	X	
California*	X	X	X	X				X	
Colorado	X	X	X	X	X		X	X	
Connecticut		X		X	X				
Delaware	X	X			X				
District of Columbia	X	X							
Florida*	X	X	X		X	X		X	X
Georgia*	X	X	X	X			X		X
Hawaii*		X							
Idaho		X							
Illinois		X							
Indiana*	X	X	X		X	X	X	X	X
Iowa*	X	X			X				X
Kansas*	X	X							
Kentucky	X	X		X					X
Louisiana	X	X		X		X		X	X
Maine*	X	X			X			X	
Maryland	X	X	X		X			X	
Massachusetts	X	X		X	X			X	X
Michigan	X	X	X		X	X		X	
Minnesota	X	X		X	X			X	X
Mississippi	X						X		
Missouri	X	X	X				X		
Montana		X					X		
Nebraska	X		X	X					
Nevada	X	X	X			X	X	X	
New Hampshire*	X	X			X		X	X	
New Jersey	X	X	X	X			X		
New Mexico*	X	X	X		X		X	X	
New York	X	X				X			
North Carolina	X			X		X	X	X	
North Dakota	X			X					
Ohio	X	X	X		X	X	X		X
Oklahoma*		X				X	X	X	
Oregon	X	X	X			X			X

Pennsylvania	X							X	
Rhode Island	X							X	
South Carolina*	X	X		X	X		X		
South Dakota		X							
Tennessee	X	X						X	
Texas	X	X	X	X		X	X	X	
Utah*	X	X			X				
Vermont				X					
Virginia		X			X				
Washington*	X	X	X	X	X		X	X	
West Virginia	X	X			X	X			X
Wisconsin*	X	X	X	X	X	X	X	X	X
Wyoming*		X					X	X	X
Total	**39**	**43**	**17**	**18**	**21**	**13**	**19**	**24**	**14**

* States responding to the December survey that they took new or additional cost containment action after the beginning of FY 2004.
** Eligibility cuts include changes made to application and enrollment procedures.
***LTC includes cuts to Home and Community Based Services.

Appendix B: Federal Medical Assistance Percentages (FMAP)

State	FY 2004 FMAP	FY 2005 FMAP
Alabama	73.7%	70.8%
Alaska	61.3%	57.6%
Arizona	70.2%	67.5%
Arkansas	77.6%	74.8%
California	53.0%	50.0%
Colorado	53.0%	50.0%
Connecticut	53.0%	50.0%
Delaware	53.0%	50.4%
District of Columbia	73.0%	70.0%
Florida	61.9%	58.9%
Georgia	62.6%	60.4%
Hawaii	61.9%	58.5%
Idaho	73.9%	70.6%
Illinois	53.0%	50.0%
Indiana	65.3%	62.8%
Iowa	66.9%	63.6%
Kansas	63.8%	61.0%
Kentucky	73.0%	69.6%
Louisiana	74.6%	71.0%
Maine	69.2%	64.9%
Maryland	53.0%	50.0%
Massachusetts	53.0%	50.0%
Michigan	58.8%	56.7%
Minnesota	53.0%	50.0%
Mississippi	80.0%	77.1%
Missouri	64.4%	61.2%
Montana	75.9%	71.9%
Nebraska	62.8%	59.6%
Nevada	57.9%	55.9%
New Hampshire	53.0%	50.0%
New Jersey	53.0%	50.0%
New Mexico	77.8%	74.3%
New York	53.0%	50.0%
North Carolina	65.8%	63.6%
North Dakota	71.3%	67.5%
Ohio	62.2%	59.7%
Oklahoma	73.5%	70.2%
Oregon	63.8%	61.1%
Pennsylvania	57.7%	53.5%
Rhode Island	59.0%	55.4%
South Carolina	72.8%	69.9%
South Dakota	68.6%	66.0%
Tennessee	67.5%	64.8%
Texas	63.2%	60.9%
Utah	74.7%	72.1%
Vermont	65.4%	60.1%
Virginia	53.5%	50.5%
Washington	53.0%	50.0%
West Virginia	78.1%	74.7%
Wisconsin	61.4%	58.3%
Wyoming	64.3%	57.9%

Source: http://aspe.hhs.gov/search/health/fmap.htm

Note: FY 2004 rates include 2.95% temporary increase in FMAP Congress provided. FY 2005 rates do not.

Appendix C: Survey Form

Medicaid Mid-Year Budget Update: Fiscal Year 2004

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

1. **State FY 2004 Medicaid Spending Growth and Enrollment Growth**:
   What is your *current estimate*, in percent, for projected Medicaid **spending** growth, and total Medicaid **enrollment** growth, in SFY 2004 (above SFY 2003):
   A. FY 2004 % Spending Growth in *Total* funds:…… _____%
   B. FY 2004 % Spending Growth in *State* funds (with enhanced FMAP) : _____%
   C. FY 2004 % Spending growth in *Federal* funds (with enhanced FMAP): _____%

   D. Without the enhanced FMAP, what would your estimate have been for the % growth in State funds? _____%

   E. **Enrollment:** FY 2004 estimated % change in total Medicaid enrollment: _____%

2. **Medicaid Budget Shortfall**:
   If you are projecting a Medicaid budget shortfall for SFY 2004, is it larger or smaller than was expected when the fiscal year began? (*Please check one response*)

   Smaller___ About the same___ Larger___ No shortfall expected___

3. **Mid-year Medicaid Budget Adjustments**:
   Are you making FY 2004 mid-year changes in Medicaid to reduce the rate of spending growth?
   Yes_____ No_____

4. **FY 2004 Budget and Policy Changes:**
   In the table on the next page, please indicate cost containment and other policy changes being made in FY 2004. For each policy listed in Column A, please indicate with an **X** in:

   Column B for each policy implemented (or to be implemented) *pursuant to the original legislative appropriation* for FY 2004.

   Column C for each policy implemented (or to be implemented) *pursuant to a decision subsequent to the original legislative appropriation* for FY 2004.

4. Medicaid cost containment and other policy initiatives in FY 2004:

A	B	C	D
Program/Policy Area	**X=In FY 04 Original Budget**	**X=Mid-Year Budget Decision**	**Brief Description**
A. Provider payments:			
a. Rate reductions			
b. Rate freezes			
c. Rate increases (including HMO increases due to "actuarial soundness")			
d. Decisions to delay adopted increases or cuts			
B. Rx controls and limits:			
a. Payment @ AWP less a greater %			
b. New or Lower state MAC rates			
c. More Rx subject to prior authorization			
d. Preferred drug list			
e. Supplemental rebates			
f. Limits on the number of Rx per month			
g. Contract with a PBM			
h. Long term care Rx initiative			
i. Other:			
C. Benefits:			
a. Benefit or service reductions or limits			
b. Benefit expansions			
c. Decisions to delay cuts or expansions			
D. Eligibility:			
a. Eligibility cuts			
b. Eligibility expansions			
c. Decisions to delay cuts or expansions			
d. Changes in eligibility, rules or process (e.g., applications, redeterminations, 12-month eligibility for children, 6-month eligibility for HMO enrollees, etc.)			
e. Establish or increase premiums			
E. Copays:			
a. New or higher beneficiary copays for Rx			
b. New or higher copays for other services			
F. Managed care and disease management:			
a. Expansions of managed care			
b. Disease management / case management			
G. Long term care:			
a. Changes to institutional LTC			
b. Changes to home and community-based care			
H. Other:			
a. Fraud and abuse controls			
b. Administration changes			
c. Other changes:			

1. **How has your state used the fiscal relief provided through the 2.95% FMAP increase for the five quarters ending June 30, 2004? (Check as many as apply.)**
   a. _____To avoid, minimize or postpone proposed cuts or freezes.
   b. _____To provide program increases that would not otherwise have been made.
   c. _____To help resolve an overall budget shortfall in the Medicaid budget.
   d. _____To help resolve an overall shortfall in the state general fund budget.
   e. _____The funds are being held in a reserve or trust.
   f. _____Decisions are yet to be made for some or all of fiscal relief funds
   g. _____Other: _____

2. **Medicaid prescription drug spending and "dual eligibles":** Estimated Medicaid spending for drugs for "dual eligibles" for this fiscal year and the past two years, for your state: (Please omit Pharmacy Plus waiver programs.)
   a. FY 2002 estimated Rx spending for duals: $_____ millions
   b. FY 2003 estimated Rx spending for duals: $_____ millions
   c. FY 2004 estimated Rx spending for duals: $_____ millions

   d. FY 2004 estimated Rx spending for duals as % of total drug spending: ____%

3. **How do you think Medicare's assumption of most of the costs for prescription drugs for dual eligibles will affect your strategies for controlling Medicaid drug spending?**
   a. _____Expect no effect
   b. _____Expect changes (describe):_____

4. **Outlook for FY 2005**:
   a. How would you describe the Medicaid budget outlook for your state for FY 2005?

      _____
      _____

   b. What do you anticipate the impact will be when the enhanced FMAP ends on July 1, 2004?

      _____
      _____

Thank you. If you have any questions, please call or email.

This survey can be returned by email (vsmith@healthmanagement.com), fax or mail to:

Vernon K. Smith, Ph.D.
Health Management Associates
120 N. Washington Sq., Suite 705
Lansing, MI 48933
Phone: 517-482-9236 or direct line: 517-318-4819
Fax: 517-482-0920

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

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