kaiser commission on medicaid and the uninsured

# States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004

## Results from a 50-State Survey

*Prepared by*
Vernon Smith, Ph.D., Rekha Ramesh, Kathy Gifford, Eileen Ellis,
Health Management Associates
and
Victoria Wachino
Kaiser Commission on Medicaid and the Uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

September 2003

# kaiser commission on medicaid and the uninsured

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

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# Executive Summary

States are beginning what is for some the fourth consecutive year of fiscal stress. State tax revenues declined significantly in 2002 and remained at that low level throughout 2003. As they completed their 2003 fiscal year and developed budgets for fiscal year 2004, states faced total budget shortfalls of at least $70 billion. To close these large budget gaps, states reduced planned spending and some began to raise taxes and fees. After the beginning of fiscal year 2003, states reduced budgeted spending levels for the year, and many states proposed to reduce fiscal 2004 spending.

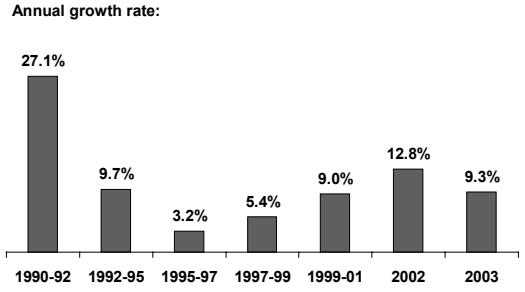
These fiscal conditions place significant pressure on Medicaid, the state/federal program that funds health and long term care coverage for 51 million low-income Americans. Medicaid, which is funded jointly by the states and the federal government, is generally the second-largest program in states' budgets. At the same time that state revenues have fallen, spending on the Medicaid program has been increasing significantly, reflecting increasing health care costs and the growing number of people living in poverty as a result of the weak economy.

As states have grappled with the challenge of balancing their budgets in the face of declining revenues, many have put in place new measures to control their Medicaid spending growth. States have been implementing new Medicaid cost containment measures over the past four years, and in the past two years state emphasis on reducing Medicaid spending growth has increased significantly. To track the changes states are making, the Kaiser Commission on Medicaid and the Uninsured sponsors a survey of Medicaid directors in all 50 states and the District of Columbia, which is carried out by Health Management Associates. This report describes the findings of the most recent survey, which was completed in June 2003, as most states were preparing to begin their 2004 fiscal years. The survey found:

**Medicaid spending continues to grow significantly, but the rate of growth declined substantially in FY 2003.** Total average spending growth in fiscal year 2003 was 9.3 percent. While this represented significant growth and Medicaid remained one of the fastest growing parts of state budgets, it was significantly lower than the 12.8 percent growth rate states reported just one year before (Figure 1).

Figure 1

**Average Annual Growth Rates of Total Medicaid Spending**




SOURCE: For 1990-1999: Urban Institute estimates prepared for the Kaiser Commission on Medicaid an the Uninsured, 2000. For 2001-2003: Health Management Associates, for the Kaiser Commission on Medicaid and the Uninsured.

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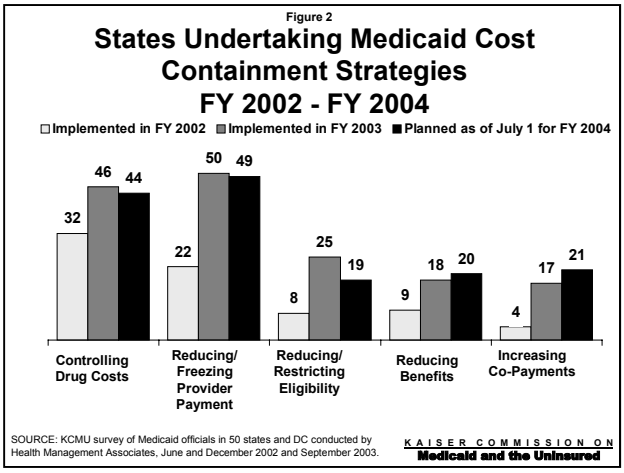
This decline, which is a one-quarter reduction in Medicaid spending growth, was the first time since 1996 that the rate of growth in Medicaid spending was less than the preceding year. The slowing growth rate of Medicaid spending is a significant departure from trends in private health insurance, where the rate of growth in employer-sponsored health benefits increased to 13.9 percent in 2003 from 12.9 percent in 2002. The primary factor behind the slowing rate of growth in Medicaid spending is likely to have been the cost containment strategies states have put in place. In addition, recent restrictions on state use of some federal financing strategies probably also contributed to the lower growth. Nevertheless, the slower rate of growth in overall spending to 9.3 percent is remarkable in light of the fact that the number of people enrolled in Medicaid increased in FY 2003 by 7.8 percent, slowing somewhat from the 9.2 percent increase in the prior year.

**All 50 states and the District of Columbia implemented Medicaid cost containment measures in FY 2003, and each of these states planned to put in additional spending constraints in FY 2004.** The KCMU survey found that every state in the nation, including the District of Columbia, executed at least one new Medicaid cost containment strategy in fiscal year 2003. This represents slight growth from the 49 states and D.C. that reported undertaking fiscal year 2003 Medicaid cost containment activity in our last survey, which was completed in December. Moreover, every state planned to undertake additional cost containment action in their Medicaid programs in fiscal year 2004.

State cost containment activity continued to focus heavily on reducing provider payments and controlling prescription drug spending (Figure 2). Forty-nine states either froze or reduced provider payments, and 44 states put new mechanisms in place to reduce their spending growth on prescription drugs in FY 2004. At the same time, 19 states planned to restrict eligibility, 20 states planned to reduce the availability of benefits, and 21 states made plans to increase co-payments in FY 2004.

Figure 2




While most of the eligibility restrictions states have put in place have been narrow, a few of these restrictions have been large. A number of the larger restrictions have reduced coverage for parents and other adults. Significant numbers of children are also likely to be affected by some of the eligibility reductions. Most states have not targeted eligibility for seniors and people with disabilities. However, many of the benefit reductions states

are making will affect seniors and people with disabilities. Moreover, as the biggest users of prescription drugs, these individuals are particularly likely to be affected by some of the many different prescription drug cost containment strategies, such as increased co-payments, that states are putting in place.

At the same time they implemented cost containment strategies in FY 2003 and FY 2004, some states also put in place some program expansions. These were generally modest, though three states undertook more significant expansions. Moreover, after reductions in FY 2003, in FY 2004 a number of states reported making improvements to their application and enrollment processes. States also continued to increase their efforts at disease and case management as well as combating fraud and abuse.

**The recent federal fiscal relief to states helped forestall additional and larger reductions to the Medicaid program, but this relief is only temporary.** In June, Congress provided $20 billion in fiscal relief to states, including $10 billion through a temporary increase in federal Medicaid matching rates. The survey found that these funds, which took effect recently and are scheduled to expire near the end of fiscal year 2004, were critical to helping to prevent additional, larger Medicaid cost containment action in states. The fiscal relief also helped some states avoid significant reductions in eligibility. At the same time, state officials expressed strong concern about their budget situations in FY 2005, when the fiscal relief is no longer available. States do not expect that their fiscal conditions will have improved significantly by the time the federal fiscal relief expires next June.

**For many states, fiscal year 2004 marked the third consecutive year the state took new action to reduce spending growth in their Medicaid programs.** When the results of this survey were compared to the results of our previous surveys, we found that between fiscal 2002 and 2004, 50 states had reduced or frozen provider payments at least once, and 50 states had restricted prescription drug spending at least once. In addition, between FY 2002 and 2004, 34 states took one or more action to reduce eligibility in the Medicaid program, 35states acted at least once to restrict benefits, and 32 states increased or added copayments at least once.

The outlook for state budgets in FY 2004 and 2005 remains challenging. The state revenue picture remains depressed. Spending pressures continue to build. States have exhausted a lot of one-time measures they have used to balance their budgets. Medicaid expenditure assumptions in FY 2004 appear optimistic, and Medicaid budget shortfalls are likely in a majority of states. Finally, the federal fiscal relief expires near the end of fiscal year 2004, which will leave states with significant gaps in their budgets. Present expectations of low revenue growth and continued substantial growth in Medicaid spending mean that states are likely to continue to look for additional ways to curb Medicaid spending growth.

States are increasingly emphasizing Medicaid cost containment as part of their overall budget balancing efforts. Most states have put in place a comprehensive array of Medicaid cost reduction strategies over the past three or four years. These strategies

appear to have been successful in reducing the rate of Medicaid spending growth. But they also raise real questions about how the program will be able to meet the health care needs of low-income people, whose numbers are growing. In some cases, reducing provider payments, restricting benefits, and some prescription drug spending controls can limit beneficiaries' access to services they need. Recent changes to eligibility mean that the program, while growing, will not be serving some low-income, uninsured persons who previously would have been eligible. These changes raise the possibility of an increase in the number of uninsured. And increases in copayments may impact the availability of services for some low-income beneficiaries. As states enter another year – or more – of Medicaid cost containment, they continue to struggle to balance the health needs of their low-income citizens with the need to close what are for many states gaping holes in their overall state budgets.

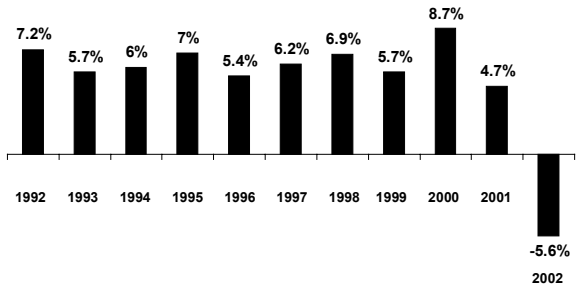
# Introduction

Medicaid is the nation's largest public health insurance program. Medicaid provides health and long-term care coverage to 51 million low-income people, including children, families, seniors, and people with disabilities, and fills in gaps in Medicare coverage for seniors, especially for prescription drugs and long-term care. On average, Medicaid covers about one in every nine Americans, with the exact percentage of residents covered by Medicaid varying by state. To meet the broad needs of the population it covers, Medicaid covers a range of comprehensive services, including physician and hospital care, nursing home care and prescription drug coverage. Medicaid also plays a major role in our country's health care delivery system, paying for nearly half of all nursing home care and 17 percent of prescription drugs.

Recently, Medicaid has become subject to strong budget pressure as a result of the states' fiscal crises. Beginning in 2001, as the national economy worsened and growth in state tax revenue slowed, states began focusing on controlling spending. By fiscal year 2002, state revenues had fallen sharply, and in fiscal year 2003 state revenue trends remained dismal (Figure 3).

Figure 3

**Change in State Tax Revenue Collections, 1992-2002**




SOURCE: Rockefeller Institute of Government, Fiscal Year 2002 Tax Revenue Summary, May 2003. Changes are shown in nominal terms and are not adjusted for tax-related legislative changes.

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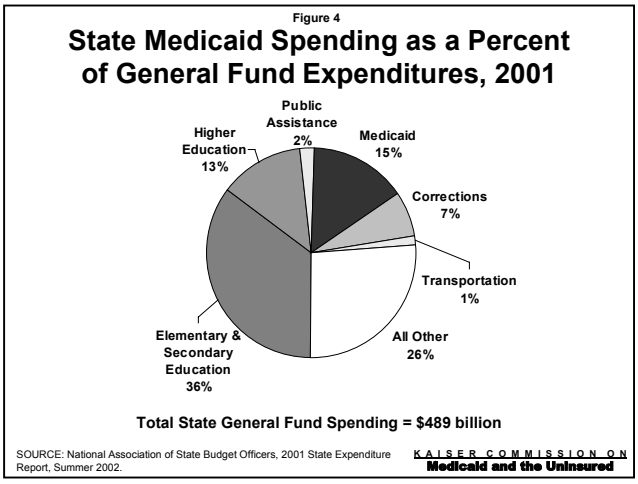
Today states continue to face extremely difficult fiscal situations. Nearly every state has spent the past three years putting in place actions to reduce spending growth in their Medicaid programs, including reducing benefits, eligibility, and provider payments. The present situation stands in stark contrast to the mid to late 1990's, when states, enjoying extremely strong revenue growth and historically low health care spending increases, used Medicaid to expand coverage and to lower the number of their residents living without insurance.

Since 2001, the Kaiser Commission on Medicaid and the Uninsured (KCMU) has worked with Health Management Associates (HMA) to survey the changes states are making to their Medicaid budgets as a result of their deteriorating fiscal conditions. The 50-state survey also tracks changes in Medicaid spending growth. This is the third comprehensive

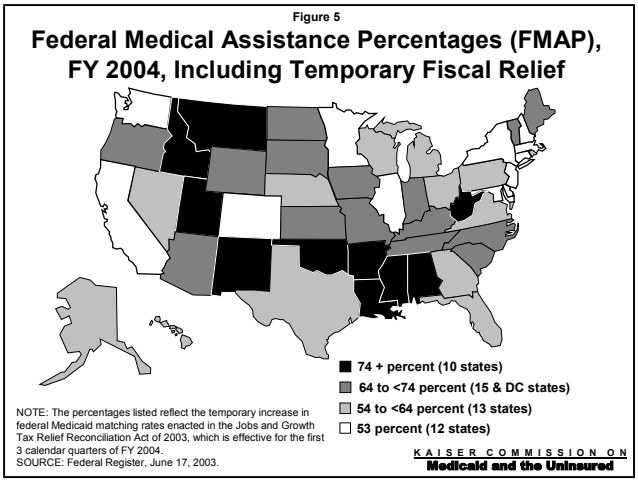
annual survey that KCMU and HMA have published. We have also published two mid-year survey updates, the most recent of which was released in January 2003. This report publishes the results of this third comprehensive survey, which was completed in June.

## Background: The Medicaid Program and State Budgets

Medicaid provides health and long-term care coverage to 51 million low-income children, families, seniors, and people with disabilities. Medicaid is jointly funded and administered by the states and the federal government. It is expected to cost the federal government $169 billion in fiscal year 2004, according to the Congressional Budget Office, with the states spending an additional estimated $127 billion. On average, states spend about 15 percent of their own funds on Medicaid making it the second largest program in most states' general fund budgets (Figure 4).




The federal government matches state spending for the services Medicaid covers on an open-ended basis. The federal matching rate, known as the federal medical assistance percentage (FMAP) varies by state (Figure 5).



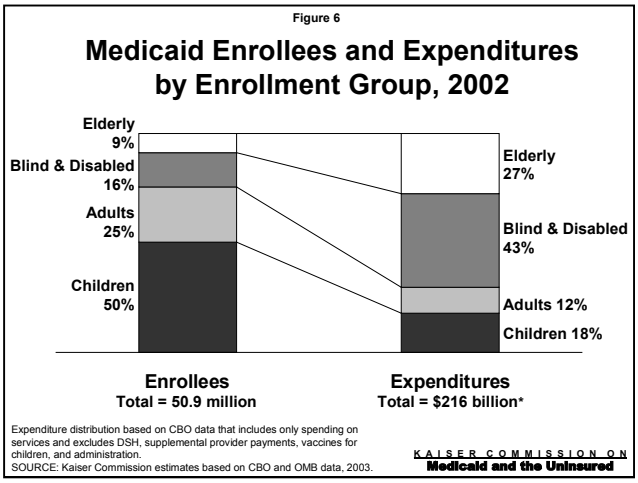

Because of the matching formula, state spending on Medicaid brings increased federal dollars to the state. For example, at a 50 percent matching rate, a state draws down $1.00 for every dollar it spends. Likewise, at a 70 percent matching rate, a state draws down

$2.33 for every $1 it spends. Medicaid's matching formula provides an important financial support for states, which use federal mathcing payments with their own dollars to fund health and long-term care services.

States have the responsibility to design and administer their program within the federal rules that define the terms and conditions under which a state can earn federal matching funds. Within the federal structure, states enroll beneficiaries using their own eligibility criteria, decide which services are covered, and set payment rates for providers. States also decide other key policies, such as which eligibility groups receive care within a managed care system, how the state will use Medicaid to finance a range of other medical services such as those provided through the mental health or public health systems, and special payments to hospitals that serve a disproportionate share of indigent patients. While the federal government requires states that participate in Medicaid to provide a core set of benefits, it also permits states the flexibility to provide "optional" services at the states' discretion. Optional services include prescription drugs, which all states have elected to provide, as well as services such as dental care, hospice care, and prosthetic devices.

Medicaid expenditures vary by the population being served. Low-income children and their parents represent about three-fourths of Medicaid beneficiaries, but their health coverage is less expensive as they account for just 30 percent of Medicaid spending (Figure 6).

Figure 6




At the same time, persons with disabilities and the elderly account for most of Medicaid's costs. In fact, the elderly and disabled represent just one-quarter of Medicaid enrollees, but they account for 70 percent of Medicaid spending, reflecting their intensive use of acute and long-term care services. Medicaid also plays a significant role in supplementing Medicare coverage for 7 million seniors and people with disabilities who are enrolled in both programs. For these people, Medicaid covers services Medicare does not, most notably prescription drugs and long-term care, and assists with Medicare cost-sharing.

After a period of historically low growth, Medicaid spending began increasing again in 1999. In 2002, total Medicaid spending increased 12.8 percent. This is consistent with the rate of growth in private health insurance premiums. This consistency is not surprising, because Medicaid purchases health care services in the same private market that employment-sponsored insurers do. Higher health care costs, especially for prescription drugs, are a major factor behind the increase in both Medicaid spending and private health insurance premiums. At the same time, Medicaid faces a significant burden that private insurers do not: during a weak economy, Medicaid frequently serves more people, while employer-sponsored health insurers generally serve fewer people. Despite this difference, as this report will discuss, athough the rate of growth in costs for employer-sponsored health insurance continued to increase in 2003, the rate of growth in Medicaid spending fell.

When state revenues decline, as has occurred in many states over the past two years, states generally scale back state spending for all services, from education to health care. Medicaid program reductions can pose a particular challenge, because the need for Medicaid is usually greatest during an economic downturn, when more people live in poverty and qualify for the program. This dynamic is inherent in the design of the program, which serves as insurer of last resort of low-income people. But Medicaid's responsiveness to economic conditions also means that the program frequently grows the fastest when state revenues are down. In other words, the need for the Medicaid program is frequently greatest when states are least able to afford it.

The severity of state fiscal conditions has forced states to consider difficult options that have affected health coverage for millions of low-income people in every state. Over the past three years, nearly every state has tried to limit prescription drug costs and cut or freeze provider payment rates. As the length of the fiscal crisis has endured, states have turned to reducing Medicaid eligibility and limiting benefit coverage.

As states prepared their budgets for FY 2004, most continued to face significant budget shortfalls as state revenue collected was not sufficient to meet state spending obligations. State "rainy day" funds, which had been set aside for difficult budgetary times, were largely depleted because the current economic downturn was severe and hit states quickly. At the same time, spending on Medicaid increased significantly due to higher health care costs and program enrollment growth. As a result, states have continued to look for new ways to control the growth of spending in their Medicaid programs.

Largely as a result of these conditions, a policy debate is underway about the future of the Medicaid program. In June 2003, Congress temporarily increased federal Medicaid matching rates, providing states with $10 billion as part of a larger $20 billion state fiscal relief package. Earlier this year, the Bush Administration proposed to allow states to replace federal matching funds with a fixed allotment of federal funds for their optional services and populations. Most recently, as Congress considers legislation to create a Medicare prescription drug benefit, attention has focused on the federal role in financing prescription drug coverage for individuals who are enrolled in both Medicaid and Medicare. These individuals are referred to as the "dual eligibles," and spending on

prescription drugs for these seven million people represents half of all Medicaid spending on prescription drugs.

In FY 2004, states are beginning what is for most the third or fourth consecutive year of fiscal stress. In each of those years, states have put in place new actions to reduce their Medicaid spending growth. As long as their revenues remain low, states will continue to focus on Medicaid cost containment, and these efforts are likely to have a significant impact on the scope of the program and how it serves low-income individuals. Because state revenue growth is projected to remain low and Medicaid costs will continue to grow substantially, states will face an ongoing challenge as they try to both balance their budgets and keep pace with Medicaid spending growth.

## Methodology

To track trends in Medicaid spending and the changes states are making to their Medicaid programs as a result of their overall budget pressures, the Kaiser Commission on Medicaid and the Uninsured commissioned Health Management Associates (HMA) to survey Medicaid officials in all 50 states and the District of Columbia. This is the third annual KCMU/HMA survey, and was designed to capture the actions states plan to undertake as they begin fiscal year 2004 and the actions taken in FY 2003.[1] In addition, mid-year update surveys were conducted in 2001 and 2002 to track additional cost containment actions taken after the beginning of the fiscal years 2002 and 2003. A midyear survey update at the end of 2003 will update the information in this report for fiscal year 2004.

The survey for this report was conducted primarily in June 2003, so states could describe Medicaid cost containment actions implemented in FY 2003 and planned for FY 2004.[2] In most cases, states had completed their legislative sessions at the time of the survey. In the 12 states where the state legislature had not yet adopted the FY 2004 budget at the time of the initial survey, HMA received updated information from the state through August 2003 as their state budgets were adopted. The 2003 survey instrument was designed to provide results consistent with those of our previous surveys.[3]

The data for this report was provided directly by Medicaid directors and other Medicaid staff. The survey was sent to each Medicaid director in late May 2003. Then, a personal telephone interview was scheduled during June 2003. The purpose of the telephone interview was to review the written responses or, if the survey had not been completed in advance, to conduct the survey itself. These interviews were invaluable to clarify responses and to record the details of state actions. Generally, the interview included the Medicaid director along with policy or budget staff. In a limited number of cases the interview was delegated to a Medicaid budget or policy official. Responses were received from and interviews conducted for all 50 states and the District of Columbia.

With regard to their FY 2004 budgets, state officials were asked to report only changes that the state planned to begin implementing in FY 2004. In some cases FY 2004 actions were put in place on July 1. In other cases, the actions are to be implemented during the year when the necessary systems changes and notice requirements are completed. Because implementing these actions is complex, involving large-scale administrative and

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[1] A few questions were added to the 2003 survey to obtain more detailed information, separately identify changes to application and enrollment processes, and to explore states' reaction to recent federal policy changes. For previous survey results, see 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. Also: Vernon Smith and Eileen Ellis, *Medicaid Budgets Under Stress: Survey Findings for State Fiscal Years 2000, 2001 and 2002*, Kaiser Commission on Medicaid and the Uninsured, January 2002.

[2] State fiscal years begin on July 1 in 46 states. New York begins its fiscal year on May 1, Texas on September 1, Alabama, Michigan and the District of Columbia on October 1.

[3] The survey instrument is included as Appendix J to this report.

systems change, and are sometimes subject to legal or political challenge, at times policy changes prove too difficult or complex to be implemented within the original timelines. For this reason, although actions described in this report for FY 2004 represent state decisions to undertake specific policy changes, a few of these actions may not be implemented during FY 2004.[4] In other instances, policies still under consideration and therefore not recorded in this survey may be implemented in FY 2004. Notwithstanding this element of uncertainty, the actions reported here for FY 2004 are those that Medicaid programs had been directed to implement and which they expected to implement as they began the fiscal year.

Because this is the third year of this survey of state Medicaid budgets, we have been able to examine state Medicaid cost containment activity over a three-year period from fiscal year 2002 to 2004. We have aggregated some of this three-year data, and in some places in the report, in addition to showing the number of states who are implementing some types of Medicaid cost containment in 2003 and 2004, we provide the total number of states who have implemented that type of strategy over the 2002 and 2004 period.

[4] For this reason, this survey identified some changes in the number of states carrying out changes in a given fiscal year. For example, in our January survey update, 27 states indicated plans to implement eligibility reductions or restrictions in fiscal year 2003. In our June survey, when states were asked for their 2003 eligibility changes, 25 states reported having made such a change. Similarly, 25 states reported in January that they planned to reduce or restrict Medicaid benefits in FY 2003. In this survey, a total of 18 of these 25 states indicated that these reductions were actually implemented in FY 2003. Similarly, although 49 states and D.C. reported undertaking any kind of Medicaid cost containment strategy in January for FY 2003, 50 states and D.C. reported doing so for FY 2003 in this survey.

# Survey Results: State Medicaid Policy Changes for Fiscal Years 2003 and 2004

The 2003 survey found that as the state fiscal crisis enters its fourth year, states increased their focus on Medicaid cost containment in both the 2003 and 2004 fiscal years, with all 50 states and the District of Columbia not only implementing Medicaid cost containment measures in 2003, but also putting additional measures in place in 2004. Probably as a result of these efforts, states have slowed the rate of growth of their Medicaid spending in 2003 to 9.3 percent, down from 12.8 percent in fiscal year 2003. While states report primarily focusing on reducing or freezing provider payments and trying to contain prescription drug spending, many states are also restricting eligibility, reducing benefits, and increasing beneficiary copayments.

The 2003 survey results for FY 2003 and FY 2004 are presented below in the following order:

1. Medicaid Spending Growth Rates
2. Medicaid Enrollment Growth
3. Factors Contributing to Increasing Medicaid Spending
4. Medicaid Cost Containment Measures
5. Provider Taxes
6. Role of "Dual Eligibles"
7. Impact of 2003 Federal Fiscal Relief
8. The Outlook for FY 2004

## *1. Medicaid Spending Growth Rates*

The survey asked states to report their total Medicaid spending and spending growth. Total Medicaid spending reflects actual Medicaid payments to medical providers for the services they provide to Medicaid beneficiaries. Total Medicaid payments also include special payments to providers such as Disproportionate Share Hospital (DSH) payments to qualifying institutions meeting specific criteria, or other payments that qualify for federal matching funds. Total Medicaid spending for this survey does not include any Medicaid administrative costs. Total Medicaid spending includes spending from all fund sources, including state, local and federal funds.[5]

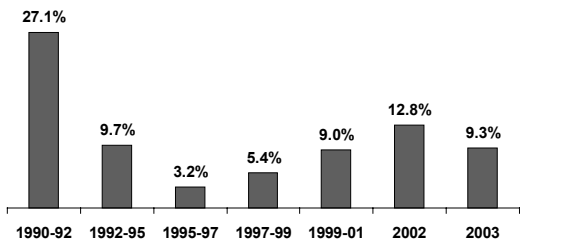
In FY 2003, total Medicaid spending increased on average by 9.3 percent. Although this is a substantial growth rate, it is significantly lower than the 12.8 percent growth rate states reported just one year ago, for fiscal year 2002 (Figure 7). Looked at another way, states reduced the rate of growth in Medicaid spending by just over one quarter in the past year. The FY 2002 total Medicaid spending increase had been the highest rate of

[5] Because it is difficult to apply consistent data definitions across states on total Medicaid spending, we report only growth rates, not total spending levels.

growth since FY 1992. FY 2003 marks the first time since 1996 that the rate of growth in Medicaid spending was less that the previous year.

Figure 7

**Average Annual Growth Rates of Total Medicaid Spending**




SOURCE: For 1990-1999: Urban Institute estimates prepared for the Kaiser Commission on Medicaid an the Uninsured, 2000. For 2001-2003: Health Management Associates, for the Kaiser Commission on Medicaid and the Uninsured.

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This significant decline in the Medicaid spending growth rate implies that states' cost containment efforts have been successful in reducing the rate of increase in their Medicaid spending. In FY 2003, a number of underlying factors, including increasing enrollments as a result of the weak economy and ongoing increases in health care costs, might have led to an even higher rate of growth, but state Medicaid programs implemented a wide range of cost control measures that slowed the rate of growth. These measures are described later in this report. Federal restrictions on Medicaid financing strategies and Disproportionate Share Hospital (DSH) payments were also likely contributors to the declining growth rate of Medicaid spending.

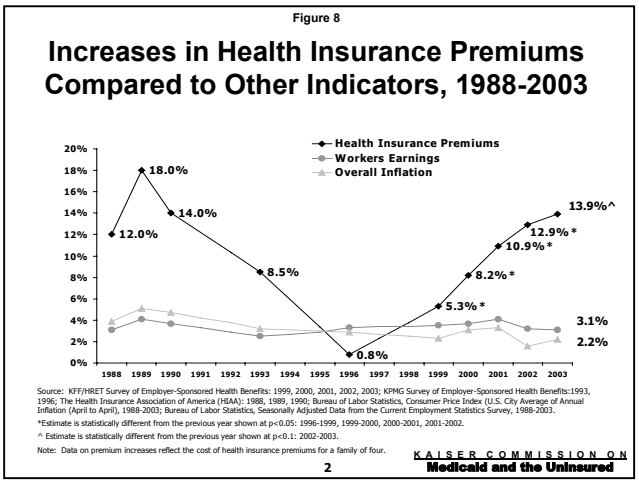
This rate of growth in Medicaid spending can be viewed through two lenses. First, it can be compared to the rate of growth in other state programs, which was negligible, and to total state revenues, which was negative. Overall state spending in 2003 for all programs increased by only 0.3 percent. Preliminary data for FY 2003 indicate that FY 2003 tax revenue declined 0.2 percent, when inflation and legislative changes are accounted for.[6] Compared to these measures, the rate of growth in Medicaid spending is substantial.

However, Medicaid spending growth can also be compared to that taking place in the private insurance market, which buys many of the same health care services and faces many of the same cost pressures as Medicaid does. Medicaid's growth rate is also significantly lower than the growth of private health insurance premiums. In 2003, the rate of growth in premiums for employer-sponsored health insurance increased by 13.9 percent from 2002, when it grew 12.9 percent (Figure 8).[7] In comparison with employer-sponsored health insurance, Medicaid spending growth rates were more than 4.5

[6] See National Governors Association and National Association of State Budget Officers, Fiscal Survey of States, June 2003, www.nga.org. and "The State Fiscal Crisis and its Aftermath" by Donald J. Boyd, Kaiser Commission and Medicaid and the Uninsured, September 22, 2003, ww.kff.org.

[7] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, "2003 Annual Employer Health Benefits Survey, September 2003, http://www.kff.org/content/2003/20030909a/

percentage points lower. This disparity would become even greater if the growth rates were compared on per-enrollee basis, because Medicaid enrollment has been growing as a result of the weak economy, while enrollment in employer-based coverage generally declines when the economy is weak and businesses employ fewer workers.



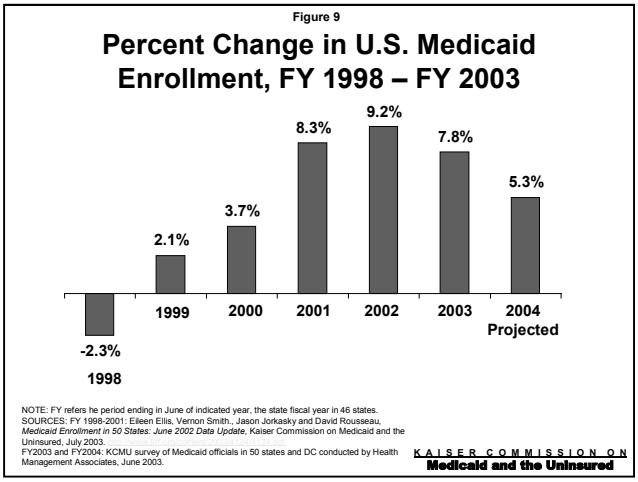

In the past, the KCMU/HMA state budget surveys have reported on the growth rate of state spending on Medicaid as well as total Medicaid spending. Although federal matching payments mean that the federal government shoulders the bulk of the Medicaid costs, states make their spending and policy decisions for Medicaid on the basis of the cost to the state in terms of the state funds that are required to maintain the program. However, the survey was not able to obtain reliable data on the change in state-only spending on Medicaid.

As the survey was being conducted, federal policy changes temporarily increased the federal share and reduced the share of state Medicaid spending. The June 2003 tax cut law included a temporary increase of 2.95 percentage points in the federal Medicaid matching rate (FMAP) for all states for the period from April 2003 through June 2004 as part of a larger fiscal relief package. Because of the timing of this survey, this temporary increase in FMAP was not completely reflected in state Medicaid spending growth rates for FY 2003 and 2004. Some states responded to the survey before the fiscal relief was enacted, and therefore did not include estimates of the effect of the fiscal relief in their growth rates; other states responded to the survey after the fiscal relief was enacted, and did include the effect of the fiscal relief. As a result, the results of the responses to this survey question were not reliable and are not reported here.

## *2. Medicaid Enrollment Growth*

Enrollment in the Medicaid program is still growing, but at a somewhat slower rate. States reported that Medicaid enrollment growth would average 7.8 percent in FY 2003, according to the results of the survey. Looking ahead to FY 2004, Medicaid officials reported that Medicaid enrollment is projected to continue to grow at a significant but slower pace, averaging 5.3 percent (Figure 9). These increases for FY 2003 and FY 2004

represent a slowing in growth from the two previous years. A separate survey designed to look specifically at Medicaid enrollment growth, which relies on data sources different from those used in this survey, documented that Medicaid enrollment increased by 8.3 percent in FY 2001 and by 9.2 percent in FY 2002.[8]




State officials attributed the current enrollment growth to the economic downturn and the associated increase in number of low-income uninsured persons newly eligible for Medicaid. The effect that a weak economy can have on enrollment in Medicaid has been well documented. The Urban Institute has estimated, for example, that a one percent increase in the unemployment adds 1.5 million people to the Medicaid program, at a cost of $1 billion in state Medicaid spending.[9] State officials also cited eligibility expansions of the late 1990s as contributing to increased enrollment.[10]

***Comments of State Medicaid Officials on Medicaid Enrollment:***
*"I am very concerned about the economy and the caseload. That is a big uncertainty for us right now."*
*"We are starting to see some leveling off [in enrollment]. Can't say it is a trend yet, but it is leveling."*
*"I am assuming our caseload growth is going to mellow out."*
*"We anticipate somewhat less dramatic growth in [children and family] caseloads in FY 2004. However, the increasing price and utilization of services used most by ABD [aged, blind and disabled] will continue to be a major factor in FY 04."*

When asked to describe which eligibility groups they believed were contributing most to current expenditure growth, many Medicaid officials mentioned children and families first, since that was the group most directly affected by the economy and where most of

[8] Eileen Ellis, Vernon Smith, Jason Jorkasky and David Rousseau, *Medicaid enrollment: June 2002 Data Update*, Kaiser Commission on Medicaid and the Uninsured, July 2003. Publication 4124. http://www.kff.org/content/2003/4124/4124.pdf
[9] "Medicaid Coverage During Rising Unemployment, Kaiser Commission on Medicaid and the Uninsured," December 2001, http://www.kff.org/content/2001/4026/4026.pdf.
[10] For a fuller discussion of this dynamic, see John Holahan and Brian Bruen, "Medicaid Spending Growth 2000-2002," Kaiser Commission on Medicaid and the Uninsured, September 2003, www.kff.org.

the enrollment growth was occurring. However, because the elderly and disabled beneficiaries are so much more expensive on average than children and families, a majority of Medicaid officials indicated that their cost growth was primarily due to the adult disabled and the elderly categories, even though enrollment growth was less dramatic for these eligibility groups.[11]

## *3. Factors Contributing to Increasing Medicaid Expenditures*

State Medicaid officials were asked to identify the factors they believed had been most significant in causing Medicaid spending to increase in their state over the past year, FY 2003, and also for FY 2004. This was an open-ended, non-structured question. HMA grouped states' responses into five categories.[12]

It was clear that in FY 2003 Medicaid spending growth was not attributable to a single dominant factor. In fact, nearly four out of five states listed three key factors that in combination were regarded as the top drivers of Medicaid spending growth: prescription drug cost growth (40 states), increasing costs of medical services (37 states), and Medicaid enrollment growth (36 states). In light of the recent and continuing significant increases in enrollment growth, it is perhaps not surprising that for the first time in the three KCMU/HMA state Medicaid budget surveys, enrollment growth was the factor most frequently listed first as the most significant contributor to Medicaid spending growth. A total of 23 states listed enrollment growth ahead of all other factors as the most important contributor to Medicaid spending increases. A total of 16 states listed increased costs of prescription drugs first, ten states listed rising costs of medical care as the most significant factor, and three states listed long-term care. (In last year's survey, the increasing cost of prescription drugs was listed first by 25 states, followed by increasing growth in Medicaid caseloads, which was listed first by 18 states.)

For FY 2004, Medicaid officials indicated that the same factors were expected to continue to drive Medicaid spending. In 45 states and the District of Columbia, officials indicated they expected exactly the same factors to influence spending growth. In five states, the order was changed, but the factors remained the same.

***Comments of State Medicaid Officials on Factors Increasing Medicaid Expenditures:***
*"We have almost every dynamic that would cause spending to go up."*
*"Even though elderly and disabled caseloads are growing just 2 percent, and most of the caseload growth is in families, the costs are mostly for the elderly and disabled. The elderly and disabled are really driving cost."*

[11] Ibid. Also, the Kaiser Commission on Medicaid and the Uninsured analyzed growth in Medicaid expenditures as projected in the Federal CMS January 2003 Medicaid baseline. The analysis showed that the elderly and disabled accounted for 62 percent of the expenditure growth from fiscal year 2002 to 2003, while children accounted for 21 percent and adults 17 percent.

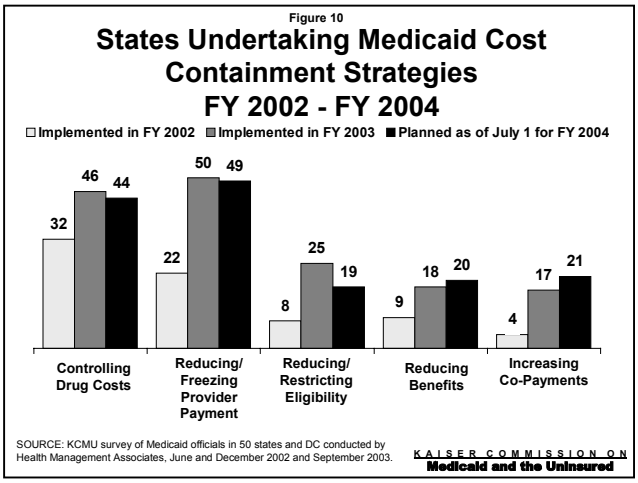
[12] For example, increasing enrollment included responses such as "higher caseloads," "more eligibles," or "higher numbers of recipients." Pharmacy cost growth included factors such as "increasing costs of drugs," "higher utilization of drugs," higher product costs for drugs." A group labeled "increasing medical costs" included "higher hospital costs and utilization," "overall medical inflation," "increases in mental health costs and utilization," "increases in managed care costs," and "higher costs for medical services." Similarly, other responses were grouped under increasing long-term care costs and other factors.

*"Hopefully we won't have another year like that. We are just holding our breath that the economy is going to pick up."*
*"The problem we have is the persistent growth in expenditures in health care."*

## *4. Medicaid Cost Containment Measures*

The survey found that every state in the nation, including the District of Columbia, executed at least one new Medicaid cost containment strategy in fiscal year 2003. This represents slight growth from the 49 states and D.C. that reported undertaking fiscal year 2003 Medicaid cost containment activity in our last survey update, which was completed in December. Moreover, every state planned to undertake additional cost containment action in their Medicaid programs at the outset of fiscal year 2004 (Figure 10). This comes on the heels of significant previous cost containment activity in Medicaid. In 2002, 45 states had implemented cost containment measures in their Medicaid programs.[13] FY 2004 will be the third, and for some states, the fourth consecutive year that states have implemented significant Medicaid cost containment initiatives. Most states are implementing not just one, but many different cost containment strategies simultaneously.[14]

Figure 10




This section outlines the different cost containment strategies states reported undertaking in fiscal years 2003 and 2004, and is divided into the following sections:

- Provider payment rate decreases or freezes
- Pharmacy utilization and cost control initiatives
- Benefit restrictions or reductions

[13] Vernon Smith, Eileen Ellis, Kathy Gifford and Victoria Wachino, *Medicaid Spending Growth: Results from a 2002 Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2002. Publication 4064.
[14] For example, Kentucky implemented 14 cost containment actions in fiscal year 2002 and 43 actions in fiscal year 2003. See "Kentucky's Roadmap in Closing the Gap," presentation by Marcia Morgan, Secretary, Cabinet for Health Services, Commonwealth of Kentucky, for Foundation for Healthy Kentucky's Forum on Medicaid, http://www.healthyky.org/

- Eligibility restrictions or reductions
- New or higher copayment requirements
- Managed care expansions
- New disease or case management programs
- Enhanced fraud and abuse controls
- Long-term care initiatives

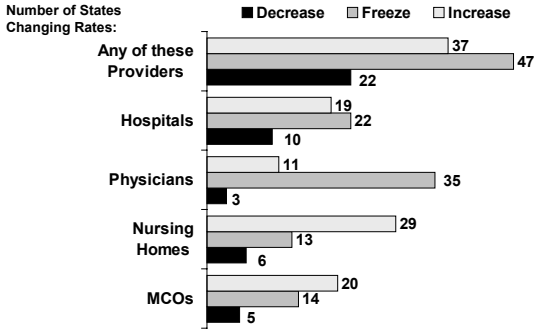
The cost containment actions described in this report are those newly adopted for implementation in each fiscal year. State actions adopted in previous years are not listed even though they may continue to be in effect. Specific cost-containment actions newly taken by states in FY 2003 are summarized in Appendix B. Actions for FY 2004 are in Appendix C. Specific state-by-state actions on pharmacy, eligibility and benefits are listed in Appendices D through I.

**Provider Rate Cuts or Freezes**

In FY 2003, fifty states reported that they cut or froze Medicaid payment rates for at least one group of providers (i.e., hospitals, physicians, managed care organizations or nursing homes). Virtually every state (49 states) froze rates (i.e., neither increased or cut rates) for one or more provider groups (Figure 11).

Figure 11

**Most Medicaid Programs Will Cut or Freeze Some Provider Rates in FY2004**




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

KAISER COMMISSION ON Medicaid and the Uninsured

In 21 states, payment rates were actually cut for one or more provider groups. At the same time, 39 states reported that they increased rates in FY 2003 for one or more other provider groups.[15]

***Comments of State Medicaid Officials on Payment Rate Cuts and Freezes:***
"*We tried to hold off on any rate decreases due to the access issues."*
*"Whenever you don't raise rates, that is an effective form of cost containment."*
*"We haven't increased Medicaid rates for a long time."*

[15] The survey recorded inflation adjustments to provider rates as increases. In our previous surveys, states were not specifically asked to record inflation adjustments as increases, so comparisons with the results of our previous surveys on provider payment reductions should not be made.

*"We've had good provider participation here. When you start freezing rates for two or three years at a time, you begin to get a little concerned."*

The results for FY 2004 are consistent with those for FY 2003. In FY 2004, a total of 49 states indicated they would be freezing rates for at least one provider group, including 21 states that will also cut rates. A total of 37 states plan to increase rates for one or more provider groups for FY 2004 (Figure 11).

- *Physicians*: Physician rates were cut or frozen in 41 states in FY 2003 and in 38 states in FY 2004. In FY 2003, five states cut and 36 states froze physician rates. In FY 2004, three states cut and 35 states froze physician rates. Physician rates were increased in 11 states in FY 2003, and again in 11 states in FY 2004.

- *Inpatient Hospitals*: Inpatient hospital rates were cut or frozen in 31 states in FY 2003 and in 32 states in FY 2004. In FY 2003, nine states cut and 22 states froze hospital payment rates. In FY 2004, ten states cut and 22 states froze hospital payment rates. Hospital rates were increased in 22 states in FY 2003, and in 19 states in FY 2004. Payment increases for hospitals often reflect state statutory requirements to increase rates annually based on a specific index.

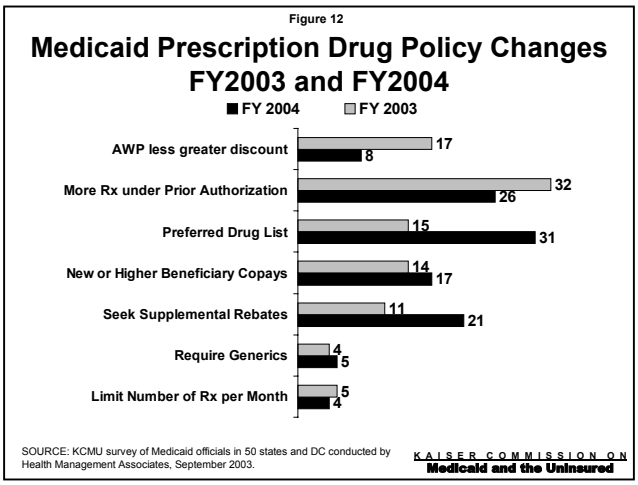
- *Nursing Homes:* Nursing home rates were cut or frozen in 17 states in FY 2003 and in 19 states in FY 2004. In FY 2003, five states cut and 12 states froze nursing home rates. For FY 2004, six states cut and 13 states froze nursing home rates. Nursing homes were the provider group most likely to be given a rate increase in both years, with increases in 33 states in FY 2003, and in 29 states in FY 2004. These increases often reflect preexisting state statutory requirements that dictate rate increases based on a cost index.

- *Managed Care Organizations*: Managed care organization (MCO) capitation rates were cut or unchanged in 21 states in FY 2003, including two states that cut and 19 states that allowed no annual change in the rates. In FY 2004, rates were cut or unchanged in 19 states, including five states that cut and 14 states that froze rates for MCOs. In states that set rates administratively, MCO rate reductions or freezes reflect actuarial adjustments made to account for the rate cuts, rate freezes or benefit cuts or restrictions that were made in the fee-for-service Medicaid program. MCO capitation rates were increased in 20 states in FY 2003, and also in 20 states in FY 2004.

**Prescription Drugs**

Cost-containment initiatives related to pharmacy were implemented by 46 states in FY 2003 (Figure 12). For FY 2004, a total of 44 states indicated that they would implement new or additional pharmacy–related initiatives. States continue to focus significant cost-

containment attention on this area, reflecting on-going efforts to slow the multi-year double-digit cost growth for prescription drugs.




***Comments of State Medicaid Officials on Pharmacy Initiatives:***
*"The resistance to cost containment initiatives for eligibility and pharmacy was significant and thwarted implementation, [but] all of those savings are assumed in this year's budget."*
*"We are still aggressively moving forward with pharmacy cost containment. We hope to enter into [supplemental] prescription drug rebates this year."*

For FY 2004, there was a trend toward more states developing and implementing preferred drug lists (PDLs) and seeking supplemental rebates, and fewer states cutting the payment they allow for drug products. In addition, as described in a later section, a significant trend is toward greater use of beneficiary copayments for prescription drugs. See Appendix D for more detail on pharmacy cost containment actions for FY 2003, and Appendix E for FY 2004.

**Changes to Benefits**

Between FY 2003 and FY 2004, there is a slight increase in the number of states that are undertaking benefit reductions. Eighteen states restricted or reduced the availability of benefits in FY 2003, and 20 states plan to reduce or restrict benefits in FY 2004. Between FY 2002 and FY 2004, 35 states have taken actions to reduce benefits in at least one of those three years.

In general, the benefit reductions in 2003 and 2004 focused on reducing or eliminating "optional" services, which states offer at their discretion. These reductions and eliminations focused primarily on adults enrolled in Medicaid, and in most cases included seniors and people with disabilities. However, as discussed below, some of these benefit reductions involved benefits related to children. And while most states put in place fairly narrow benefit restrictions, two states Oregon and Utah, significantly restructured their entire benefits package through federal waivers to offer different benefits to different groups of people enrolled in the program. Three states (Connecticut, Massachusetts and

Utah) dropped a range of optional services for all adults on Medicaid in FY 2003 (although Utah and Massachusetts restored some of the benefits in FY 2004) and Texas dropped a number of optional benefits for all adults in FY 2004.

*Fiscal Year 2003*

In FY 2003, a total of 18 states cut or restricted benefits. Half of these 18 states cut or restricted adult dental benefits and six states cut or restricted adult vision benefits. Most commonly, the dental benefit for adults was not completely eliminated but was restricted to emergency procedures while the vision services were usually described as being eliminated rather than reduced or restricted.[16] Other restrictions included:

- Eliminating chiropractic, podiatric, psychological and naturopathic services;
- Eliminating therapies (occupational, physical, speech and mental health);
- Eliminating orthodics and prosthetics;
- Eliminating audiology services;
- Eliminating dentures;
- Limits on hospital lengths of stay;
- Limits on the annual number of covered hospital days;
- New limits on long-term care home therapy, targeted case management, and personal care services;
- Eliminating coverage for circumcisions, and
- Reducing benefits covered through HMOs to parallel previous reductions in fee-for-service Medicaid coverage.

For a state-by-state summary of benefit reductions in FY 2003, see Appendix H.

***Comments of Medicaid Officials on Benefit Reductions***:
*"When we cut a service, we don't really save what we thought we'd get because of the provider reaction. If they don't do the one thing, they do another."*
*"We don't have a lot of room to go before we are cutting bone."*

*Fiscal Year 2004*

In FY 2004, 20 states cut or restricted benefits. This includes seven states that reduced adult dental services, seven states that reduced chiropractic services and five states that reduced vision or eyeglass coverage. Other cuts or restrictions included:

- Eliminating or restricting podiatric and psychological services;
- Eliminating or restricting therapies (occupational, physical, speech and mental health);

[16] Certain vision-related services are not "optional" and therefore cannot be eliminated. For example, the medical treatment of an eye condition by an ophthalmologist is a mandatory physician service. Eyeglasses and eye exams done to determine eyeglass prescriptions are optional services.

- Eliminating or restricting non-emergency transportation;
- Eliminating audiology services and hearing aids;
- Eliminating dentures;
- Eliminating or limiting home health, care management and personal care services;
- Eliminating respiratory care;
- Limits on number of physician visits;
- Eliminating coverage for circumcisions, and
- Limiting non-emergency outpatient scans (MRI, CAT and PET).

For a state-by-state summary of benefit reductions in FY 2004, see Appendix I.

Although most states focused on eliminating or restricting only one or two services, Connecticut, Massachusetts, Utah and Texas eliminated a broader array of optional services:

> *Connecticut.* In FY 2003, the state eliminated chiropractic services, naturopathic services, podiatry, occupational therapy, physical therapy, speech therapy and psychology services for all adults impacting an estimated 100,000 people.
>
> *Massachusetts.* In FY 2003, the state eliminated prosthetics, orthodics, eyeglasses, chiropractic services and dentures for all adults impacting an estimated 513,000 people. Coverage for prosthetics and orthodics was restored for FY 2004.
>
> *Utah.* During FY 2003, the state eliminated podiatry, speech therapy, audiology, occupational therapy, physical therapy, and vision care and also reduced chiropractic services benefit for all adults impacting an estimated 60,000 people. Coverage for speech therapy, audiology, occupational therapy and physical therapy and limited coverage for podiatry was restored for FY 2004.
>
> *Texas.* In FY 2004, the state eliminated eyeglasses, hearing aids, chiropractic services, podiatry and some mental health services for all adults in the state, including seniors and people with disabilities. The state estimates that these changes will affect 175,000 people in the Medicaid program.[17]

The changes Oregon undertook in 2003 and again in 2004 also stand out. Late least year, the state restructured the Oregon Health Plan (OHP) into three distinct benefit packages. For adults enrolled in "OHP Standard" (which includes parents of children enrolled in Medicaid and SCHIP and childless adults was well as seniors and people with disabilities whose incomes are at or above 75 percent of the federal poverty level), a number of optional services were eliminated in FY 2003, including vision, dental, non-emergency transportation, durable medical equipment, mental health services and chemical dependency services. Prescription drug coverage was eliminated for 13 days, until the

[17] Texas also eliminated a range of benefits in its Children's Health Insurance Program.

state identified funds to use to restore this coverage. At the same time, the state also instituted an additional benefit reduction. Under the 1992 waiver that created the Oregon Health Plan, Oregon set up a prioritized list of covered services. Although eliminating coverage of these services was controversial, Oregon reduced coverage for eight services on the list (from line 566 to line 558) in FY 2003.[18]

In FY 2004, Oregon will make additional significant benefit reductions. Oregon is seeking federal approval to amend its current Medicaid waiver to provide a primary care benefit package to its "OHP Standard" population, eliminating non-emergency hospital services, therapies and home health services for this group while also restoring coverage for mental health and chemical dependency services as well as medical supplies and emergency dental services. Oregon is also seeking federal approval to further reduce coverage under the OHP "Prioritized List" by 30 lines (from line 549 to line 519.)

Although states seem to have focused their benefit reductions on adults, seven of the 20 states that reduced benefits in FY 2004 reduced benefits that could affect families with children. These changes include reductions in non-emergency transportation coverage, limitations on orthodontic care, restrictions on dental coverage and limitations on the annual number of services covered, including limits on physician visits to 12 per year, chiropractic visits to 12 per year, occupational therapy to 20 per year, psychological therapy to 40 per year, speech therapy to 50 per year and physical therapy to 15 per year. It is not clear what affect these limitations will have on children, because under the requirements of the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) provisions of Medicaid, enrolled children are entitled to all services considered medically necessary, even if the Medicaid program in that state does not otherwise cover them.

Although many states undertook benefit eliminations and restrictions, a few states added benefits or lifted restrictions. In FY 2003, five states expanded or restored previously reduced coverage, including reinstating emergency dental services for adults, adding a new hospice benefit, adding case management for chemically dependent adults and adding other new services for waiver populations. In FY 2004, four states fully or partially restored benefit reductions that were made in the previous year, including adult dental services, orthotic, prosthetic, vision and audiology services. One state restored all benefits to levels previously in effect in 2002.

**Changes to Eligibility**

In FY 2003, twenty-five states reduced or cut eligibility for Medicaid enrollees. In FY 2004, 19 states made new plans to restrict or cut eligibility.[19] Between fiscal years 2002 and 2004, 34 states have made reductions to eligibility in at least one of those three years.[20] These changes are described in detail in Appendixes F and G.

[18] For more information on Oregon's waiver, see the Kaiser Commission on Medicaid and the Uninsured's "Oregon Section 1115 Waiver" fact sheet, http://www.kff.org/content/2003/4101/4101.pdf

[20] For purposes of this survey, changes in eligibility include instituting premiums and changes made to the application and renewal process.

In most cases, states' eligibility restrictions were targeted somewhat narrowly. States reduced continuous eligibility, reduced the length of time during which people can obtain transitional Medicaid, and increased transfer penalties for individuals receiving nursing home care. However, in a few cases states eliminated eligibility for large numbers of people.[21] In addition, three states have either eliminated or significantly reduced their medically needy programs, which allow people with low incomes and high medical bills to qualify for Medicaid.

At the same time, a number of states also made modest eligibility expansions. For example, states that had previously not done so took up recently available options to offer coverage to the working disabled and to uninsured women with breast and cervical cancer. These options typically benefit small numbers of people. A number of expansions provided prescription drug-only coverage to elderly Medicaid beneficiaries. These programs were created through federal waivers, and in most cases provide new federal financing for existing state coverage. Notably, as described below, three states adopted significant eligibility expansions.

*Fiscal Year 2003*

Twenty-five states reduced eligibility in FY 2003.[22] In most states, these reductions were targeted narrowly, and were expected to affect relatively small numbers of people. For example, states made slight reductions in income limitations, restricted Transitional Medical Assistance, instituted additional income testing, and imposed higher premiums for some groups.[23]

Of the 25 states that reduced eligibility in 2003, six states took actions that were intended to eliminate eligibility for large numbers of people:

- Missouri cut 32,600 people from Medicaid by lowering the threshold at which parents become eligible from 100 percent of the federal poverty level to 77 percent of the federal poverty level. It also reduced transitional Medicaid coverage and reduced women's health coverage, affecting an additional

[21] The survey asked states to estimate the numbers of people who would be affected by eligibility and benefits changes. States did not respond consistently, but for those states that did respond, the results are reported in Appendixes D, E, F, and G. Because states did not respond consistently, these numbers cannot be aggregated across all states to obtain national estimates of the numbers of people who have lost or gained coverage.

[22] This includes three states that made changes to their application and enrollment processes but did not otherwise reduce eligibility.

[23] States also eliminated the Qualified Individuals (2) program after the federal law authorizing the program expired. CMS informed states in a State Medicaid Director letter issued on November 6, 2002 that the expiration date for Qualified Individuals (2) (QI-2s) was not extended, thereby terminating the program as of January 1, 2003. QI-2s are a category of dual eligibles that have incomes from 135 to 175 percent of the federal poverty level and were enrolled in Medicaid only for assistance with their Medicare Part B premiums. Because this change was made pursuant to federal law, states' elimination of these programs was not counted as an eligibility change.

11,000 people, and restricted the ability of people to "spend down" to Medicaid coverage, affecting another 24,000 people.

- Nebraska adopted eligibility reductions designed to cut 25,000 people from the Medicaid program, including about 13,000 children.
- Massachusetts enacted a budget that eliminated Medicaid coverage for almost 50,000 long-term unemployed individuals effective April 1, 2003.
- TennCare eligibility standards were modified as of July 2002 under a new Section 1115 waiver. As part of implementation, Tennessee initiated eligibility re-determinations that removed 200,000 persons from TennCare.
- Michigan adopted a December 2002 executive order intended to eliminate coverage for about 43,000 adults.
- Connecticut eliminated eligibility for 19,000 low-income adults with incomes between 100 percent and 150 percent of the federal poverty level.

The actions in these six states alone were intended to remove about 400,000 persons from Medicaid coverage. In the time since these actions were adopted, implementation of each one has been delayed or limited. Coverage was, for example, restored temporarily for some of the beneficiaries who lost coverage in Missouri and Nebraska by court order. The Michigan eligibility cut was blocked permanently by court order. In Connecticut, a court order has temporarily restored eligibility for approximately 16,000 low-income adults. In Tennessee, at the end of 2002 the court ordered reinstatement of all 200,000 individuals who lost coverage. An appeal by the state delayed this action. In March 2003, during the appeal, the state offered a twelve-month "grace period" during which 150,000 individuals that had failed to contact TennCare during the re-determination period could re-apply for TennCare. At the end of August 2003 a settlement was reached that offered the grace period to an additional 40,000 individuals. In Massachusetts the eligibility cut was implemented and affected approximately 34,000 unemployed individuals. The state now has plans to restore this coverage, effective October 1, 2003.

The fact that these eligibility decisions have been partially or fully restored means that some of the 400,000 people who were slated to lose coverage will retain or regain coverage. How many of these beneficiaries will do so is unclear. In some cases, only some groups of beneficiaries were granted restored coverage. In other cases, beneficiaries will have to complete re-enrollment requirements.

In addition to these six states, two states, Oregon and Oklahoma, eliminated their medically needy programs in FY 2003. At their option, states can offer medically needy programs to allow people with high medical expenses whose incomes otherwise exceed program eligibility levels to qualify for Medicaid. As of the beginning of 2003, 35 states offered medically needy programs; with the decisions of Oregon and Oklahoma to end their programs, that number should fall to 33.[24] Oklahoma estimated that its elimination will leave 800 children, 6,500 parents and other adults, and 1,000 seniors without coverage.

[24] Jeff Crowley, "Medicaid Medically Needy Programs: An Important Source of Medicaid Coverage, Kaiser Commission on Medicaid and the Uninsured, January 2003, www.kff.org.

***Comments of Medicaid Officials on Eligibility Actions:***
*"It was a tough year. For 20 some years we were geared to building a program to help people and then we had to focus on cutting it back. It was kind of painful."*
*"All I've done since I got here was cut. Throughout the year we were asked to find new ways to cut. What I feel good about is that we made those cuts and didn't throw anyone off."*

*Fiscal Year 2004*

In FY 2004, nineteen states plan to restrict or cut eligibility for Medicaid enrollees.[25] As in FY 2003, most of these changes were not broad and were expected to affect relatively small numbers of Medicaid enrollees. For example, states decreased resource allowance and income standards for nursing home and other long-term care, eliminated presumptive eligibility for children, and tightened disability criteria.

In FY 2004, three states plan to make eligibility reductions that will affect large numbers of beneficiaries:

- Massachusetts eliminated coverage for "special status" immigrants, affecting an estimated 9,850 people;
- Nebraska eliminated "Ribicoff" coverage for persons ages 19-20 (affecting 3,100 individuals); and
- Texas eliminated coverage for adults in the Temporary Assistance for Needy Families program who failed to meet personal responsibility agreement requirements.[26] It also reduced eligibility for pregnant woman to 158 percent of the federal poverty level (FPL) from its previous level of 185 percent of the FPL. It also dramatically reduced income eligibility for its adult medically needy program to 17 percent of the FPL from 24 percent. These changes together were estimated to affect over 44,000 Texans on the Medicaid program. In addition, although data on the SCHIP program was generally outside the scope of this survey, it is notable that Texas is making significant enrollment and eligibility changes to its SCHIP program. These changes have been estimated to result in over 150,000 children losing coverage.

The impact of these eligibility changes will be felt by a wide variety of beneficiaries. Clearly, in terms of loss of coverage, parents seem to be most at risk, as states like Missouri, New Jersey,[27] and Connecticut have made changes designed to affect large numbers of beneficiaries who are parents.

[25] This includes one state that increased the redetermination frequency from once every twelve months to once every six months, but did not otherwise make any other eligibility reductions.
[26] This change has been temporarily suspended by court order.
[27] As of June 15, 2002, New Jersey stopped accepting applications from parents for Family Care, which provided coverage for parents with incomes up to 200 percent of the FPL, and also changed how it treats income under Section 1931 for parents applying for Medicaid.

Perhaps more significantly, a number of eligibility changes may also affect children, who have been a high coverage priority for states in recent years. In FY 2003, ten states implemented eligibility reductions that affected children (including reductions that affected families with children). In these ten states, reductions included eliminating continuous eligibility; reducing the amount of earnings disregarded and changing the treatment of household composition for eligibility; counting parental income for pregnant minors. Indiana eliminated continuous eligibility for children, and estimates that 32,000 children will be affected.

In FY 2004, seven states made eligibility reductions that specifically affected Medicaid coverage for children. These cuts included:

- Alaska reduced eligibility levels for its Medicaid expansion SCHIP program from 200 percent to 175 percent of the FPL, affecting approximately 1,300 children;
- Minnesota decreased income eligibility levels and reduced the eligibility period for newborns from 24 to 12 months (affecting approximately 5,000 individuals), and
- Nebraska eliminated presumptive eligibility for children and eliminated coverage for 19 to 20 year-olds, affecting approximately 3,400 children.

In addition, a number of states indicated that they intend to begin charging children and families premiums as a condition of coverage in their SCHIP and Medicaid programs. This change, which is available to SCHIP programs under law but requires a waiver to be implemented in Medicaid, is likely to make coverage unaffordable for some low-income families and reduce enrollment in Medicaid and SCHIP.[28]

At this time, states are not reducing income eligibility for the elderly and disabled in large numbers. They are, however, turning to a variety of more targeted measures, such as changing disability criteria, changing spend down and asset transfer policies, and changing spousal impoverishment criteria, that will affect the number of seniors and persons with disabilities who are eligible for Medicaid coverage of needed long-term care services. In addition, although few states had changed eligibility for immigrants, two states, Massachusetts and Colorado, recently made significant reductions in eligibility for immigrants.

Although some states have made major eligibility reductions, a number of states also undertook expansions. Generally, these expansions were quite modest and affected small numbers of people. States, for example, implemented new Breast and Cervical Cancer coverage or the new "Ticket to Work" coverage for the working disabled[29]. Other states, like Utah, implemented waivers that extended limited benefits coverage to new enrollees.

[28] Because premiums affect individuals' enrollment in the Medicaid program, states that impose premiums are recorded as having made an eligibility change. Co-payments, which are reported later in the survey, do not include premiums.

[29] This optional category was created by the federal "Ticket to Work and Work Incentives Improvement Act of 1999" (P.L. 106-170).

A number of states implemented "Pharmacy Plus" waivers, which provide drug-only coverage to seniors. These waivers typically allow states to refinance their existing state-funded drug programs for seniors to qualify for Medicaid matching funds, as well as extending drug coverage to some new beneficiaries. States that have received these waivers have generally agreed to cap total spending on their elderly and disabled enrollees.

***Comment of a Medicaid Official on His State's Eligibility Policy Direction:***
*"We are clearly focused on program expansion."*

A few states enacted significant eligibility expansions for FY 2004:

- Illinois extended coverage through its SCHIP program to cover 15,000 adults in 2003 and an additional 12,000 children and 65,000 adults in FY 2004;
- Missouri extended eligibility for seniors and people with disabilities from 80 percent to 90 percent of the federal poverty level;
- The District of Columbia built on an FY 2003 eligibility expansion for childless adults to extend coverage to low-income adults between the ages of 19 and 21 and 50 to 64.

In addition, Maine recently enacted legislation that will expand Medicaid eligibility effective in FY 2005. Maine is extending Medicaid eligibility to parents with income up to 200 percent of the FPL and childless adults with income up to 125 percent of the FPL as part of its comprehensive health care reform plan that was enacted in June 2003, Dirigo Health.

**Application and Renewal Process Changes**

Throughout the late 1990s, states increasingly adopted measures intended to simplify and streamline the eligibility application and re-determination processes. However, in the face of budget shortfalls, fewer simplifications have occurred, and the recent direction has been to reverse some of the previous simplifications.

In FY 2003, eleven states modified the application or renewal process. In two cases, the action was to simplify the process for enrollees, including eliminating a face-to-face interview requirement for re-determinations and renewals, and simplifying the application forms. However, the other nine states reversed previous simplifications. These actions included reducing the amount of time allowed to respond for re-determinations and adding to the application form to obtain additional information about disability status and third party resources.

In FY 2004, ten states indicated that they would make changes to their application and renewal procedures. Unlike FY 2003, most of these changes are designed to simplify and streamline the process. Although one state eliminated phone centers, thereby stopping telephonic application and interviews and making it harder for beneficiaries to apply, that

was the exception, rather than the rule. The other changes adopted for FY 2004 were positive for the beneficiary, including beginning online applications and implementation of call centers to assist with eligibility determination.

**Co-payments**

Over FY 2003 and FY 2004, increasing co-payments for services has become a central mechanism of state Medicaid cost containment. Federal Medicaid law specifies that copayments must be "nominal," and the law provides exemptions so copayments cannot apply to services provided to children or pregnant women. "Nominal" is generally a maximum of $3.00 per service. Federal law requires that a provider must render a service regardless of whether the copayment is collected. Limits on co-payment amounts in Medicaid law are supported by a substantial body of research indicating that even nominal copayments can deter low-income individuals from receiving needed care.[30]

In FY 2003, a total of 17 states imposed new or higher co-payments. Most frequently, in fourteen states, new or higher copayments were for prescription drugs. States also applied new or higher co-pays to non-emergency transportation, hearing, vision, dental and therapies, physician office visits and ambulatory services, and outpatient hospital services. In nine states the new co-pays applied to all adults (except pregnant women). Four states imposed new or higher co-pays for certain groups of adults or waiver recipients, and one state imposed co-pays for all adult populations, and intended to allow no exemptions for federally specified groups.

***Comments of Medicaid Officials on Use of Copayments:***
*"The legislature wanted copays and limits on about everything we could do. We have a mandate from the legislature to do this."*
*"We have added copays on everything."*

For FY 2004, a total of 21 states imposed new or higher copayments. In most but not all cases, states adopted the maximum allowed copayment of $3 per service. Prescription drugs were again the service most frequently subject to a new or higher copayment, with 17 states adding or increasing this copayment for FY 2004. States also imposed new or higher copays for hospital stays (three states), durable medical equipment or lab and x-ray services (three states), outpatient hospital visits (three states), hospital ER visits for non-emergency services (two states), physician office visits (two states), and on FQHC/RHC services, therapies, psychology, podiatry services and hearing tests/hearing aids. Of the 21 states adding or increasing copayments, 17 states imposed copayments for all adults for whom a copayment might be applied and four states imposed new or higher copays on specific certain groups of adults or waiver recipients. Some states reported that they would seek federal waivers to increase copayment amounts for subsets of the

[30] Julie Hudman and Molly O'Malley, Health Insurance Premiums and Cost Sharing: The Impact on Low-Income Populations, Kaiser Commission on Medicaid and the Uninsured, April 2003. See also Leighton Ku, Charging the Poor More for Health Care: Cost-Sharing in Medicaid, Center on Budget and Policy Priorities, May 2003.

Medicaid population above levels currently allowed by federal law. Between 2002 and 2004, 32 states increased or added beneficiary copayments for one or more services.

**Fraud and Abuse**

In a program that spends as much public money as does Medicaid, it is always important to ensure program and fiscal integrity. In FY 2003, a total of 19 states indicated that they were undertaking new or enhanced fraud and abuse activities. These actions sometimes involved contracts with organizations that specialize in this activity, or the authorization to hire additional staff to focus on this area. For FY 2004, a total of 21 states plan new or enhanced fraud and abuse detection or prevention activities. Between 2002 and 2004 34 states have put at new fraud and abuse mechanisms in place in at least one of those three years.

***Comment of Medicaid Official on Efforts to Control Fraud and Abuse:***
*"We had a great deal of support from our legislature for additional fraud and abuse and for our pharmacy savings."*

**Disease and Case Management**

In FY 2003, thirteen states reported new disease and case management initiatives. For FY 2004, the number of states planning to undertake new disease or care management programs increased to 18. Between 2002 and 2004, 31 states put disease management program in place in at least one of those three years. These initiatives continue to focus on asthma, diabetes, hypertension, depression and congestive heart failure, with new initiatives focusing on case management for complex or high cost cases. Specific responses for FY 2003 included:

- Mississippi: diabetes, asthma and hypertension programs;
- Missouri: asthma, diabetes, depression, and congestive heart failure programs;
- Oregon: disease management for asthma, diabetes, congestive heart failure and case management for fee-for-service clients with annual costs exceeding $20,000;
- Washington: diabetes, renal care, congestive heart failure and asthma programs, and
- Wyoming: chronic care case management.

Specific responses for FY 2004 included the following:

- Idaho: diabetes, asthma and hemophilia programs;
- Massachusetts: high cost cases targeted for care management;
- New Jersey: disease management introduced under the pharmacy program;
- North Dakota: disease management efforts initiated through pharmacies for diabetes, asthma and heart disease;
- Ohio: care management for the aged and disabled population and other high cost cases;

- Oregon: expand to chronic obstructive pulmonary disease, and
- Wyoming: expanding chronic care case management to include prescription drug case management.

***Comments of State Medicaid Officials on Cost Containment Actions:***
*"I'm concerned if we have to go further. We've gone about as far as we can go without negatively affecting other aspects of the program."*
*"The cost containment strategies proved more elusive in terms of our ability to implement them. This is not a program that lends itself to quick adjustments to respond to budget shortfalls. The problem came up very quickly and it was tough to respond."*
*"Savings were not as great as anticipated."*
*"They've [the legislature] taken what used to be just a complicated program and made it impossibly complicated."*
*"With all these changes, we know we have several [lawsuits] on the horizon."*
*"We had substantial administrative cuts last year and this year. [That makes it harder to implement these policy changes.]"*

**Long-Term Care and Home and Community Based Services**

Long-term care is a substantial share of Medicaid spending. Yet, only a small share of state budget-driven policy actions were directed at controlling long-term care spending in FY 2003 and FY 2004. Most long-term care spending is for nursing home services, and Medicaid payment rates for nursing homes were increased in 33 states in 2003 and in 29 states for FY 2004. During these years many states have been seeking to enhance home and community-based services (HCBS) as a patient-preferred, lower-cost alternative to institutional nursing home care. At the same time, many states have tightened eligibility criteria to qualify for HCBS services.

In FY 2003 and FY 2004, about four-fifths of states reported policy actions relating to HCBS waivers and services. A total of 24 states expanded the number of HCBS waivers or expanded the number of HCBS waiver "slots,' which defines the number of persons who can be served in these programs. In 16 other states, there were budget-driven efforts to restrict the number of slots, decrease benefits covered under the waiver, institute waiting lists or use other means to limit caseload and expenditure growth in these programs. State officials from several states mentioned that they expected to continue increases in the number and proportion of Medicaid long-term care beneficiaries receiving home and community-based services. Between fiscal years 2002 and 2004, 18 states put restrictions on long-term care in place.

***Comment of Medicaid Official on Long-Term Care Policies:***
*"One of the things we have a problem with is we are trying to do more alternatives to nursing homes…It is going to be a fight all the way."*

## *5. Provider Taxes*

In FY 2003, 10 states imposed new provider assessments or taxes. New provider taxes or assessments were most frequently imposed on nursing facilities (5 states), HMOs (2 states) and hospitals (2 states). At the beginning of FY 2003, a total of 21 states had a provider tax of some sort in place. Among those taxes already in place, the most common were taxes or assessments on nursing homes (14), hospitals (10), ICFs/MR (5) and pharmacies (2). In 16 states taxes or assessments applied to more than one category of provider tax.

For FY 2004, 18 states imposed one or more new provider assessments or taxes. Eleven states added a nursing home provider assessment, making it the most frequently imposed new provider assessment, as also had been the case for FY 2003. Three states imposed new assessments on HMOs, three on hospitals and three on ICFs/MR. Two states added new pharmacy taxes. Two states reversed existing provider taxes; one by decreasing a hospital assessment and another state planned to phase out a physician provider tax. States appear to be using the federal funds these provider taxes generate in a number of ways. Some states are devoting the resources to their overall Medicaid budgets. Others are using the funds to give some providers rate increases. Still others are using them to help fill holes in their overall state budgets.

## *6. Role of "Dual Eligibles"*

Elderly and disabled Medicaid beneficiaries also enrolled with Medicare account for a large share of state Medicaid spending, and for a large share of expenditure increases. In this survey, states were asked to indicate the share of Medicaid spending in their state related to these "dual eligibles." The Urban Institute has calculated that spending on dual eligibles accounts for 40 percent of spending on Medicaid.[31]

State Medicaid spending typically is not recorded in a way that makes it easy to determine all spending related to dual eligibles. Although virtually all Medicaid officials expressed great interest in this percentage, many were unable to calculate the percentage from available data. Others offered a response based on the best available data but indicated they believed they were under-reporting this statistic. [32]

A total of 27 states responded to this question. In these states, dual eligibles on average accounted for 34 percent of total Medicaid spending in FY 2003. States indicated percentages that ranged from a high of 60 percent to a low of 13 percent, with the median being 35 percent. Despite the relatively low number of states that responded to this survey question, the results are consistent with other analyses of the share of Medicaid spending the dual eligibles represent.

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[31] Jocelyn Guyer et al., "A Prescription Drug Benefit in Medicare: Implications for Medicaid and Low-Income Medicare Beneficiaries" Kaiser Commission on Medicaid and the Uninsured, September 2003.
[32] Twenty-seven states responded to the dual eligible question. Several of these states did a special data analysis to calculate this statistic. Other states did not have this information immediately available or were unable to obtain the information in the time available for this survey.

## *7. Impact of 2003 Federal Fiscal Relief*

The Jobs and Growth Tax Relief Reconciliation Act of 2003, enacted in June 2003, contained two provisions that provided a total of $20 billion in fiscal relief to states in federal fiscal years 2003 and 2004.[33] The legislation provided a total of $10 billion dollars in the form of a temporary 2.95 percentage point increase in each state's federal matching rate for Medicaid programs. The legislation also provided $10 billion in temporary grants for states to use for Medicaid or other state programs. A maintenance-of-effort provision said that only states that maintain eligibility at the levels that were in effect as of September 2, 2003 will receive the fiscal relief.

The intent of this legislation was for states to use the additional funding to address both Medicaid and overall budget shortfalls for FY 2003 and FY 2004. To a great extent, the funds accomplished this purpose. This was the case even though the law was adopted and the funds made available to the states nearly at the end of FY 2003 and after more than half the states had adopted their budgets for FY 2004.

Twenty-nine states indicated in this survey that the additional funding was made available after the FY 2004 budget was adopted and thus not officially considered in developing the FY 2004 budget for Medicaid. Medicaid officials in 19 states indicated that their legislatures explicitly factored the additional funding into their Medicaid budget decisions before their legislative sessions came to a close and the FY 2004 budget adopted. However, even states where the legislature had completed the FY 2004 budget were able to describe how the FMAP adjustment would impact the program through the upcoming fiscal year.

In every state, Medicaid officials indicated the fiscal relief was needed and will have a specific positive impact on Medicaid. Indeed, Medicaid directors indicated that the additional federal funding could not possibly have arrived at a time when it was needed more. Twenty-one states indicated the enhanced FMAP would provide general relief within their Medicaid programs. In an additional 19 states, the enhanced FMAP was going to be used to soften or prevent cuts that otherwise would have been made, or to restore reductions that had already been made. Specific examples are provided below:

- Alaska reported that the state plans to delay Medicaid cuts by one year.
- In Arizona the fiscal relief prevented cuts for small optional programs, such as Ticket to Work for the working disabled, coverage for women with breast and cervical cancer, and Medicaid waiver expansion for parents of Medicaid and SCHIP children.

[33] The FMAP increase is in effect for the last two quarters of FY 2003 and the first three quarters of FY 2004.

- In Louisiana, the fiscal relief reduced the severity of originally planned long-term care and pharmacy cuts that had been proposed to reduce state Medicaid funding by up to 15 percent.
- Missouri reported that the fiscal relief helped reduce the severity of eligibility cuts for parents, and allowed increase the state to increase eligibility for aged and disabled significantly, from 80 percent to 90 percent of the FPL.
- Ohio said that the fiscal relief allowed the state to prevent a planned parent eligibility rollback that affected approximately 60,000 people
- In Oregon, the fiscal relief reduced additional cuts that would have been made to the Oregon Health Plan
- According to South Carolina, the fiscal relief prevented cuts that otherwise were being considered to eligibility for SCHIP, to lower eligibility for the elderly and disabled, which could have been reduced from 100 percent to 85 percent of the FPL and to eliminate optional services.

In five states, officials said that the additional funding would be placed into a dedicated Medicaid trust fund or into the state general fund for future reserves. These are funds that support the program and from which funding might be drawn when a Medicaid budget shortfall occurs, so it may prevent future Medicaid cutbacks. Four states indicated that the enhanced FMAP would be used specifically to relieve the existing Medicaid shortfall. In two states Medicaid officials indicated that the enhanced FMAP would facilitate eligibility expansions that were being discussed.

State officials reported that the temporary enhanced FMAP on Medicaid had helped them through a very difficult fiscal period. However, Medicaid officials did not see this temporary relief as addressing the longer-term significant problems of financing Medicaid. Medicaid directors expressed strong concern about FY 2005, after the fiscal relief expires. Because their FY 2005 budget preparation was already underway, many state officials were keenly aware of the temporary nature of the enhanced FMAP, and the dramatic fiscal impact on states when the funding ends on June 30, 2004.

***Comments of State Medicaid Officials on Federal Fiscal Relief:***
*"We were short of appropriations [for FY 2003]. Because of the new federal match, we know we are going to make it. It was a tight year."*
*"The fiscal relief package is a one year deal. After that it gets real bad."*
*"It should help us get back on track."*
*"The eligibility cut has been prevented by the new FMAP."*
*"We have a budget but we have a significant hole in that budget. There is a big cloud hanging over it, even after accounting for the FMAP relief."*
*"Had we not had that [fiscal relief], golly, I don't know what we would have done, because there is not other money laying around."*
*"We were being pushed very hard. This will take off some of the pressure."*
*"We are focused on program expansions and we are committed to them. The FMAP will help us in the overall picture."*
*"The special match rate really bailed us out this year."*
*"The federal relief has allowed us to step back from the brink."*
*"That [enhanced FMAP] is the only saving grace. People were looking at some pretty draconian cuts, that now we can put on the back burner."*
*"FMAP was a godsend to us."*

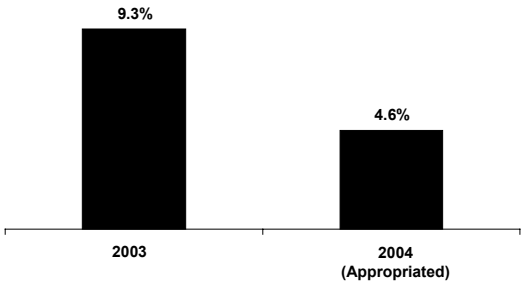
*"The increase in FMAP virtually assures that we will not have to make cuts even if we have increases in utilization. The outlook for '04 is much more positive now."*
*"The FMAP change has given us some temporary breathing room."*
*"They sent us the FMAP and it was gone before it got here."*

## *8. The Outlook for FY 2004*

The overall state budget picture is not expected to improve in the near term. State revenue collections will remain low, and spending pressures continue to build. At the same time, there is evidence that the FY 2004 growth rates states have adopted are optimistic. States expect Medicaid spending growth rates to fall further in FY 2004. For FY 2004, legislatures authorized increases in total Medicaid spending that averaged 4.6 percent (Figure 13). This is almost the same level as the 4.8 percent legislatures originally authorized for FY 2003[34], when actual spending turned out to increase by 9.3 percent. The FY 2003 experience illustrates that the FY 2004 authorization should not be interpreted as a projection of actual spending, even though it is the current legal limit on Medicaid spending.[35] Actual Medicaid spending growth is likely to be significantly higher.

Figure 13

**Average Annual Growth Rates for Total Medicaid Spending**




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

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Because original FY 2003 Medicaid appropriations on average were substantially below actual spending levels, many states found themselves needing to appropriate additional funds for Medicaid during the fiscal year. In FY 2003, a total of 35 states experienced a Medicaid budget shortfall. A "Medicaid budget shortfall" occurs when the legislative appropriation is insufficient to cover expected actual expenditures. States closed their FY 2003 budget gaps through supplemental appropriations (in 16 states), from reserve funds (5 states), from savings from additional program reductions (6 states), from tobacco settlement funds (2 states) and from the temporary increase in the federal Medicaid matching rate (6 states).

[34] See 2002 survey, September 2002.
[35] In a few states, such as Kansas and Rhode Island, the legislative authorization for Medicaid is adjusted automatically to the required level based on a statutorily established periodic re-estimation process.

At the outset of FY 2004, fewer Medicaid officials expected a Medicaid budget shortfall in the upcoming year: in 32 states Medicaid officials believed the likelihood of a Medicaid budget shortfall in FY 2004 was at least 50-50. Given an average appropriated growth rate of 4.6 percent, a significant number of states are likely to need additional funds or additional program cuts over the course of FY 2004.

***Comments of Medicaid Officials Concerning Potential FY 2004 Shortfalls:***
*"We are going to have to manage the shortfall. We may have to take more drastic actions. Our state budget situation is not good and our Governor is committed to not draw from our reserves. We are not allowed to have a supplemental this year."*
*"The legislature believes it fully funded our budget request but we are concerned."*
*"We have made all kinds of assumptions for budget cuts. If the assumptions are not correct, we have no wiggle room."*

***Comments of State Medicaid Officials on Outlook into FY 2004:***
*"It is highly likely that sometime this year [FY 2004] we will be asked for more cuts."*
*"[FY 2003 was] a challenging year, but I think '04 will be even more challenging."*
*"I don't see it letting up. Everybody keeps placing new demands on us, but with no money. I don't know where it stops."*
*"A lot of funding for this year [FY 2004] was from non-recurring sources. If the economy picks up, we might not have to cut too much more in '04."*
*"'04 and '05 are all about controlling the rate of growth. We are still seeing rates of growth that are unsustainable."*
*"The real problem is '05. '05 will be huge. You have all this pent up demand, and we've used one-time money to plug the gaps in '03 and '04. Come '05, there is going to be a huge gap between available revenue and forecasted expenditures. You can keep the cork on the bottle only so long. I don't know where the cushion is going to come from to get us through '05."*
*"We are hoping to get stable. We've been in a state of flux for too long. We are hoping to do some positive things."*
*"It is going to be an interesting year. But it's a lot better than we'd anticipated in the middle of FY 2003."*
*"I don't have any extra money. I think '04 will be a horrible year. There is a cliff coming ['05] and they [the legislature] don't want to deal with it."*
*"There is so much uncertainty right now. I'm just looking to try to stabilize the program and to begin to look at new initiatives and program implementation, not just survival."*
*"The budget process this year was brutal. We've already started the process of '05. We don't even get a break. It's going to be just as tough or tougher next year."*

# Conclusion

States continue to face extraordinary budgetary pressures. With revenues declining and spending increasing, they have tried to contain costs in all programs in their budgets. Over the past several years, all states have focused on reducing Medicaid spending. This survey found the pace of state Medicaid spending growth declined in FY 2003 for the first time since 1996. Aggressive state cost containment efforts are believed to be the primary factor contributing to states' ability to hold Medicaid spending to just over 9 percent. The survey also found that all 50 states and the District of Columbia initiated

new Medicaid cost containment action in FY 2003, and that all 50 states and the District of Columbia planned additional new cost containment strategies in FY 2004. While states have focused heavily on reducing provider payments and controlling spending on prescription drugs, they have also reduced benefits and eligibility and increased copayments. Together, these actions served to slow the rate of increase in overall Medicaid spending.

Medicaid is intended to be a counter-cyclical program, with higher enrollment and costs during times of economic downturn and depressed state revenues. Its recent spending rates have been substantial, and have been difficult for states to accommodate within overall state spending that has been flat. States' Medicaid cost containment efforts appear to have been successful in reducing Medicaid spending growth. Still, success in Medicaid cost control came at the price of freezes and cuts in already low provider rates, limits and restrictions on covered benefits, including prescription drugs, new and higher copayments, and scaling back on eligibility levels. The net result of these cuts is an increasing likelihood that providers will decide not to serve Medicaid patients, and that patients would not be able to get health care they need due to limits on benefits, access to some prescription drugs, and increased cost-sharing. And while program enrollment is still growing as a result of the weak economy, recent eligibility restrictions mean that the Medicaid program is not serving all the low-income, uninsured people who were previously eligible.

As states begin fiscal year 2004, they will be challenged to maintain Medicaid coverage while they work to address large budget shortfalls. Over the past three years, states have examined every possible cost reduction strategy as they have struggled with the difficult budget-driven cutbacks. A depressed economy, and little prospect for a near-term recovery in state revenues means the task will continue to be difficult. At the same time, Medicaid spending is expected to grow rapidly. If further cuts become necessary, the likely result will be declines in the accessibility, availability, and affordability of health care for low-income people.

The data in this report was last updated on October 8, 2003.

**Profiles of Selected State Medicaid Cost Containment Policies:**

- **Connecticut**
- **Illinois**
- **Oregon**
- **Texas**

**Profile of Medicaid Cost Containment Policies: Connecticut**

In January 2003, the State of Connecticut faced a FY 2003 budget shortfall of $638.3 million due to declining state revenue collections and state expenditure increases largely driven by increasing Medicaid costs. The ongoing structural budget deficit for FY 2004 was estimated to be over $2 billion (based upon a FY 2004 total general fund current services budget of $13.6 billion). In early 2003, Governor Rowland and the state legislature took action to close the FY 2003 gap by enacting $350 million in ongoing and temporary tax increases and by making $223 million in spending cuts including the elimination of Medicaid coverage for 19,000 low-income adults and the elimination of continuous eligibility for children. Despite these actions, the state continued to face a structural budget deficit of over $800 million in FY 2004 and over $1.3 billion for FY 2005 as the Governor and state legislature continued to work to craft a state budget for the 2003-2005 biennium.

FY 2004 began on July 1, 2003 with the General Assembly still unable to come to agreement on the new biennial budget. As work on the budget continued, Governor Rowland operated state government by executive order. Although a budget was finally passed by the General Assembly on July 31, 2003, it went without the Governor's signature while lawmakers continued working on other bills that implemented various budget details. On August 16, 2003, one hour before the final deadline for signature, Governor Rowland signed the $27.5 billion biennial budget. Among other things, the new budget cuts cash assistance and medical benefits under the general assistance program, increases premium and copayment requirements for the HUSKY health insurance program (Connecticut's Medicaid/SCHIP program), and raises revenues by securitizing Connecticut's Tobacco Settlement Funds.

Due to ongoing litigation challenging the Medicaid eligibility cuts passed in FY 2003, Medicaid coverage for 16,000 low-income adults remains in doubt. In March 2003, a federal district court judge issued a temporary restraining order blocking the eligibility reductions. The legal action was later dismissed, however, and the Department of Social Services (DSS) proceeded to issue recipient notices to implement the eligibility cuts as of June 30, 2003. On June 26, 2003, the U.S. Second Circuit Court of Appeals granted a stay pending appeal that required DSS to restore coverage to 16,000 adults. The stay was later extended until such time as the court files an opinion on the appeal or upon further order. As of August 28, 2003, DSS expected coverage for the 16,000 adults to continue through at least September 30, 2003, and perhaps longer.

| **Provider Rates:** |
|---|
| ▪ Rates for hospitals, doctors and dentists frozen in '03 and '04<br>▪ Intend to competitively bid DME, medical supplies and lab services in '04 |
| **Eligibility Reductions:** |
| ▪ Continuous eligibility for children eliminated in '03 |

| |
|---|
| ▪ Eligibility eliminated in ’03 for 19,000 low-income adults between 100% and 150% of the FPL (although eligibility for approximately 16,000 subsequently restored by court order) |
| **Benefit/Service Reductions:** |
| ▪ A number of optional services were eliminated for adults in ’03 including chiropractic, naturopathic, podiatric and psychology services and occupational, physical and speech therapy. |
| **Prescription Drug Controls and Limits:** |
| ▪ A $1 copay imposed in ‘03<br>▪ Lower state MAC rates adopted in ‘03<br>▪ Dispensing fee reduced from $4.10 to $3.60 in ‘03<br>▪ In ’03, prior authorization imposed in certain drug classes, and on prescriptions costing over $500, and in ’04, prior authorization imposed on brand medically necessary prescriptions and on early refills<br>▪ Plan to implement a PDL and require supplemental rebates in ’04. |
| **Other:** |
| ▪ Enhanced home care agency audits<br>▪ Contracted with a vendor in ’03 to develop a decision support system that will enable the state to enhance fraud and abuse prevention activities. |

## Profile of Medicaid Cost Containment Policies: Illinois

When Governor Rod Blagojevich took office in January 2003, he faced a projected state budget deficit of $1.2 billion for FY 2003 and $3.6 billion for FY 2004. Despite these shortfalls, Governor Blagojevich proposed a state budget for FY 2004 that increased funding for education and continued to build on previous health care expansions. In FY 2002, Illinois extended comprehensive drug benefits ("SeniorCare") to more than 150,000 seniors with incomes between 100% and 200% FPL under a Medicaid waiver. Also, Illinois implemented FamilyCare in FY 2003, which provided comprehensive medical benefits to 15,000 adult parents of Medicaid and SCHIP children.

The $52 billion FY 2004 state budget passed in May (including over $23 billion in General Funds) includes a $400 million increase in education funding, $66 million total funds to expand FamilyCare eligibility to an additional 65,000 working parents and $11 million total funds to expand KidCare eligibility to 20,000 more children. The FY 2004 budget shortfall was closed, in part, by funding 6,000 fewer state employees and by increasing revenues from higher riverboat taxes, the closing of certain corporate tax loopholes and increased non-consumer fees for state regulatory services and licenses. The budget also assumes pharmacy savings of $120 million resulting from an initiative to gain better prices on the nearly $2 billion worth of prescription drugs purchased by Illinois yearly. Finally, the budget also relies heavily on certain one-time revenue sources including $1.9 billion raised from a pension obligation bond financing, $350 million from the sale of the State's tenth riverboat casino license and $200 million from the "sale-leaseback" of certain state assets (including the James R. Thompson Center in Chicago).

| **Provider Payments:** |
|---|
| ▪ Rates for doctors, dentists, HMOs and nursing homes decreased by 2.6%, 3%, 5% and 5.9%, respectively, in '03<br>▪ Rates for hospitals and home care providers were frozen in '03<br>▪ Rates for HMOs were reduced by an average of 8.5% for '04 (due primarily to case-mix/actuarial changes)<br>▪ Nursing home reimbursement methodology changed to end bed reserve payments for hospital stays for '04<br>▪ All other provider rates frozen for '04 |
| **Eligibility Changes:** |
| ▪ Prescription drug benefits ("SeniorCare," implemented June 2002) enrollment ramped up for seniors with incomes between 100% and 200% FPL in '03.<br>▪ FamilyCare implemented for parents with incomes up to 49% FPL in '03<br>▪ FamilyCare expanded to cover parents with incomes up to 90% FPL in '04<br>▪ KidCare income eligibility standard increased from 185% to 200% FPL in '04<br>▪ SeniorCare income eligibility standard increased to 250% FPL in '04 (subject to federal waiver approval) |
| **Benefit/Service Reductions:** |
| ▪ Copayments for physician, podiatry, optometric and chiropractic office visits were increased from $1 to $2 in '03 |

| **Prescription Drug Controls and Limits:** |
|---|
| ▪ Copayments for brand name drugs increased from $1 to $3 in ‘03<br>▪ $1 copayment for generic drugs rescinded in ‘04<br>▪ AWP discount increased from 11% to 12% for brand name drugs and from 20% to 25% for generic drugs in ‘03<br>▪ Dispensing fee decreased from $4.00 to $3.40 for brand name drugs and from $5.10 to $4.60 for generic drugs in ‘03<br>▪ Continued enhancements to state’s PDL and supplemental rebate program in ’03 and ‘04<br>▪ Continued enhancements to state MAC list in ’03 and ‘04<br>▪ In ’04, prior authorization extended on new drugs by an additional six months and prior authorization added for brand medically necessary prescriptions |
| **Other actions:** |
| ▪ Asset discovery initiative implemented in ’03 to identify unreported or under-reported assets of persons applying for long term care<br>▪ In ’03, pharmacies required to bill Medicare as the primary payor on select drug items<br>▪ Medically fragile and technology dependent children’s HCBS waiver slots increased with the latest waiver renewal beginning with 450 in waiver year 1 (9-1-02 to 8-30-03) and phasing to 700 in waiver year 4 (beginning 9-1-03) |

**Profile of Medicaid Cost Containment Policies: Oregon**

Like many other states, Oregon's efforts to adopt a state budget for FY 2004 were made all the more difficult due to the large cuts that had already been made to cover shortfalls in the 2001-2003 budget. Throughout 2002, Governor Kitzhaber and the Oregon Legislative Assembly struggled – through five special sessions – to enact legislation to rebalance the 2001-2003 biennial state budget. As they worked, the state revenue projections continued to worsen with each quarterly update. By the time of the fifth special session in September 2002, the forecast predicted $1.7 billion less than was assumed when the $12 billion 2001-2003 General Fund budget was passed.

When newly elected Governor Kulongoski took office in January 2003, over $1.4 billion in cuts had already been made throughout state government including significant cuts in K-12 education and the Oregon Health Plan. Also, a ballot measure that would have generated $313 million in additional General Fund revenues through a temporary income tax increase and allowed the state to restore some cuts was defeated by voters on January 28, 2003. While Governor Kulongoski's proposed 2003-2005 budget included a 12 percent increase in General Fund spending over the 2001-2003 *reduced* budget, almost all of the increase was needed to replace one-time funds used to balance the 2001-2003 budget including $346.5 million in Medicaid Upper Payment Limit revenue, $333.2 million of Tobacco Settlement Funds and $150 million of Tobacco Settlement bond proceeds. State revenue collections continued to fall, however, forcing the Governor to propose a revised budget in April 2003 that was over $300 million lower.

The Oregon Legislative Assembly was unable to complete work on all agency budgets by the start of the fiscal year on July 1, 2003. In mid August 2003, 19 agency budgets still remained to be passed including budgets for K-12 education, higher education, human services and corrections. By that time, Oregon was the only state in the nation that had not yet fully adopted a state budget for FY 2004. A breakthrough finally occurred on August 20th when the Legislative Assembly narrowly approved a measure to raise $800 million in new revenue for the 2003-2005 biennium by temporarily increasing income taxes (for three years), increasing corporate taxes and imposing new taxes on certain healthcare providers. Governor Kulongoski stated his intent to sign the measure (although he had previously opposed any tax increases) stating:

> "The revenue forecasts over the last two years have forced us to reduce the general fund by 20%. We had to cut $3 billion out of this [2003-2005] budget and I cannot in good faith make that up in cuts in services for children, education, seniors and public safety. The fact is that we need additional revenue to keep the school doors open."

Legislative approval of the new revenue raising measure paved the way for the approval of the remaining agency budgets and the longest session in the history of the Oregon Legislative Assembly concluded on August 27, 2003. However, opponents of the new tax increases immediately stated their intent to wage a petition drive to obtain the 50,420

signatures needed to force a statewide election in February or March of 2004 to repeal the increases.

As part of its effort to contain rising health care costs, Oregon received federal approval in October 2002 to restructure the Oregon Health Plan ("OHP") – Oregon's groundbreaking Medicaid demonstration program. Oregon's HIFA waiver (the "Oregon Health Plan 2," or "OHP2") enables Oregon to utilize its unspent SCHIP funds and restructure the Oregon Health Plan into three distinct benefit packages:

- *OHP Plus* applies to all mandatory Medicaid populations and some optional populations (including pregnant women and children up to 185 percent of the FPL) and provides a comprehensive benefit package equivalent to that offered through the original OHP;
- *OHP Standard* includes a reduced benefit plan and higher cost-sharing requirements and covers low-income adults up to 100 percent FPL. This category includes the parents of children enrolled in Medicaid and SCHIP and childless adults as well as seniors and people with disabilities with incomes at or above 75 percent of the poverty line. In FY 2003, the reduced benefit plan excluded coverage for a number of optional services including vision, dental, non-emergency transportation, durable medical equipment, mental health, and chemical dependency services.
- *The Family Health Insurance Assistance Program ("FHIAP"),* a previously existing state-funded premium assistance program, has been folded into the OHP2 HIFA waiver enabling Oregon to receive federal matching funds. The FHIAP is available to families and individuals with income up to 200 percent of the FPL and will provide premium assistance on a sliding-scale basis for employer-sponsored insurance.

In FY 2004, Oregon will make additional significant benefit reductions. Oregon is seeking federal approval to amend its current Medicaid waiver to provide a primary care benefit package to its "OHP Standard" population, eliminating non-emergency hospital services, therapies and home health services for this group while also restoring coverage for mental health and chemical dependency services as well as medical supplies and emergency dental services. Oregon is also seeking federal approval to further reduce coverage under the OHP "Prioritized List" by 30 lines (from line 549 to line 519.

Other health care cost containment and related policy measures are described below.

| **Provider Rates:** |
|---|
| ▪ Hospital rates cut by 12% and most outlier payments (excluding those for patients under age one in DSH hospitals) eliminated in '03 |
| ▪ Rates for dentists, home care providers and most physicians frozen in '03 |
| ▪ Rates for OB/GYNs increased by 31.6% and rates for anesthesiologists decreased by 30% in '03 |
| ▪ Rates for nursing homes increased by 1.9% in '03 |
| ▪ Rates for doctors, dentists and home health providers frozen in '04 |

- Rates for nursing homes, residential and adult foster homes frozen in ’04 at their June 30, 2003 levels
- Nursing home provider tax adopted for ’04 that will result in a 14% increase in rates
- Rates for assisted living providers will increase by 2.95% effective September 1, 2003, and by another 2.6% on July 1, 2004
- In ’04, hospital rates will be increased to restore the 12% cut taken in ’03 and to provide an additional increase (not yet calculated)
- Physical health MCO rates increased by 8.1% in ’03 and will increase by 9.2% in October 2003 and by another 5.8% in April 2004
- Behavioral health MCO rates increased by 4.9% in ’03 and decreased by 17.2% in ‘04
- Dental health plans frozen in ’03 and increased by 1.2% in ‘04
- Provider taxes levied on hospitals MCOs and nursing homes in ‘04

**Eligibility Changes:**

- In ’03, the implementation of the OHP2 HIFA waiver included:
  - Moving 110,00 non-categorically eligible adults below the poverty level into the OHP Standard Plan
  - An expansion of SCHIP eligibility from 170% to 185% FPL
  - An expansion of eligibility for pregnant women from 170% to 185%
  - An elimination of retroactive eligibility for the OHP Standard population
  - A requirement that the OHP Standard population be uninsured for six months before becoming eligible
  - Folding into OHP2 a previously state-funded premium assistance program
- Eliminated the Medically Needy program in ‘03
- Restricted eligibility requirements (number of “survivability levels” covered reduced) for long term care services in ‘03
- A new prescription drug only program for seniors and disabled up to 133% FPL planned for ‘04
- SCHIP eligibility expanded to 200% FPL in ‘04
- FHIAP expanded to 200% FPL in ‘04
- Statutory authority to expand OHP Standard eligibility above 100% FPL repealed in ‘04

**Benefit/Service Reductions:**

- Eliminated a number of optional services for the OHP Standard population in ’03 including vision, dental, non-emergency transportation, DME, mental health, and chemical dependency services.
- Prescription drug coverage for the OHP Standard population eliminated for 13 days in ’03.
- Coverage under the OHP Prioritized List reduced from line 566 to line 558 in ‘03
- In ’03, OHP2 imposed new mandatory copayments (ranging from $2 for a generic prescription to $250 for an inpatient hospital admission) and premium requirements (ranging from $6 to $20 per month per person) for the OHP Standard population
- Optional copayments for pharmacy and ambulatory services added for (non-OHP Standard) adults
- Coverage under the OHP Prioritized List reduced from line 549 to line 519 in ‘04
- For the OHP Standard population in ’04, non-emergency hospital services, therapies

| |
|---|
| and home health services eliminated and mental health, chemical dependency, medical supplies and emergency dental services added. |
| **Prescription Drug Controls and Limits:** |
| ▪ AWP discount increased to 15% for retail (non-institutional) pharmacies and decreased by 3.5% for institutional pharmacies in ‘03<br>▪ Dispensing fee for institutional pharmacies increased by 2.9% in ‘03<br>▪ Prior authorization imposed in certain drug classes in ’03<br>▪ PDL implemented for five drug classes in ’03 and new classes will be added in ‘04<br>▪ Voluntary mail-order incentive program implemented in ’03 (AWP-21% for brand; AWP-60% for generic, and a $3.50 dispensing fee)<br>▪ Implemented a new point of sale claims processing system in ‘03<br>▪ Copayment requirements added for OHP Standard population and certain OHP Plus eligibles in ‘03<br>▪ Implemented cost-avoidance TPL policy for pharmacy claims in ‘03<br>▪ Implemented pharmacy lock-in program for fee-for-service eligibles (restricting clients to one pharmacy) in ‘03<br>▪ Supplemental rebate requirement added in ‘04<br>▪ Authority to subject non-PDL drugs to prior authorization repealed in’04<br>▪ In ’04, prior authorization added for persons using more than 15 drugs in the preceding six month period |
| **Other:** |
| ▪ Disease management programs for asthma, diabetes and congestive heart failure added in ‘03<br>▪ Case management program added for highest cost eligibles (over $20,000 per year) in ‘03<br>▪ Growth in home and community based services waivers to be capped at 5% in ‘04 |

**Profile of Medicaid Cost Containment Policies: Texas**

At the beginning of CY 2003, Texas had a projected budget shortfall of $1.8 billion for FY 2003 (5.8 percent of the General Revenue budget) and $8.1 billion of FY 2004 (12 percent of the General Revenue budget). On January 23, 2003, Governor Rick Perry directed all state agencies to immediately cut their 2003 General Revenue spending by at least 7 percent which would result in an estimated $700 million in savings. The only programs exempted from the mandatory cuts were the Foundation School Program, the Children's Health Insurance Program and acute care Medicaid services. At about the same time, Governor Perry submitted a proposed biennial budget for FY 2004 and FY 2005 to the Texas Legislature – a spending plan that started at "zero" for every agency and every category of spending to allow state legislators to re-evaluate all state spending.

On June 22, 2003, Governor Perry signed into law a $117 billion state budget for FY 2004 and FY 2005. The new budget does not raise taxes and reduces general revenue spending $2.6 billion while at the same time drawing down more federal funds. Thus, the total budget increases by 1.4 percent while the General Revenue budget decreases by 4.3 percent. Among other things, the new budget cuts 10,000 state jobs, implements certain payment delays to schools (to shift some costs into FY 2006) and makes a number of significant reductions in the Medicaid and SCHIP programs. In particular, the FY 2004 budget eliminates Medicaid coverage (on an average monthly basis) for an estimated 7,800 pregnant women, 8,400 medically needy adults and 28,000 adult TANF recipients who fail to meet their personal responsibility agreement requirements. Also, by the end of FY 2004, the average monthly caseload of the SCHIP program is expected to fall by over 169,000 due to changes made to the SCHIP eligibility requirements including the imposition of an assets test for families with incomes over 150 percent of the FPL, the reduction of continuous eligibility from 12 months to six months, the imposition of a 90-day waiting period between eligibility determination and coverage and the elimination of income disregards. Other Medicaid cost containment measures are listed below.

| **Provider Rates:** |
|---|
| ▪ All provider rates frozen in '03<br>▪ Quality Assurance Fee (6% of gross receipts per occupied bed) imposed on mental health/mental retardation state schools in '03<br>▪ Rates for acute care providers such as hospitals, doctors and HMOs decreased by 5% in '04 (although partially restored to a 2.5% cut using new federal funds)<br>▪ Rates for non-acute care providers such nursing homes, community care providers and ICF/MR providers decreased by 2.2% to 3.5% in '04 (although partially restored to a 1.1 to 1.75% cut using new federal funds)<br>▪ Funding for Graduate Medical Education discontinued for '04<br>▪ Insurance premium taxes expanded to previously exempt contracted health plans on '04<br>▪ Quality Assurance Fee for ICFs/MR increased from 5.5% to 6% in '04 |
| **Eligibility Reductions:** |
| ▪ Coverage for pregnant women between 158% FPL and 185% FPL eliminated for '04<br>▪ Coverage for medically needy adults between 17% FPL and 24% FPL eliminated for |

| |
|---|
| ‘04<br>▪ Eligibility eliminated in ’04 for TANF adults who fail to meet personal responsibility agreement requirements<br>▪ Personal Needs Allowance reduced for nursing home residents in ‘04<br>▪ SCHIP continuous eligibility reduced from 12 to 6 months for ‘04<br>▪ A 90 day eligibility waiting period imposed for SCHIP between eligibility determination and coverage in ‘04<br>▪ An asset test was added for SCHIP families over 150% FPL and the SCHIP income test was changed to eliminate income disregards in ‘04<br>▪ In FY 2004 for limited circumstances, reinstated policy of conducting face-to-face interviews on applications for children. |
| **Benefit/Service Reductions:** |
| ▪ Copayments for drugs and emergency room services added in ’03 (but were subsequently enjoined by court order)<br>▪ A number of optional services were eliminated for adults in ’04 including eyeglasses, hearing aids and chiropractic, podiatric, psychology and counseling services.<br>▪ Number of service hours provided to home and community-based services recipients reduced by 15% in ‘04<br>▪ The SCHIP benefit package was reduced in ’04 to exclude most mental health services, dental, chiropractic, eye exams and glasses, substance abuse treatment, hospice care and skilled nursing<br>▪ Cost-sharing for Medicaid and SCHIP authorized at federal maximum levels for ‘04 |
| **Prescription Drug Controls and Limits:** |
| ▪ New state MAC rates added in ‘03<br>▪ Drug Utilization Review activities increased in ‘03<br>▪ Plan to implement a PDL with prior authorization required for non-preferred drugs in ‘04<br>▪ Supplemental rebate requirement added for ‘04<br>▪ Dispensing fee reduced in ‘04<br>▪ Four brand-name limit and a 34-day supply limit authorized (if cost effective) in ‘04 |
| **Other actions in ‘04:** |
| ▪ Estate recovery authorized<br>▪ Increased program integrity and fraud and abuse efforts planned<br>▪ Prior authorization to be imposed on high-cost medical services<br>▪ Legislative requirement to implement disease management programs and expand managed care programs statewide if cost-effective to do so |

## Appendix A: Factors Contributing to Expenditure Growth in FY 2003—State Responses

| State | Primary Factor | Secondary Factor | Other |
|---|---|---|---|
| Alabama | Increase in number of eligibles | Medical inflation | Mandated expansions/some lawsuits/technology change |
| Alaska | Cost of medical care | Increase number of enrollees | Home and Community Based services |
| Arizona | Enrollment growth | Medical inflation | Pharmacy |
| Arkansas | Increase in eligibles | Medical inflation | Prescription Drugs |
| California | Eligibles | Cost increases | Utilization (aged) |
| Colorado | Reduced budget | Caseload | |
| Connecticut | Pharmacy | Home care—Home and Community Based waiver | Nursing Home |
| Delaware | Pharmacy | Nursing homes | |
| District of Columbia | Increased utilization | Rate increases | |
| Florida | Prescription drugs | Cost of nursing home care | Increase in Inpatient and Outpatient Hospital costs including additional special payments |
| Georgia | Eligibility growth--enrollment | Utilization—Outpatient Hospital | Price |
| Hawaii | Pharmacy | Enrollment growth | |
| Idaho | Prescription drugs | Hospitals | Home and Community Based waivers |
| Illinois | Population expansion | Pharmacy | Intergovernmental Transfer |
| Indiana | Nursing Home | Prescription drugs | Inpatient Hospital |
| Iowa | Caseload--increase in number of eligibles | Prescription drug expenditures | Nursing facility |
| Kansas | Growth in beneficiaries | Utilization increases, especially Inpatient hospital and Mental Health | Prescription drugs, but held down by policy |
| Kentucky | Pharmacy | New eligibles (caseload) | Medical inflation |
| Louisiana | Utilization | Pharmacy | HCBW slots for nursing home alternatives |
| Maine | Prescription drugs | Behavioral Health | Hospital outpatient |
| Maryland | Enrollment | Pharmacy | Managed care organizations |
| Massachusetts | Utilization | Caseload | Rates |
| Michigan | Caseload | Pharmacy | Provider assessment based rate increases |
| Minnesota | Home and Community Based waiver caseloads | Children and parents | Prescription drug costs |
| Mississippi | Prescription drugs | Enrollment | Cost increases |
| Missouri | Pharmacy | Caseload growth | Utilization increase |

| | | | |
|---|---|---|---|
| Montana | Caseload | Utilization | Outpatient Hospital |
| Nebraska | Nursing facility expenditures | Drug expenditures | Outpatient expenditures |
| Nevada | Caseload increase | Pharmacy costs | Provider rate increases |
| New Hampshire | Prescription drugs | Outpatient Hospital | Enrollment growth, especially elderly |
| New Jersey | Pharmacy | Inflation (managed care capitation) | |
| New Mexico | Utilization | Enrollment | Prescription drugs |
| New York | Pharmacy | Enrollment | Hospital |
| North Carolina | Mental Health | Utilization of outpatient hospital service | Utilization of personal care services |
| North Dakota | Increase in number of eligibles | Hospital | Physician |
| Ohio | Aged Blind and Disabled price and utilization | Covered families and children caseload growth | Aged Blind and Disabled caseload growth and increasing utilization |
| Oklahoma | Enrollment | Drugs | |
| Oregon | Hospital costs | Prescription costs | |
| Pennsylvania | Pharmacy cost/utilization | Long Term Care | Caseload, increased number of eligibles |
| Rhode Island | Prescription drugs/pharmacy | Inpatient Hospital-fee-for-service and some managed care demand | |
| South Carolina | Number of recipients | Service cost | Pharmacy |
| South Dakota | Enrollment, increased number of new eligibles | Inpatient and Outpatient Hospital, increased per capita cost | Prescription drugs |
| Tennessee | Pharmacy | Cost/enrollee | Supplemental payments to providers exceed projections |
| Texas | Caseload | Prescription drugs | Increased utilization |
| Utah | Caseload growth and utilization | Pharmacy | PCM waiver |
| Vermont | Long Term Care | Inpatient Hospital | Mental Health |
| Virginia | Health care inflation | Pharmacy (new and higher cost drugs) | |
| Washington | Caseload | Prescription drugs | |
| West Virginia | Pharmacy costs | Enrollment | |
| Wisconsin | Caseload growth | Increasing service costs | Expansion of benefits (SeniorCare) |
| Wyoming | Caseload growth | Higher reimbursement rates | Prescription drugs |

## Appendix B: Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2003

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

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Rhode Island | X | X | | X | | | X | | |
| South Carolina | X | X | | X | | X | | X | |
| South Dakota | | X | | | | | | | |
| Tennessee | X | | | X | | | | | |
| Texas | X | X | | | | | | X | |
| Utah | X | X | X | | X | | | | |
| Vermont | X | X | X | | X | | | | |
| Virginia | X | X | | | X | | | | |
| Washington | X | X | | X | | | X | X | |
| West Virginia | X | X | | | | | | | |
| Wisconsin | X | X | | | | | | | |
| Wyoming | X | X | | | | | X | X | |
| **Totals** | **50** | **46** | **18** | **25** | **17** | **6** | **13** | **19** | **10** |

Note: A blank indicates the state reported no action**.**

*****Eligibility changes include instituting premiums and changes to application and enrollment processes.

## Appendix C: Cost Containment Actions Taken in the 50 States and 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 | X | X | | | | | | | |
| Alaska | X | X | | X | | | | X | |
| Arizona | X | | | X | | | | | |
| Arkansas | X | | | | | | | | |
| California | X | X | | X | | | X | X | |
| Colorado | X | | X | X | X | | | X | |
| Connecticut | X | X | | | X | | | X | |
| Delaware | X | | | | X | | | | |
| District of Columbia | X | X | | | | X | | | |
| Florida | X | X | X | | X | X | | | |
| Georgia | X | X | X | | X | | | | |
| Hawaii | X | X | | | | | | | |
| Idaho | X | X | | | | | X | | |
| Illinois | X | X | | | | | | | X |
| Indiana | X | X | | X | X | X | X | | |
| Iowa | X | X | | X | X | | | | |
| Kansas | X | X | | | | | X | X | |
| Kentucky | X | X | | X | | | | | |
| Louisiana | X | X | X | | | | | | |
| Maine | X | X | | | X | | | X | |
| Maryland | X | X | | | | | | X | |
| Massachusetts | X | X | | X | X | | X | | X |
| Michigan | X | X | X | | X | | | X | X |
| Minnesota | X | X | X | X | X | | | | |
| Mississippi | X | X | X | | | | X | | |
| Missouri | X | X | X | | | | X | | |
| Montana | | | | | | | X | | |
| Nebraska | X | | X | X | | | | | |
| Nevada | X | X | X | | | X | X | X | |
| New Hampshire | X | X | X | | X | | X | X | |
| New Jersey | X | X | X | | X | | X | X | |
| New Mexico | X | X | | | | | | X | |
| New York | X | X | | | | | | X | |
| North Carolina | X | X | | X | | X | | | |
| North Dakota | X | X | X | X | X | | X | | |
| Ohio | X | X | X | | X | | X | | |
| Oklahoma | X | X | | | | | X | X | |
| Oregon | X | X | X | | | X | X | | X |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Pennsylvania | X | X | X | | X | | | X | |
| Rhode Island | X | | | | | X | | | |
| South Carolina | X | X | | | | X | | | |
| South Dakota | | X | | | | | | | |
| Tennessee | X | X | | | | | X | X | |
| Texas | X | X | X | X | | X | X | X | |
| Utah | X | X | X | X | | | | | |
| Vermont | X | X | | X | X | | | | |
| Virginia | X | X | X | X | X | | | | |
| Washington | X | X | X | X | X | | | | X |
| West Virginia | X | X | | X | X | X | | | |
| Wisconsin | X | X | | X | X | X | | X | |
| Wyoming | X | X | | | | | X | X | |
| **Totals** | **49** | **44** | **20** | **19** | **21** | **11** | **18** | **19** | **5** |

Note: A blank indicates the state reported no action.

* Eligibility changes include instituting premiums and changes to application and enrollment processes.

**Appendix D: Pharmacy Cost Containment Actions Taken in Each of the 50 States and District of Columbia as reported in the middle of FY 2003**

| State | AWP | New or Lower State MAC | Reduction in Dispensing Fees | More Drugs Subject to Prior Authorization | Preferred Drug List | Supplemental Rebates | Limits on the Number of Scripts |
|---|---|---|---|---|---|---|---|
| Alabama | | | | | | | |
| Alaska | | | | X | | | X |
| Arizona | | | | | | | |
| Arkansas | | | | | | | |
| California | X | | X | X | | X | |
| Colorado | X | | | X | | | |
| Connecticut | | X | X | | | | |
| Delaware | X | X | | X | | | |
| District of Columbia | | | | X | X | | |
| Florida | | | | | | | |
| Georgia | | X | X | X | | | |
| Hawaii | | | | | | | |
| Idaho | | X | | X | | | |
| Illinois | X | X | X | X | X | X | |
| Indiana | | | | X | X | | |
| Iowa | | X | | X | | | |
| Kansas | X | X | X | X | X | X | X |
| Kentucky | X | X | | | X | | |
| Louisiana | | | | X | X | X | X |
| Maine | X | | | | X | X | |
| Maryland | | | X | | | | |
| Massachusetts | X | X | X | X | X | | |
| Michigan | | X | | X | | | |
| Minnesota | X | X | | X | X | X | |
| Mississippi | X | | X | X | X | | X |
| Missouri | | X | | X | | | |
| Montana | X | | | | | | |
| Nebraska | X | | | X | | | |
| Nevada | X | | | X | | | |
| New Hampshire | | | | X | | | |
| New Jersey | | | | | | | |
| New Mexico | | | X | | | | |
| New York | | | | X | | | |
| North Carolina | | X | | | | | |
| North Dakota | | | | | | | |
| Ohio | | | | X | X | X | |
| Oklahoma | | | | X | | | X |
| Oregon | X | | | X | X | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Pennsylvania | | | | X | | | |
| Rhode Island | | | | X | | | |
| South Carolina | | | | X | X | X | |
| South Dakota | | X | | | | | |
| Tennessee | | | | | | | |
| Texas | | X | | | | | |
| Utah | X | | | X | | | |
| Vermont | | X | | X | | X | |
| Virginia | X | | | | | | |
| Washington | X | X | | X | X | X | |
| West Virginia | | | | | X | X | |
| Wisconsin | | | | X | | | |
| Wyoming | | X | | X | | | |
| **TOTAL** | **17** | **18** | **9** | **32** | **15** | **11** | **5** |

**Appendix E: Pharmacy Cost Containment Actions Taken in Each of the 50 States and District of Columbia as reported in the middle of FY 2004**

| State | AWP | New or Lower State MAC | Reduction in Dispensing Fees | More Drugs Subject to Prior Authorization | Preferred Drug List | Supplemental Rebates | Contract with a PBM | Limits on the Number of Scripts |
|---|---|---|---|---|---|---|---|---|
| Alabama | | | | X | | X | | |
| Alaska | X | X | | | X | | | |
| Arizona | | | | | | | | |
| Arkansas | | | | | | | | |
| California | | X | | X | | | | |
| Colorado | | | | | | | | |
| Connecticut | | | | X | X | X | | |
| Delaware | | | | | | | | |
| District of Columbia | | | | X | X | | | |
| Florida | | X | | | | X | | |
| Georgia | | X | | X | X | X | | |
| Hawaii | | | | | | | | |
| Idaho | | X | | X | X | | | |
| Illinois | | X | | X | X | X | | |
| Indiana | | X | | X | X | | | |
| Iowa | X | | X | X | X | | | |
| Kansas | | X | | X | X | X | X | |
| Kentucky | | | | | X | X | | |
| Louisiana | | | | X | X | X | | |
| Maine | | | | | | | | |
| Maryland | X | | | | X | X | | X |
| Massachusetts | X | X | | X | X | | X | X |
| Michigan | | X | | | X | | | |
| Minnesota | X | X | | X | X | X | | |
| Mississippi | | X | | X | X | | | |
| Missouri | | X | | | | X | | |
| Montana | | | | | | | | |
| Nebraska | | | | | | | | |
| Nevada | | X | | | X | X | | |
| New Hampshire | X | | | | | | | |
| New Jersey | | | | | | X | | |
| New Mexico | | | | | | | | |
| New York | X | | | | X | X | X | X |
| North Carolina | | | | | | | | |
| North Dakota | | | X | X | | | X | |
| Ohio | | | | X | X | X | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Oklahoma | | | | X | X | | | |
| Oregon | | | | X | X | X | | |
| Pennsylvania | | | | | | | | |
| Rhode Island | | | | | | | | |
| South Carolina | | | | X | X | | | |
| South Dakota | | | | X | | | | |
| Tennessee | | | | | X | X | X | |
| Texas | | | X | X | X | X | | X |
| Utah | | | | | X | | | |
| Vermont | | | | X | X | | | |
| Virginia | | | X | X | X | X | | |
| Washington | | X | | X | X | X | | |
| West Virginia | | X | | | X | | | |
| Wisconsin | X | | X | X | X | X | | |
| Wyoming | | X | | X | X | | | |
| **TOTAL** | **8** | **17** | **5** | **26** | **31** | **21** | **5** | **4** |

## Appendix F: Eligibility Actions Taken in the 50 States and District of Columbia in FY 2003

| State | Eligibility Change |
|---|---|
| Alabama | **Other**: Added AL technology waiver (1915c) for adult private duty nursing (people who age out of EPSDT) |
| Alaska | |
| Arizona | **Disabled**: Implemented Freedom to Work (209) |
| Arkansas | **Parents/Adults**: Expansion – Pregnant Women and family planning to 200% of FPL; TEFRA category became a waiver instead of state plan. Now state is able to charge a premium, 1% of income. |
| California | Change to semi-annual income redetermination |
| Colorado | **Other**: Eligibility expanded to BCC patients<br>**Other**: Law passed to remove optional legal immigrants from Medicaid eligibility (those located in US for 5 years or more). |
| Connecticut | **Children**: Elimination of continuous eligibility<br>**Parents/Adults**: Elimination of eligibility for low-income adults between 100% and 150% of the FPL (-19,000). Eligibility for approximately 16,000 people has been temporarily restored by court order through at least the end of September 2003.<br>**Other**: Expansion to Breast and Cervical Cancer patients |
| Delaware | |
| District of Columbia | **Parents/Adults**: Childless adult (50-64 years) up to 50% FPL (+1065)<br>**Disabled**: Elderly and physically disabled waiver (+290)<br>**Other**: HIV Waiver |
| Florida | **Disabled and Aged**: Income standard for eligibility reduced from 90% to 88% of FPL (July 1, 2002) (-3400)<br>**Other**: Implemented Silver Saver Drug Program for Seniors who are dually eligible with incomes up to 120% of the FPL, including some refinancing of an existing state-funded program (+58,000) |
| Georgia | |
| Hawaii | |
| Idaho | |
| Illinois | **Parents/Adults**: FamilyCare (+15,000)<br>**Aged**: SeniorCare, seniors between 100-200% FPL, includes refinancing through Medicaid of existing state-funded program (+150,000) |
| Indiana | **Children**: Elimination of continuous eligibility (-32,000) |
| Iowa | |
| Kansas | **Disabled**: Working healthy expansion (ticket to work) effective July 1, 2002 (+571) |
| Kentucky | **Children**: Children needing psych care incur 30 days of treatment before parental income counts (-600)<br>**Disabled and Aged**: Expansion<br>**Other**: Aliens – Changed policy to reflect rest of southeastern states<br>**Other**: TANF – Lose Medicaid card if not complying with work requirement |
| Louisiana | **Children and Disabled**: Expansion<br>**Aged**: Expansion<br>**Other**: Pregnant Women – expanded program January 2003 to 200% FPL (after 15% income disregard) (+2,795) |

| | |
|---|---|
| | **Other**: Medically Needy – Bills for services incurred more than 3 months prior to application were excluded beginning with applications dated January 1, 2003 (-2,000) |
| Maine | **Parents/Adults**: Waiver to cover non-categorical adults 100% FPL (+15,000) |
| Maryland | **Other**: Senior Pharmacy Waiver – took state-only program and converted to Medicaid expansion to 175% under waiver amendment (+48,000) |
| Massachusetts | **Other**: Elimination of services for certain long -term Unemployed (1115 waiver pop) (-33,832)<br>**Other:** Implement new premiums for 1115 population (4,000) |
| Michigan | **Parent/Adults**: Childless adults under 35% FPL (+62,000). No caretaker relative proposed but blocked by litigation. Will not be done (25,000) |
| Minnesota | **Children**: Expansion – income eligibility to 170% of FPL (+12,000)<br>**Parents/Adults**: income eligibility to 100% of FPL (+8,000) |
| Mississippi | |
| Missouri | **Children**: Extended presumptive eligibility to children (+1,685)<br>**Parents/Adults**: Cut custodial parents over 77% (from 100%), cut all non-custodial parents, cut all parent's fair share participants, reduced transitional Medicaid to under 100% FPL and to one year extended coverage, reduced women's health to under 100% FPL and to one year extended coverage (47,297)<br>**Disabled**: Expanded medical assistance to include workers with disabilities (ticket to work) (357)<br>**Other**: Restricted spend down recipients by requiring out of pocket expense instead of incurring spend down amount (24,000) |
| Montana | |
| Nebraska | **Children**: Reduction in length of TMA (24 to 12 months), reduction in amount of earnings disregard (20% of earnings to flat $100), change in treatment of household composition for eligibility (17,500)<br>**Parents/Adults**: Reduction in length of TMA, reduction in amount of earnings disregard, change in treatment of household composition for eligibility (7,000) |
| Nevada | **Parent/Adults**: Expansion of breast and cervical cancer coverage (+69)<br>**Other**: ALL – eliminated unemployment insurance income exemption in eligibility determination (2,925) |
| New Hampshire | |
| New Jersey | |
| New Mexico | **Other**: Added breast and cervical cancer coverage in 2003 (+158) |
| New York | **Children**: Net income 100-133%, April 1, 2002<br>**Parents/Adults**: Gross income increase from 133% to 150%, October 1, 2002<br>**Other**: Breast and Cervical Cancer program added October 1, 2002 (+2,000) |
| North Carolina | **Children**: Count parental income for pregnant minors (650)<br>**Other**: Impose transfer of asset penalties on persons receiving personal care services in their homes<br>**Other**: Include real property held under a life estate or tenancy in common as a countable asset when determining Medicaid eligibility (3,000) |
| North Dakota | **Children and Parents/Adults**: Implemented 100 hour rule (2,400)<br>**Disabled and Aged**: Implemented to only allow $15 for offset (i.e. limited to amount can write off) (256) |

| | |
|---|---|
| Ohio | **Other**: Breast and Cervical Cancer program for women (+200) |
| Oklahoma | **Children**: Eliminated Medically Needy (-800)<br>**Parents/Adults**: Eliminated Medically Needy (-6,500)<br>**Aged**: Eliminated Medically Needy (-1,000) |
| Oregon | **Children**: Expand CHIP kids from 170% to 185% FPL (OHP2) (+1,253); folded previously state funded premium assistance program into OHP2.<br>**Parents/Adults**: Expand pregnant women from 170-185%, eliminate retroactive eligibility for standard population effective March 1, 2003, require standard population be uninsured for 6 months before becoming eligible for Medicaid (200,178); new premium policies, higher premiums and penalties for non-payment of premiums for standard population (192,832); moved non-categorical adults under the poverty level into OHP standard plan (110,000)<br>**Disabled**: Reduced eligibility based on elimination of certain Medicaid LTC survivability levels, eliminated Medically Needy program<br>**Other**: included ESI program under new Medicaid demonstration waiver (+7,716) |
| Pennsylvania | |
| Rhode Island | **Children**: higher premium (5% from 3%) on RiteCare for families at or over 150% FPL |
| South Carolina | **Parent/Adults**: Add a 185% gross income test of the TANF need standard for low income families (7,000)<br>**Aged**: Refinanced existing state-only program to expand Medicaid eligibility for pharmacy coverage to 200% of the FPL for people age 65 and older under pharmacy waiver (+50,000) |
| South Dakota | |
| Tennessee | **Children**: Children in waiver population must now be below 200% of poverty and have no access to group health insurance. Kids with access to insurance who were enrolled as of 12/31/01 allowed to be "grandfathered" into the program, must meet income standards<br>**Parents/Adults**: Uninsured adults must be < 100% poverty and without access to group health insurance.<br>**Aged**: 40,000 individuals grandfathered, anyone applying after 12/31/01 with access to Medicare would be denied based on ability to access Medicare<br>**Other**: Previously uninsured TennCare enrollees reduced to 200% FPL kids 100% FPL adults, uninsurable still open for under 100% FPL, enrollment slowed for uninsured<br>**Other**: Implemented reverification process to reverify eligibility of entire waiver population and requested modification to existing waiver regarding benefits, copay, etc. (600,000) |
| Texas | |
| Utah | **Parents/Adults**: Expansion for PCN 1115 waiver for limited benefits (+25,000)<br>**Disabled**: Working disabled, premium reduced (170) |
| Vermont | **Aged**: Added Healthy Vermonter (+5,100) |
| Virginia | **Children**: Increased income limit for children ages 6-19 from 100-133% FPL.<br>**Parents/Adults**: Increased the income limits for the 1931 group by the increase in the CPI<br>**Other**: Medically Needy Population – Increased the income limits by the increase in CPI<br>**Other**: Pregnant Women – Implemented a Family Planning Waiver to |

| | |
|---|---|
| | provide up to 24 months of family planning services for women whose pregnancy was covered under Medicaid |
| Washington | **Parents/Adults**: Premiums on adults in 2nd six months of transitional medical benefits (3,500) |
| West Virginia | |
| Wisconsin | **Parents/Adults**: Family planning waiver (+20,446)<br>**Aged**: SeniorCare waiver expansion (+94,383) |
| Wyoming | |

Note: Numbers and parentheses are estimates of numbers of people affected by the policy described. Descriptions of policies and estimates of numbers of people affected were provided by state officials who responded to the survey in June 2003. This table does not describe changes to application and enrollment processes, which are included in Appendixes B and C.

## Appendix G: Eligibility Actions Taken in the 50 States and District of Columbia in FY 2004

| State | Eligibility Change |
|---|---|
| Alabama | |
| Alaska | **Children**: Reduction from 200% FPL to 175% FPL. Subsequent freeze of income level at 2003 value of 175% of FPL for expansion group (1,300)<br>**Parents/Adults**: Income level frozen at 2003 value of 175% of FPL for optional group (300)<br>**Other**: 300% of current SSI institutional group frozen at current dollar value of SSI |
| Arizona | |
| Arkansas | **Children**: Add coverage for undocumented aliens for pregnancy and child birth and child<br>**Other**: Seeking federal approval of a Medicaid waiver to subsidize for employer health insurance |
| California | |
| Colorado | **Other**: Fees for waiver families |
| Connecticut | |
| Delaware | |
| District of Columbia | **Children**: Eligibility expansion under 1902 (r)(2) to 19-21 year olds up to 200% FPL (+500 to 1,000)<br>**Parents/Adults**: Expansions: Pregnancy related State Plan Amendment; 50-64 year olds up to 100% of FPL; 21-27 year old up to 50% FPL |
| Florida | **Aged**: Silver Saver expanded and Lifesaver Rx discount program is authorized for certain seniors with incomes up to 200% of the FPL, includes refinancing through Medicaid of existing state-funded program (+100,000) |
| Georgia | |
| Hawaii | |
| Idaho | |
| Illinois | **Children**: Kids with family income up to 200% FPL eligible for SCHIP (+12,000)<br>**Parents/Adults**: Parents with family income up to 90% eligible for FamilyCare (+65,000)<br>**Aged**: Seeking federal approval to expand SeniorCare eligibility from 200-250% (+50,000) |
| Indiana | **Disabled and Aged**: Spend down days |
| Iowa | **Disabled**: Premium increase of MEPD – working disabled (1,500) |
| Kansas | |
| Kentucky | **Parents/Adults**: Premium on KCHIP for 150% to 200% FPL. Premium on 2nd sixth months of TMA<br>**Disabled and Aged**: For NH or LTC eligibles, decrease resource allowance and income standards for community spouse. Looking at transfer of asset issue in addition to Miller trust |
| Louisiana | **Children**: Counting unborn in need standard when determining eligibility for siblings (+250)<br>**Disabled**: Expansion on more liberal resources methodology, cost neutral. Optional program for people with working disabilities (ticket to work) |
| Maine | |
| Maryland | **Parents/Adults**: New program for Traumatic Brain Injury (+10) |

| | |
|---|---|
| | **Other**: Maryland Pharmacy Program – 2nd phase discount program. Open up eligibility to Medicare up to 185%.<br>**Other**: General Assembly has made the following changes to the MCHP and MCHP Premium effective July 1, 2003. (1) Non-Medicaid now starts at 185% - Lowered the upper income limit for free MCHP coverage from 200% FLP to 185% FPL so that for those families whose income falls between 185% and 200% FPL will have to pay a monthly premium. (2) The MCHP Premium, which covers families with income between 200% FPL and 300% FPL, will no longer accept any new enrollments after July 1, 2003. Children enrolled in MCHP before that date would continue to be covered, however, If these children lose eligibility, they will not be reenrolled. (3) The employer sponsored insurance option for enrollees in the MCHP Premium, whereby the program subsidizes private insurance premium to keep MCHP Premium children enrolled in private insurance rather than HealthChoice, will be discontinued effective July 1, 2003. |
| Massachusetts | **Children**: Greater use of premiums (150,000)<br>**Parents/Adults**: Asset test Restriction – Enrollment Freeze/Cap Reduction – Elimination of Benefits for Special Status Immigrants (24,600)<br>**Disabled**: Reduction: Tightening of the Disability Criteria – **Reduction**: – Asset test Restriction – Enrollment Freeze/Cap Reduction – Elimination of Benefits for Special Status Immigrants (26,050)<br>**Aged**: Reduction – Elimination of Benefits for Special Status Immigrants<br>**Othe**r: Cost Shifting – Compulsive application to Medicare (adults, disabled and aged)<br>**Other**: Cost Shifting – Investigation of employer sponsored insurance (adults, disabled and aged) (30,000) |
| Michigan | **Other**: HIFA family planning waiver, SCHIP funded plan |
| Minnesota | **Children**: Rolled back to 150% from 170% FPL. Auto newborn eligibility reduced from 24 to 12 months (-5,000) |
| Mississippi | |
| Missouri | **Disabled and Aged**: Increase from 80-90% FPL October 1, 2003 |
| Montana | |
| Nebraska | **Children**: Presumptive eligibility for children no longer available effective 9.1.03, eliminate Ribicoff coverage for 19-20 year-olds, eliminate presumptive eligibility for children (3,440) |
| Nevada | |
| New Hampshire | |
| New Jersey | |
| New Mexico | **Parents/Adults**: Proposed Medicaid waiver to expand coverage of working adults (+10,500) |
| New York | **Disabled**: Adding a working disabled buy-in up to 250% (+2,500) |
| North Carolina | **Children and Parents/Adults**: Eliminate 12 month State Transitional Medicaid Coverage for families and children who are working and no longer receiving welfare payment |
| North Dakota | **Disabled**: Buy-in program for working disabled – expansion (+300)<br>**Aged**: Spousal asset limit (spouse not residing in an institution can retain half of joint assets, up to a max (200) |
| Ohio | **Parents/Adults**: To receive federal relief, parent coverage for 90-100% FPL will not be eliminated. 100% FPL will not be eliminated. Reduction in eligibility at a later date is still under consideration |

| | |
|---|---|
| | (60,000) |
| Oklahoma | |
| Oregon | **Children**: Expand SCHIP from 185% to 200% FPL (+4,030)<br>**Disabled and Aged**: Planned new eligibility program for seniors and disabled that will be an Rx program only and will probably cover up to 133% FPL (+7,000)<br>**Other**: FHIAP expanded to 200% FPL<br>**Other**: Statutory authority to expand OHP standard eligibility above 100% FPL repealed |
| Pennsylvania | |
| Rhode Island | |
| South Carolina | |
| South Dakota | |
| Tennessee | |
| Texas | **Parents/Adults**: Reduced eligibility to pregnant women to 158% from 185% FPL (+7,831); Eliminated TANF adults who fail to meet personal responsibility agreement requirements (-28,000). This TANF penalty has been temporarily stayed by court order.<br>**Aged**: Eliminated adult medically needy program between 17% and 24% of FPL (-8,472)<br>**Other**: Reduced the personal needs allowance for nursing home residents<br>**Other**: Monthly cost sharing will be imposed |
| Utah | **Disabled and Aged**: Spend down eligibility threshold increased 50% to 100% for ABD (4,000)<br>Other: Blind – Eligibility increase 75% to 100% (+12) |
| Vermont | **Parents/Adults**: Ended 6-month guaranteed eligibility for PCCM enrollees<br>**Disabled and Aged**: Changed LTC asset rule to cover bonds<br>**Other**: Waiver Population – replaced copayments with premiums as of January 1, 2004 |
| Virginia | **Parents/Adults**: Eliminate 12 months TMA provided for VIEW participants who lost financial asset under welfare reform (-3,750)<br>**Other**: Medically Needy Populations – Froze CPI adjustment to income limits for FY 2004 |
| Washington | **Parents/Adults**: Parents and children who used to benefit from 12 months continuous eligibility now have a status review every six months. (-4,800)<br>**Disabled**: Raising functional requirements and eliminating services for clients needing minimal assistance with one or two activities for Medicaid personal care program. No new applicants with lower level of care admitted<br>**Other**: Co-premiums on children over 100% FPL (62,000) |
| West Virginia | |
| Wisconsin | **Parents/Adults**: Require verification of health insurance and wages for employed BCC applications/recipients as a condition of eligibility. Increase premiums for BadgerCare enrollees with income above 150% FPL to 5% of net income, from current 3% of net income (18,439)<br>**Aged**: Provide that annuities be treated as countable asset if there is a market in which the annuity could be sold and tighten policies related to transfers to a community spouse to ensure assets so transferred are for the sole benefit of the community spouse and increase the required annual enrollment fee for SeniorCare applicants from $20 to $30 per person. Condition of eligibility |

| | |
|---|---|
| | (108,156)<br>**Other**: Families addition – Eliminate 100 hour rule for 2 parent families (+500) and expand eligibility for women with BCC to include women diagnosed with precancerous conditions and women eligible for HIS (+13) |
| Wyoming | |

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Note: Numbers and parentheses are estimates of numbers of people affected by the policy described. Descriptions of policies and estimates of numbers of people affected were provided by state officials who responded to the survey in June 2003. A blank indicates the state reported no action. This table does not describe changes to application and enrollment processes, which are included in Appendixes B and C.

## Appendix H: Benefit Related Actions Taken in the 50 States and District of Columbia in FY 2003

| State | Benefit Change |
|---|---|
| Alabama | |
| Alaska | **Parents/Adults**: Limit length of hospital stay to 4 days without PA except maternal and newborn hospital stays related to childbirth which are limited to 48 hours IPH following normal vaginal delivery and 96 hours IPH following cesarean |
| Arizona | **Other**: No more circumcisions |
| Arkansas | |
| California | **Parents/Adults, Disabled and Aged**: Restricted dental to one exam per lifetime and one cleaning |
| Colorado | **Other**: Reduction of home health LTC therapies |
| Connecticut | **Parents/Adults, Disabled and Aged**: Optional cuts – chiropractic, naturopathic, podiatry, occupational therapy, physical therapy, speech therapy, psychology (100,000) |
| Delaware | |
| District of Columbia | **Disabled**: Added 7 new services to MR/DD waiver (365)<br>**Aged**: Added 2 new services to Elderly/Physical Disabilities Waiver (299) |
| Florida | **Parents/Adults, Disabled and Aged**: Eliminate dental services for adults except for emergency dental services (7.1.02) (82,000) |
| Georgia | |
| Hawaii | |
| Idaho | **Parents/Adults, Disabled and Aged**: Reinstated Emergency Dental and decreased TCM from 8 hours to 4 hours for MI and 5 hours to 3hours for DD (18,114) |
| Illinois | |
| Indiana | **Parents/Adults, Disabled and Aged**: Dental cap at $600. Added buy-in |
| Iowa | |
| Kansas | **Parents/Adults**: Eliminate vision, audiology and diapers – effective 1.03 to 6.03 (10,000) |
| Kentucky | **Disabled and Aged**: Expansion |
| Louisiana | **Children, Disabled and Aged**: Expansion |
| Maine | |
| Maryland | |
| Massachusetts | **Parents/Adults, Disabled and Aged**: Eliminate adult optional services: prosthetics, orthotics, eyeglasses, chiropractor services and dentures. (513,000) |
| Michigan | |
| Minnesota | |
| Mississippi | **Other**: Pregnant Women – Eliminated vision and dental (21,200) |
| Missouri | |
| Montana | **Parents/Adults**: Dental restricted to emergency and previous procedures (7,000) and restrictions on MH therapies and eyeglasses |
| Nebraska | |
| Nevada | |
| New Hampshire | |
| New Jersey | |
| New Mexico | |

| | |
|---|---|
| New York | |
| North Carolina | **Other**: Limit PCS to 3.5 hrs/day while maintaining 80 hr/month limit<br>**Children and Parents/Adults**: Reduce case management services by reducing rates, streamlining services, and eliminating duplicative services |
| North Dakota | **Parents/Adults, Disabled and Aged**: Reduction in adult dental (services still available, include exams, x-rays, cleaning and fillings) (27,712) |
| Ohio | |
| Oklahoma | **Parents/Adults**: HMOs reduced benefits, reduced number of hospital days, eliminated adult dental (46,000)<br>**Disabled and Aged**: HMOs reduced benefits and number of hospital days (120,000) |
| Oregon | **Parents/Adults**: Reduced benefits for OHP standard clients (eliminated vision, partial dental, non-emergency transport, partial DME) effective February 1, 2003; Eliminated drug coverage for 13 days (100,000)<br>**Other**: Reduction of services by 8 line movement on OHP prioritized list form 566-558 |
| Pennsylvania | |
| Rhode Island | |
| South Carolina | |
| South Dakota | **Children, Parents/Adults, Disabled and Aged**: Added hospice benefit effective January 1, 2003 (58) |
| Tennessee | |
| Texas | |
| Utah | **Parents/Adults, Disabled and Aged**: Eliminated dental (6/02), podiatry, speech and audiology (7/02), OT/PT and vision (2/03). Chiropractic services were scaled back around 10/02. |
| Vermont | **Parents/Adults, Disabled and Aged**: Eliminated chiropractic services and dentures for all adults |
| Virginia | |
| Washington | **Other**: DASA – Added CM for chemically dependent clients |
| West Virginia | |
| Wisconsin | |
| Wyoming | |

Note: Numbers and parentheses are estimates of numbers of people affected by the policy described. Descriptions of policies and estimates of numbers of people affected were provided by state officials who responded to the survey in June 2003. A blank indicates the state reported no action.

## Appendix I: Benefit Related Actions Taken in the 50 States and District of Columbia in FY 2004

| State | Benefit Change |
|---|---|
| Alabama | |
| Alaska | |
| Arizona | |
| Arkansas | |
| California | |
| Colorado | **Children, Parents/Adults, Disabled and Aged**: Non-emergency Medical Transport reduction |
| Connecticut | |
| Delaware | |
| District of Columbia | |
| Florida | **Parents/Adults**: Vision and hearing services were eliminated, effective 7.1.03 (82,000)<br>**Other**: Eliminate reimbursement for circumcision services (14,100) |
| Georgia | **Children, Parents/Adults, Disabled and Aged**: Dental restriction |
| Hawaii | |
| Idaho | **Parents/Adults, Disabled and Aged**: Restore adult dental limitations (1,450) |
| Illinois | |
| Indiana | |
| Iowa | |
| Kansas | **Parents/Adults**: Restore vision/audiology and diapers |
| Kentucky | |
| Louisiana | **Other**: No longer reimburse for circumcisions |
| Maine | |
| Maryland | |
| Massachusetts | **Parents/Adults, Disabled and Aged**: Restored orthotics and prosthetics |
| Michigan | **Parents/Adults**: Elimination in ambulatory benefits for dental; Elimination in option ambulatory – podiatry, chiropractic, dentures, non-emergency dental, personal care services, non-emergency transport, care management, and respiratory care. |
| Minnesota | **Parents/Adults, Disabled and Aged**: $500 dental cap (100,000) |
| Mississippi | **Parents/Adults**: Designed benefits packages for certain groups (85,000)<br>**Disabled**: Designed benefits packages for certain groups (130,000)<br>**Aged**: Designed benefits packages for certain groups (72,000) |
| Missouri | **Parents/Adults**: Expand psychologist services to adults, restore adult dental and optical (22,908)<br>**Other**: Set limits and PA for counseling therapies |
| Montana | **Children, Parents/Adults, Disabled and Aged**: All restored back to 2002 levels |
| Nebraska | **Children**: Orthodontic care limited to extremely severe conditions (1,800)<br>**Parents/Adults**: Chiropractic visits and eye glass replacements limited (500)<br>**Disabled**: Community based expenditures for high needs individuals capped (20) |
| Nevada | **Disabled and Aged**: Limit personal care aide IADL hours (34,248) |
| New Hampshire | **Children**: Reduced orthodontic coverage |

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|---|---|
| New Jersey | **Parents/Adults, Disabled and Aged**: Proposed to eliminate dental and chiropractic for all adults, exclude federally exempt populations (14,000) |
| New Mexico | |
| New York | |
| North Carolina | |
| North Dakota | **Children**: Limit physician visits to 12/year, chiropractic visits to 12/year, OT to 20/year, psychological therapy to 40/year, limit SP to 50/year, and limit PT to 15/year; EPSDT will allow exceptions (54,000)<br>**Parents/Adults, Disabled and Aged**: Limit physician visits to 12/year, chiropractic visits to 12/year, OT to 20/year, psychological therapy to 40/year, limit SP to 50/year, limit PT to 15/year, and limit adult glasses to once every 3 years |
| Ohio | **Parents/Adults, Disabled and Aged**: The executive budget proposed elimination of optional benefits for adults – dental, vision, chiropractic, podiatry, and psychology. Based on most recent information, all but chiropractic services will be restored. (800,000) |
| Oklahoma | |
| Oregon | **Parents/Adults**: For OHP Standard population, eliminated non-emergency hospital services, therapies, home health services. Added mental health, chemical dependency, medical supplies and emergency dental services.<br>**Other**: Native Americans – Submitting waiver amendment to CMS to give OHP+ package to all eligible AI and Alaskan Native clients (3,000)<br>**Other**: All – Reduction of services by a 30 line movement of the OHP prioritized list from 549-519 |
| Pennsylvania | **Parents/Adults:** Elimination of podiatry, optometry and chiropractic services for all adults |
| Rhode Island | |
| South Carolina | |
| South Dakota | |
| Tennessee | |
| Texas | **Parents/Adults, Disabled and Aged**: Eyeglasses, hearing aids, chiropractic services, podiatry, counselors and psychologists cut (175,000) |
| Utah | **Children:** Circumcision eliminated<br>**Parents/Adults, Disabled and Aged**: Occupational therapy, physical therapy, speech and audiology restored for all non-pregnant adults, further restrictions in chiropractic visits, 2nd podiatry restoration of certain surgeries (60,000) |
| Vermont | |
| Virginia | **Children, Parents/Adults, Disabled, Aged**: Prior authorization will be required for home health, outpatient rehab and outpatient mental health services after the fifth visit; prior authorization will be required for non-emergency outpatient scans (MRI, CAT, PET). |
| Washington | **Parents/Adults, Disabled and Aged**: Dental scaled back |
| West Virginia | |
| Wisconsin | |
| Wyoming | |

Note: Numbers and parentheses are estimates of numbers of people affected by the policy described. Descriptions of policies and estimates of numbers of people affected were provided by state officials who responded to the survey in June 2003. A blank indicates the state reported no action.

**Appendix J: Survey Instrument**

# Medicaid Budget Survey
# for Fiscal Years 2002, 2003 and 2004

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

## Section I. Medicaid Expenditures for State Fiscal Years 2002, 2003 and 2004

**A**. Below, please indicate Medicaid expenditures, excluding administration, and the source of funds. A consistent definition for spending across all three years is important for the calculation of annual percentage changes. Please note here your definition of Medicaid expenditures (e.g., does it include or exclude mental health, long term care, etc.):

_____

| | Source of Funds | | | |
|---|---|---|---|---|
| | **State Funds** | **Local or Other Funds** | **Federal Funds** | **Total: All Fund Sources** |
| *FY 2002* | | | | |
| 1. Medicaid Expenditures (Actual) | | | | |
| *FY 2003* | | | | |
| 2. Original Medicaid Appropriation | | | | |
| 3. Current Projected Medicaid Expenditures | | | | |
| 4. Percentage Change: FY 2003 Medicaid Projected Expenditures over FY 2002 Actual Expenditures (line 3 over line 1) | | | | |
| *FY 2004* | | | | |
| 5. Legislative Appropriation for Medicaid (If adopted; otherwise expected) | | | | |
| 6. Percentage Change: FY 2004 Medicaid Appropriation over FY 2003 Projected Expenditures (line 5 over line 3) | | | | |

This space is provided for any comments or explanations:

_____

_____

If FY 2003 projected spending is greater than the original appropriation (i.e., if line 3 above is greater than line 2), how is your state covering the shortfall?

## Section II. State Fiscal Year 2003

1. **Cost Drivers:**
   a. What would you consider *the most significant factor* contributing to the increase in Medicaid spending in FY 2003? _____
   b. What would be the *second most significant factor*? _____
   c. Other significant factors? _____

2. **Enrollment increases in FY 2003, and their contribution to Spending Increases**:
   a. Overall % enrollment growth, FY 2003 over FY 2002: _____%
   b. What would you consider *the most significant eligibility group* contributing to the increase in Medicaid *expenditures* in FY 2003? _____
   c. What would be the *second most significant group*? _____
   d. Other significant groups? _____

**3**. **Dual Eligibles:** If available, what percentage of your spending can be attributed to dual eligibles? _____%

**4.** **Provider payment rates**: For each provider type, please describe any rate increases, decreases, or freezes in FY 2003 (e.g. indicate % increase, or % decrease, or X under Freeze for no change):

| Provider Type | + % Increase | -% Decrease | X=Freeze |
|---|---|---|---|
| a. Pharmacy | | | |
| b. Inpatient hospital | | | |
| c. Outpatient hospital | | | |
| d. Doctors | | | |
| e. Dentists | | | |
| f. Managed care organizations | | | |
| g. Nursing homes | | | |
| h. Home health providers | | | |
| i. Home and community-based waiver providers | | | |
| j. Others: | | | |

**5.** **Provider Taxes/Assessments**:
Please describe any provider taxes that were in place in FY 2003, and indicate which were first used in FY 2003.

| Provider Group subject to Tax in | Was this tax new in FY 2003? (Yes or No) | Description |
|---|---|---|
| a. | | |
| b. | | |
| c. | | |
| d. | | |

**6. Changes in Eligibility Standards or Application/ Renewal Process in FY 2003:**
In the table below please describe any expansion, reduction, restriction or other change in ***eligibility standards*** (e.g., income standards, asset tests) *implemented* during FY 2003.

| Eligibility Category | Nature of Eligibility Change: Expansion, Reduction, Restriction or Other Change | How many people were affected? * |
|---|---|---|
| a. Children | | |
| b. Parents/ Adults | | |
| c Disabled | | |
| d. Aged | | |
| e. Other | | |

*For this and following questions, please indicate your *estimate* of the number of persons.

**6.f.** Did your state make any changes to the ***application or renewal process*** in FY 2003 (e.g., changes in verification requirements, face to face interview requirements, application forms, re-determination process, etc.)?
Yes ____ No ____ If "yes," please describe those changes, and the estimated number of people affected: _____
_____

**7. Changes in Benefits or Services in FY 2003:** Please describe below any expansion, reduction, restriction or other change in benefits or services *implemented* during FY 2003.

| Populations affected by change in benefits | Nature of Benefit or Service Change Expansion, Reduction, Restriction or Other Change (E.g., for adults, dental coverage ended 1/03) | How many people were affected? |
|---|---|---|
| a. Children | | |
| b. Parents/ Adults | | |
| c. Disabled | | |
| d. Aged | | |
| e. Other | | |

8. **New or Higher Copayments**: Please describe any beneficiary cost sharing that was *newly implemented or increased* in FY 2003:

| Populations affected by new or higher cost sharing | New or Higher Beneficiary Copays (or other cost sharing requirements) by Service, e.g., for prescription drugs, dental, etc. | How many people were affected? |
|---|---|---|
| a. Parents/ Adults | | |
| | | |
| b. Disabled | | |
| | | |
| c. Aged | | |
| | | |
| d. Other | | |

9. **Prescription Drug Program Changes:** What new actions were *implemented* during FY 2003 to slow the growth in Medicaid expenditures for prescription drugs? Please briefly describe those that apply.

| Program or Policy Actions | Description |
|---|---|
| a. Payment for Rx @ AWP less a greater discount *or* WAC plus a smaller discount | |
| b. New/lower state MAC rates | |
| c. Reduction in dispensing fees | |
| d. More drugs subject to prior authorization | |
| e. Preferred drug list | |
| f. Supplemental rebates | |
| g. Limits on the number of Rx per month | |
| h. Requirements to use generics | |
| i. Mail order pharmacy contract | |
| j. Contract with PBM | |
| k. Long term care pharmacy initiative | |
| l. Other | |

10. **Other Cost Containment Measures:** Were other program or policy actions *implemented* during FY 2003 to slow the growth in Medicaid expenditures? Please briefly describe those that apply.

| Program or Policy Actions | Description | How many people affected? |
|---|---|---|
| a. Expansion of managed care (e.g. geographic expansion of PCCM or MCOs, enrollment of additional eligibility groups, mandatory enrollment.) | | |
| b. Disease management or case management | | |
| c. Enhanced fraud and abuse controls | | |
| d. Long-term care changes (excluding rate changes listed in Question 4 above.) | | |
| e. Medicare crossover claims policies | | |
| f. Accounting change (e.g., shift to cash acctg.) | | |
| g. Other: | | |
| | | |

Notes on above actions: _____
_____
_____
_____

11. **Estimate of FY 2003 Savings**: What is your *estimate* of the amount of savings from the cost-containment activities listed above for FY 2003?
Total Savings $_____Millions (all fund sources)
State General Fund Savings $_____Millions

Comments? _____

**12. Reflections on FY 2003 Cost Containment**: As you look back on actions taken in FY 2003, could you comment on whether any cost containment activities were blocked or delayed by litigation, whether savings were as great as anticipated, whether you received support or opposition from the advocate community, or anything else that may have surprised you, etc.?

_____

_____

_____

## Section III: State Fiscal Year 2004

Next, let's talk about Medicaid for next year, FY 2004:

**13. Legislative Action**: Has your legislature approved the Medicaid budget for FY 2004? Yes_____ No _____

**14. Cost Drivers:** Do you expect the factors that will contribute to Medicaid expenditure growth in FY 2004 to be the same as or different from those that contributed in FY 2003?

a. Same cost drivers as in FY 2003 _____
b. Different in FY 2004, in this way:

_____

_____

**15. Enrollment increases in FY 2004 and their contribution to Spending Increases**:

a. Projected overall % enrollment growth in FY 2004 over FY 2003: _____%
b. What would you consider *the most significant eligibility group* contributing to the increase in Medicaid *expenditures* in FY 2004? _____
c. What would be the *second most significant group*? _____
d. Other significant groups? _____

**16. Provider payment rates**: For each provider type, please describe any rate increases, decreases, or freezes to be implemented in FY 2004 (e.g. indicate % increase, or % decrease, or X under Freeze for no change). If a rate increase is a restoration of a previous rate cut, please write "**R**" after the indicated % increase.

| Provider Type | +% Increase (R?) | -% Decrease | X=Freeze |
|---|---|---|---|
| a. Pharmacy | | | |
| b. Inpatient hospital | | | |
| c. Outpatient hospital | | | |
| d. Doctors | | | |
| e. Dentists | | | |
| f. Managed care organizations | | | |
| g. Nursing homes | | | |
| h. Home health providers | | | |
| i. Home and community-based waiver providers | | | |
| j. Others: | | | |

**17**. **Provider Taxes or Assessments**: Please describe briefly any provider taxes (or provider tax increases) that are new for FY 2004:

a._____
b._____
c._____
d._____

**18. Changes in Eligibility Standards or Application Process in FY 2004:**
**Standards**: Please describe below any expansion, reduction, restriction or other change in ***eligibility standards*** (i.e., income or asset tests) to be adopted during FY 2004. Please indicate with an "**R**" if any change is a restoration of a previous reduction.

| **Eligibility Category** | **Nature of Eligibility Change: Expansion, Reduction, Restriction or Other Change (R = Restoration)** | **How many people will be affected?** |
|---|---|---|
| a. Children | | |
| b. Parents/ Adults | | |
| c. Disabled | | |
| d. Aged | | |
| e. Other | | |

**18.f. Process:** Is your state making any changes to the ***application or renewal process*** in FY 2004 (e.g., changes in verification or face to face interview requirements, applications, renewal process, etc.)? Yes ___ No ___ If "yes," please briefly describe those changes, and the estimated number of people affected: _____

_____

_____

**19. Changes in Covered Benefits in FY 2004:** Please describe below any expansion, elimination, restriction or other change in *benefits or services* that are to be adopted during FY 2004. Please indicate with an "R" if any change is a restoration of a previous reduction.

| **Populations** | **Nature of Benefit or Service Change: Expansion, Reduction, Restriction or Other Change (R = Restoration)** | **How many people will be affected?** |
|---|---|---|
| a. Children | | |
| b. Parents/ Adults | | |
| c. Disabled | | |
| d. Aged | | |
| e. Other | | |

**20. Prescription Drug Program Changes:** What program or policy actions are to be adopted for FY 2004 to slow the growth in Medicaid expenditures for prescription drugs? Please briefly describe those that apply.

| Program or Policy Actions | Description |
|---|---|
| a. Payment for Rx @ AWP less a greater discount or WAC plus a smaller discount | |
| b. New/lower state MAC rates | |
| c. Reduction in dispensing fees | |
| d. More drugs subject to prior authorization | |
| e. Preferred drug list | |
| f. Supplemental rebates | |
| g. Limits on the number of Rx per month | |
| h. Requirements to use generics | |
| i. Mail order pharmacy contract | |
| j. Contract with a PBM | |
| k. Long term care pharmacy initiative | |
| l. Other | |

**21. New or Higher Copayments**: Please describe any beneficiary cost sharing that is *newly implemented or increased* for FY 2004:

| Populations affected by new or higher cost sharing | New or Higher Beneficiary Copays (or other cost sharing requirements, e.g., for Rx, dental, etc.) | How many people will be affected? |
|---|---|---|
| a. Parents/ Adults | | |
| | | |
| b. Disabled | | |
| | | |
| c. Aged | | |
| | | |
| d. Other | | |

**22. Home and Community Based Services in FY 2003 and FY 2004**: Please describe if and how the provision of Home and Community Based Services changed in FY 2003 and how you expect it to change in FY 2004. (E.g. addition or reduction of slots, refinancing under waiver authority, new waiver groups, etc.)?

_____

_____

_____

_____

**23. Other Cost Containment Measures:** What other actions are to be used for FY 2004 to control the growth in Medicaid expenditures? Please describe those that apply.

| Program or Policy Actions | Description | How many people affected? |
|---|---|---|
| a. Expansion of managed care? Specify type of expansion (e.g. geographic expansion of PCCM or MCOs, expansion of eligibility groups, mandatory enrollment, etc.) | | |
| b. Disease management or case management | | |
| c. Enhanced fraud and abuse controls | | |
| d. Long-term care changes (excluding rate changes reported in Question 16? | | |
| e. Medicare crossover claims policies | | |
| f. Accounting change (e.g., shift to cash acctg.) | | |
| g. Other | | |

Notes on above actions: _____
_____

**24. Potential Shortfall:** When you look now at the amount appropriated (or that you expect to be appropriated) for FY 2004 for Medicaid, how likely do you believe it is that your state will experience a Medicaid budget shortfall in FY 2004? (Indicate with an **X**.)

| Almost Certain To be No Shortfall | Not Likely | 50-50 | Likely | Almost Certain to be a shortfall |
|---|---|---|---|---|

**25. Other Comments:** We are interested in your brief comments on the outlook for Medicaid in your state in FY 2004, and what you see as the most important issues Medicaid will face over the next year?
_____
_____
_____

**26. Fiscal Relief:** The Jobs and Growth Tax Relief Reconciliation Act of 2003 provided $20 billion in fiscal relief to states, including $10 billion in federal Medicaid matching funds, by raising each state's matching rate by 2.95 percent, and "holding harmless" states whose matching rates were scheduled to fall.

Has this increase in the matching rate affected the decisions your state made this year about funding for the Medicaid program? _____

Has the enhanced matching rate allowed the state to avoid making spending reductions in Medicaid that it would have made otherwise? _____

Has the enhanced matching rate allowed the state to avoid making spending reductions in other programs in the state's budget that it would have made otherwise?
_____

Do you have any documents that you could send that describe the factors associated with increasing Medicaid costs, and the actions you are taking in your state to control Medicaid costs?

Please send the survey and any documents to:

Vernon K. Smith, Ph.D.
Health Management Associates
120 N. Washington Sq., Suite 705
Lansing, MI 48933

Phone: 517-318-4819
Fax: 517-482-0920
E-mail: Vsmith@hlthmgt.com

***Thank you very much***. Please feel free to call if you have any questions.

This survey is being conducted by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured. The report based on this survey of all 50 states will be sent to you as soon as it is available.

**Appendix K: 2003 Legislative Regular Session Calendar**

| State | Convenes | Adjourns |
|---|---|---|
| Alabama | Mar 4 | Jun 16 |
| Alaska | Jan 21 | May 21 |
| Arizona | Jan 13 | June 19 |
| Arkansas | Jan 13 | April 16 |
| California | Dec 2, 2002 | Mid-Sept |
| Colorado | Jan 8 | May 7 |
| Connecticut | Jan 8 | Jun 4 |
| Delaware | Jan 14 | Jun 30 |
| Florida | Mar 4 | May 2 |
| Georgia | Jan 13 | April 25 |
| Hawaii | Jan 15 | May 1 |
| Idaho | Jan 6 | May 3 |
| Illinois | Jan 8 | * |
| Indiana | Jan 07 | Apr 27 |
| Iowa | Jan 13 | May 2 |
| Kansas | Jan 13 | May 6 |
| Kentucky | Jan 7 | Mar 25 |
| Louisiana | Mar 31 | Jun 23 |
| Maine | Dec 4, 2002 | Jun 14 |
| Maryland | Jan 8 | Apr 7 |
| Massachusetts | Jan 1 | * |
| Michigan | Jan 8 | * |
| Minnesota | Jan 7 | May 19 |
| Mississippi | Jan 7 | Apr 6 |
| Missouri | Jan 8 | May 16 |
| Montana | Jan 6 | April 26 |
| Nebraska | Jan 8 | May 30 |
| Nevada | Feb 3 | Jun 3 |
| New Hampshire | Jan 8 | Late June |
| New Jersey | Jan 14 | * |
| New Mexico | Jan 21 | Mar 22 |
| New York | Jan 8 | * |
| North Carolina | Jan 29 | Early July |
| North Dakota | Jan 7 | Apr 25 |
| Oklahoma | Feb 3 | May 30 |
| Oregon | Jan 13 | Mid-July |
| Pennsylvania | Jan 7 | * |
| Rhode Island | Jan 7 | Late June |
| South Carolina | Jan 14 | Jun 5 |

| State | Convenes | Adjourns |
|---|---|---|
| South Dakota | Jan 14 | March 24 |
| Tennessee | Jan 14 | May 29 |
| Texas | Jan 14 | Jun 2 |
| Utah | Jan 20 | Mar 5 |
| Vermont | Jan 8 | May 30 |
| Virginia | Jan 8 | Feb 22 |
| Washington | Jan 13 | Apr 27 |
| West Virginia | Jan 8 | Mar 16 |
| Wisconsin | Jan 6 | * |
| Wyoming | Jan 14 | March 6 |
| American Samoa | Jan 13 | |
| District of Columbia | Jan 2 | * |
| Guam | Jan 13 | * |
| Puerto Rico | Jan 13 | Jun 30 |
| Virgin Islands | Jan 13 | * |

*=Legislature meets throughout the year

SOURCE: National Conference of State Legislatures, 2003 Legislative Session. Accessed September 12, 2003 at:
http://www.ncsl.org/programs/legman/about /sess2003.htm

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