kaiser commission on medicaid and the uninsured

Medicaid Spending Growth:

Results from a 2002 Survey

Prepared by
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Health Management Associates

Victoria Wachino
Kaiser Commission on Medicaid and the Uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

September 2002

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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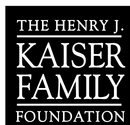

September 2002

Acknowledgements

The authors are especially grateful to Medicaid directors and other Medicaid and budget officials in all 50 states and the District of Columbia for their cooperation and assistance in completing the survey on which this study is based. Without exception, these officials graciously and generously offered their time and information about their programs and their plans for the future. Without their help the study could not have been carried out, and we appreciate their help.

We also appreciate the assistance provided by our colleagues at Health Management Associates. Rosanne Jekot assisted in the compilation of the data, and Dennis Roberts managed the database and helped turn the data into information from which we could do the analysis and write the report. Their work was excellent and we happily extend our appreciation to them. Thanks also to Molly O'Malley of the Kaiser Commission on Medicaid and the Uninsured for her help producing the report.

Finally, we are grateful to the Kaiser Commission on Medicaid and the Uninsured and the Kaiser Family Foundation, for their support of this project and for significant contributions to the project at every step of its development and completion. We especially thank Diane Rowland and Barbara Lyons for their personal interest and support.

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Executive Summary

Medicaid, a joint federal-state program, plays a significant role in the lives of low-income people. It is expected to cover more than 47 million people this year, according to the Congressional Budget Office, including nearly 24 million children, 11 million adults, and more than 13 million elderly and disabled individuals. Federal Medicaid matching payments are projected to be $147 billion in fiscal year 2002, while state spending is estimated at about $100 billion.

Medicaid is often the only source of health coverage available for low-income children, a critical support for people with disabilities in the community and the sole source of financial assistance for most nursing home care. Medicaid covered about one in every 10 Americans, although this percentage varies by state (Figure 1).

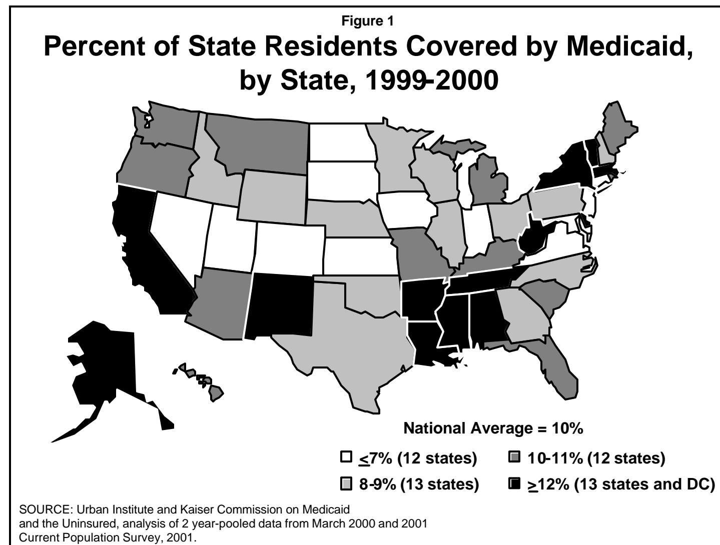
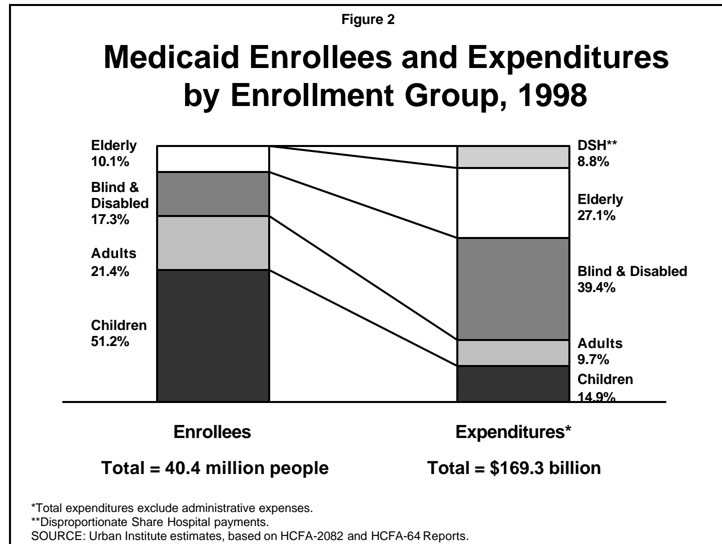


Figure 1
Percent of State Residents Covered by Medicaid, by State, 1999-2000

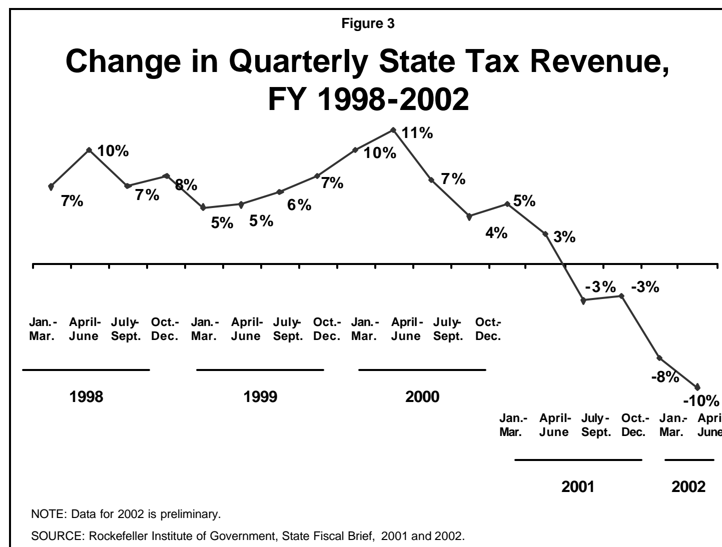
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of 2 year-pooled data from March 2000 and 2001 Current Population Survey, 2001.

To meet the diverse needs of the population it serves, Medicaid covers a broad range of health and long-term care services, including physician and hospital services, nursing home care and prescription drugs. Because the elderly and disabled tend to use more expensive services, they account for most of Medicaid's costs – although the elderly and disabled represent just over one-quarter of Medicaid enrollees, they account for two-thirds of Medicaid spending (Figure 2). Medicaid is the largest single purchaser of maternity care and pays for half of all nursing home care. Its significant support for hospitals and other health care providers means that Medicaid also plays a role in sustaining local economies. Medicaid is also the largest source of federal funds to the states, accounting for 43 percent of all federal grants-in-aid.



During the 1990's, states enjoyed the benefits of the nation's sustained economic expansion. Strong revenue growth, coupled with low rates of Medicaid spending growth, enabled states to improve their Medicaid programs. Notably, during the past five years, many states broadened health insurance coverage through Medicaid and the State Children's Health Insurance Program (SCHIP). They also took steps to increase participation by making enrollment in Medicaid and the State Children's Health Insurance Program easier. In recent years, states have also increased provider payments in their Medicaid programs.

Now, after more than a decade of economic growth, states are facing increasingly difficult fiscal situations. Nationally, state tax revenues are falling more sharply than they have at any time in more than ten years. Total state tax revenues fell by ten percent for the April to June 2002 quarter, which was the fourth straight quarter of declining tax state revenues (Figure 3).



The vast majority of states faced significant budget shortfalls this year, meaning that the revenue the state collected was not sufficient to meet its spending obligations. State "rainy day" funds, which are spending reserves designed to help states during difficult budgetary times, are rapidly

being depleted as states face what is for many their third consecutive year of budget shortfalls. At the same time, as the cost of health care services has grown, spending on Medicaid has been increasing significantly. During times of economic downturn, enrollment in Medicaid generally increases, adding to states' Medicaid costs.

Because Medicaid represents such a large part of their budgets and Medicaid costs are increasing faster than those of other state programs, many states have focused on Medicaid as a key part of their efforts to balance their state budgets. To identify state Medicaid spending trends and how states are responding to these trends and their overall fiscal conditions, the Kaiser Commission on Medicaid and the Uninsured contracted with Health Management Associates (HMA) to conduct a survey of Medicaid officials in all 50 states and the District of Columbia. The survey was purposefully conducted in May and June 2002, so states could describe specific actions taken in FY 2002 and their plans for FY 2003. This is the second year in which this survey has been conducted by HMA for the Kaiser Commission on Medicaid and the Uninsured. This report presents the findings from the 50- state survey.

The survey found that states are facing significantly increased Medicaid costs and that the overwhelming majority of states are implementing Medicaid cost control strategies. For the second year in a row, Medicaid spending has increased by more then 10 percent. States reported that in fiscal year 2002, total Medicaid spending increased 13 percent, while the state share of Medicaid spending increased 11 percent. These rates of growth are consistent with those of private health insurance, where premiums grew 12.7 percent in 2002, according to a recent Kaiser Family Foundation/Health Research and Educational Trusts survey.

According to the states, increasing pharmacy costs and increased enrollment are the primary factors behind Medicaid spending growth:

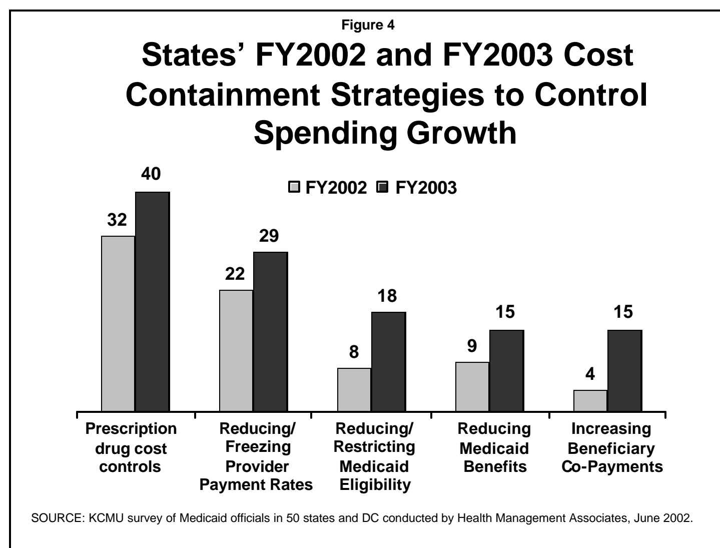
- Forty-four states cited increased spending on prescription drugs as one of the three most significant factors increasing their Medicaid costs, and 25 of those states ranked prescription drugs as the single most significant factor behind increased Medicaid costs. States reported that increased use of drugs, the use of new drugs, and price increases for prescription drugs were factors behind their overall increased pharmacy spending.

- Thirty-nine states indicated that increased enrollment was one of the three greatest sources of Medicaid spending growth. Eighteen states cited increased enrollment as the most significant factor behind the state's Medicaid spending increase. States described two dynamics as underlying the growth in Medicaid enrollment: the economic downturn, which has caused more people to qualify to be eligible for Medicaid, and expansions in eligibility and outreach that states have undertaken in recent years.

Increased cost and use of medical care services as well as the cost of long-term care are also significant factors increasing Medicaid spending, according to the state officials surveyed. These factors, and the increasing cost of prescription drugs, are also significant factors driving the increase in private-sector health insurance.

In response to their overall fiscal situations and these Medicaid cost pressures, 45 states took action to reduce their Medicaid spending growth in Fiscal Year 2002. Forty-one states reported that they have plans underway to take additional actions for FY 2003, which started July 1 in

most states. As the fiscal year progresses, it is likely that more states will act to reduce their Medicaid spending. It is also notable that for each type of cost containment strategy, more states reported planning to undertake action in FY 2003 compared to FY 2002.



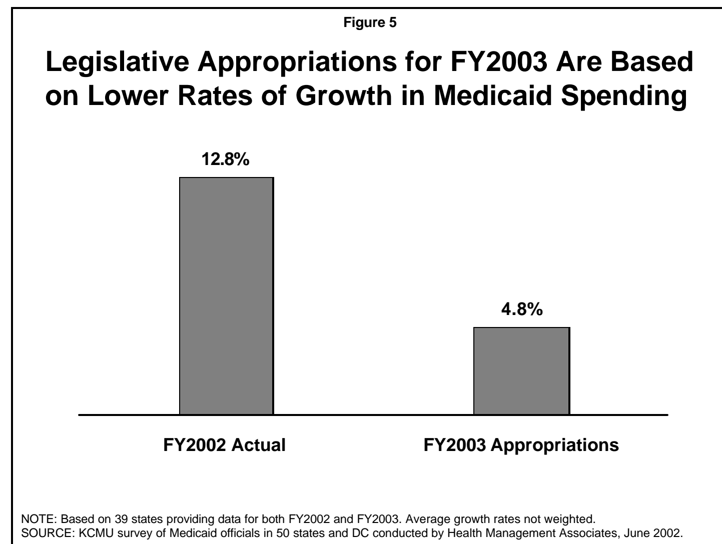
The most common cost containment action that states are undertaking are policies to control the cost and use of prescription drugs, but states are also limiting payments to providers, eliminating some benefits, and restricting eligibility (Figure 4):

- Forty states are planning to implement prescription drug cost controls in FY 2003, an increase over 32 states in FY 2002.
- A majority of states, 29, are either reducing or freezing some of their provider payment rates in FY 2003. Twenty-two states reported provider rate cuts or freezes for FY 2002.
- Fifteen states are reducing Medicaid benefits in FY 2003. Eight of these states reduced dental benefits; states reduced other benefits, such as home health, podiatry, and optical services as well. Nine states reduced benefits in FY 2002.
- Eighteen states are reducing or restricting Medicaid eligibility. Eight states implemented eligibility restrictions in FY 2002. Four states (Missouri, New Jersey, Nebraska, and Massachusetts) eliminated eligibility for thousands of people. States have also restricted eligibility by changing rules related to transitional medical assistance or changing rules related to their medically needy programs that will make fewer people eligible for Medicaid.
- Fifteen states are increasing beneficiary co-payments for services other than prescription drugs. Four states increased co-payments for non-prescription drug services in FY 2002.

In most cases, these cost reduction strategies slowed the rate of growth in Medicaid spending, but not enough to keep spending within the original legislative appropriation for the program. As a result, additional funding was required. Thirty-six states reported that their Medicaid programs received supplemental funding for Medicaid in FY 2002, an increase from the 31 states with supplemental funding in FY 2001. For FY 2003, 41 states reported that it is at least as likely as not that their Medicaid programs will require supplemental funding, with several states reporting that the need for supplemental Medicaid funding was already known to be certain.

Many states also indicated that they are seeking to make some longer-term, structural changes to their Medicaid programs through waivers. Seventeen states reported that they are developing or considering seeking waivers under the Center for Medicare and Medicaid Services' (CMS) Health Insurance Flexibility and Accountability initiative. Eighteen states also reported that they are developing pharmacy waivers, many of which would be submitted under CMS' "Pharmacy Plus" waiver guidelines.

The same pressures that increased Medicaid costs in FY 2002 will persist in FY 2003. State officials indicated that Medicaid enrollment is likely to continue to increase, particularly if the economy does not improve. State Medicaid enrollment forecasts are for increases that average 6.2 percent. Medical costs are expected to continue to increase as well, adding to the cost pressure, with prescription drug costs likely increasing again at double-digit rates. The factors that affect Medicaid are largely the same as those that increase costs for private insurance, where premiums increased by nearly 13 percent in 2002.

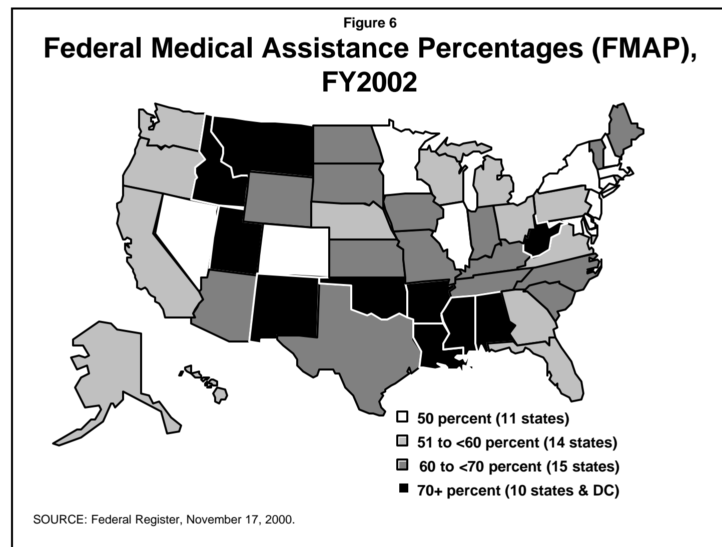


Despite these cost pressures, state legislatures appropriated increased funding for Medicaid for FY 2003 that averaged less than 5 percent (Figure 5). This suggests that in many states the original legislative appropriation will be insufficient to meet actual program expenditures. Medicaid officials indicated that further program cuts will likely be considered and additional funds will likely be needed in FY 2003. However, with state reserve and rainy day funds substantially depleted, it will be more difficult to find the funds needed to finance Medicaid this fiscal year and next.

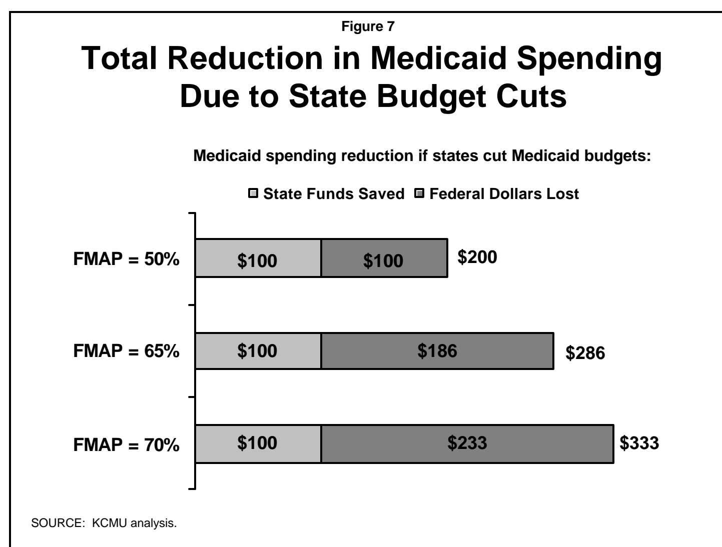
Introduction and Background

Medicaid is a joint federal and state program that is administered by the states within federal guidelines. Each state's Medicaid program is different, reflecting each state's priorities in coverage and benefits within the substantial flexibility states are afforded under federal law.

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 like dental care, hospice care, and prosthetic devices.



The federal government and the states share responsibility for financing Medicaid. 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 and currently ranges from 50 percent to 77 percent and is based on state per capita income (Figure 6). On average, the federal government pays at least 57 percent of states' Medicaid expenditures. 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 one federal dollar for each state dollar it spends. At a 70 percent matching rate, a state draws down $2.33 for every $1 it spends (Figure 7). Medicaid's matching formula provides an important vehicle for states to leverage federal dollars to increase funding for health and long-term care services.



Medicaid finances almost three quarters of all state health spending. Federal Medicaid matching payments are designed to provide a fiscal incentive to states to extend health care coverage, because the federal government will pay at least half the cost of services that are allowable under Medicaid. Most states have used these open-ended matching payments to maximize the amount of federal Medicaid funds they obtain. States use Medicaid to fund many state public health services, mental health care, home health care, or school-based services, since many of the beneficiaries of these services are eligible for Medicaid. A few states also fund state health insurance programs or public health and hospital services through Medicaid, which can take significant fiscal pressure off of the state.[1] States have also employed a number of creative financing strategies to claim federal Medicaid matching funds up to upper payment limits, to the extent they are allowed under regulation. Using these strategies, sometimes in conjunction with intergovernmental transfers of funds, taxes on medical providers, or payments to disproportionate share hospitals, states can increase federal Medicaid payments with minimal or no increase in state funds. As a result of these state Medicaid maximization strategies, state spending on Medicaid frequently includes significant funding for a range of activities that go beyond a narrow definition of vendor payments for specific Medicaid services.

From a state fiscal perspective, Medicaid is a large program relative to the overall state budget. It is the second-largest item in most states' budgets, after elementary and secondary education. On average, states spend about 15 percent of their own funds on Medicaid, although that percentage varies from state to state based on the size of states' budgets and the decisions each state makes about how to carry out its program. Medicaid is the primary source of federal grant support to states, representing almost 43 percent of all federal grants to states.

Because of Medicaid's size, Medicaid expenditure growth can have an important impact on the overall fiscal condition of a State. As shown in Table 1, the share of state budgets allocated to Medicaid increased during the early 1990s, remained fairly stable in the late 1990s, and has recently started to increase somewhat.

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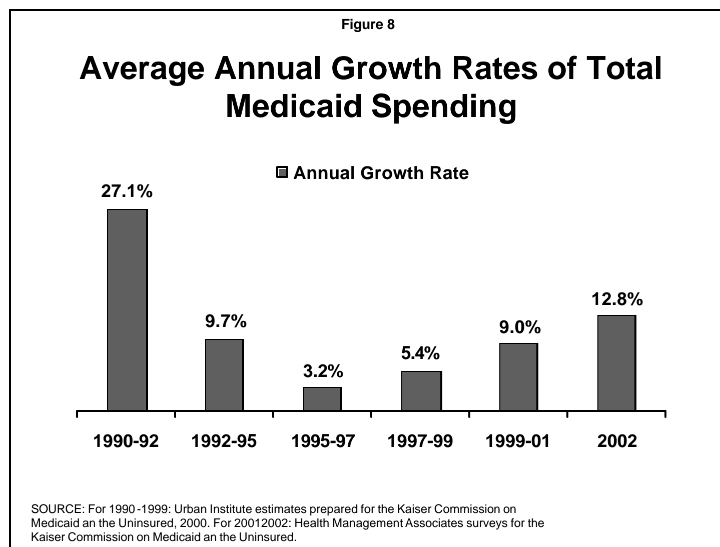
[1] Teresa Coughlin and Stephen Zuckerman, "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues," The Urban Institute, June 2002.

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

State Fiscal Year	Medicaid General Fund Spending as % of State General Fund Expenditures	Medicaid Total Spending as % of Total State Expenditures, all Fund Sources
1987	8.1%	10.2%
1989	9.0%	11.3%
1991	10.5%	14.2%
1993	13.3%	18.8%
1995	14.4%	19.8%
1997	14.6%	20.0%
1999	14.4%	19.5%
2000	15%	19.1%
2001	15.1%	19.6%
2002	16%	20.5%

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

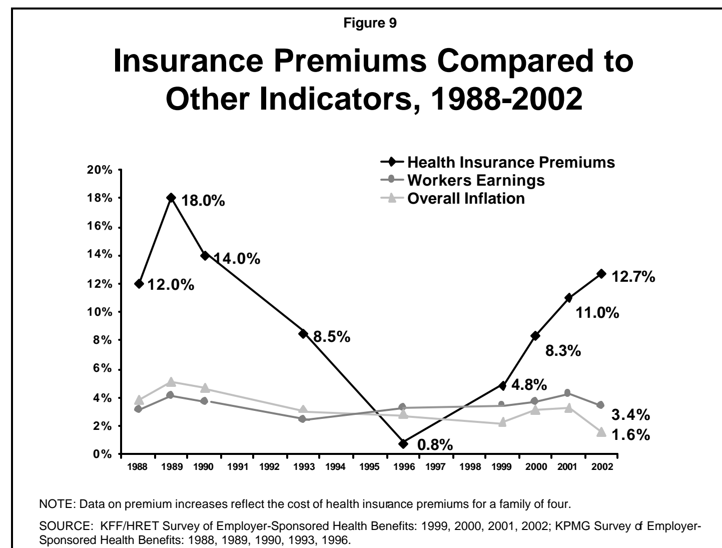
Recent Medicaid Spending Trends



The recent rise in Medicaid expenditures follows a period of unprecedented low growth (Figure 8). Between 1995 and 1997, the average annual growth rate in Medicaid expenditures averaged 3.2 percent, the lowest rates in the history of the program. [2] This period was characterized by a robust economy, rapidly dropping welfare rolls and a decline in the number of people enrolled in Medicaid. In addition, low health care inflation, restrictions on disproportionate share hospital payments, state limits on provider payments, and increased use of managed care contributed to the slow growth in spending.[3]

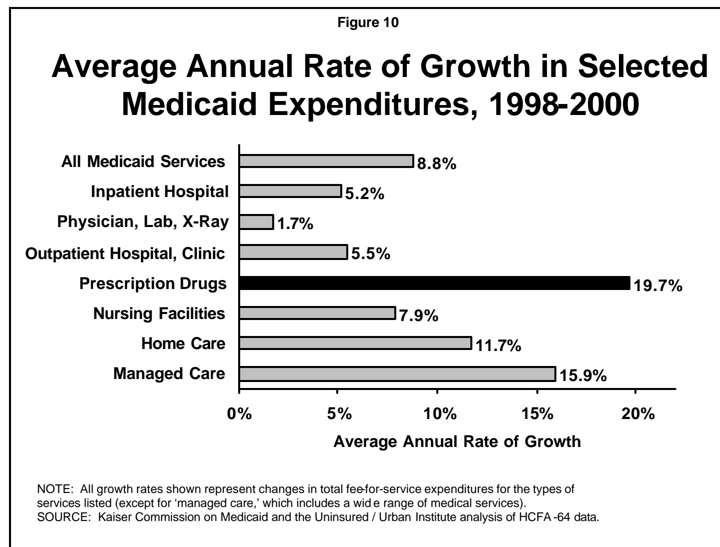
[2] See also Brian Bruen and John Holahan, "Acceleration of Medicaid Spending Reflects Mounting Pressures," Kaiser Commission on Medicaid and the Uninsured, May 2002.
[3] Bruen and Holahan, 2001. Also see: U.S. General Accounting Office, "Medicaid: Sustainability of Low Spending Growth is Uncertain," GAO Report No. HEHS-97-128 (Washington, DC: GAO, June 27, 1997).

After this period of relatively slow spending growth, the rate of increase in spending on Medicaid has recently accelerated. Between 1998 and 2000, Medicaid spending increased at an average annual rate of 7.9 percent. In August 2002, the Congressional Budget Office estimated that federal Medicaid costs would grow 14 percent in fiscal year 2002 and an average of nine percent a year between 2001 and 2012. This rate of spending growth is comparable to the growth that is occurring in the market for private health insurance, where health insurance premiums rose 12.7 percent in 2002[4], and recent forecasts are for growth rates of 14 to 16 percent for 2003 (Figure 9).[5]



The primary sources of Medicaid's spending growth are largely the same factors that are causing private health insurance premiums to grow more quickly. These can broadly be defined as increases in the costs of health care services and prescription drugs. In a recent Kaiser Family Foundation/Health Research and Educational Trust survey, 64 percent of employers surveyed reported that higher spending on prescription drugs, whose spending for several years has been growing at double-digit rates, contributed "a lot" to increased health care premiums. [6] Employers also reported that spending increases for hospitals and doctors were increasing health care premiums. These factors are also increasing costs in the Medicaid program (Figure 10).

[4] "Employer Health Benefits 2002 Annual Survey," Kaiser Family Foundation and Health Research and Educational Trust, September 2002.
[5] "The 2003 Segal Health Plan Cost Trend Survey," The Segal Company, August 2002.
[6] "Employer Health Benefits 2001 Annual Survey," Kaiser Family Foundation and Health Research and Educational Trusts, 2001.



At the same time, some of the factors that are contributing to the increase in Medicaid spending are unique. One of the most crucial factors behind Medicaid cost growth is enrollment. Medicaid enrollment has begun to increase, reversing a three-year downward trend, as states have implemented methods to expand eligibility and simplify enrollment in Medicaid. Welfare reform "de-linked" Medicaid eligibility from eligibility for welfare, and after 1996 enrollment declined as states tried to adapt their systems and processes to Medicaid's new eligibility rules. Some estimates indicated that during this time period, the proportion of children who were eligible for Medicaid who were enrolled in the program fell by almost five percent.[7]

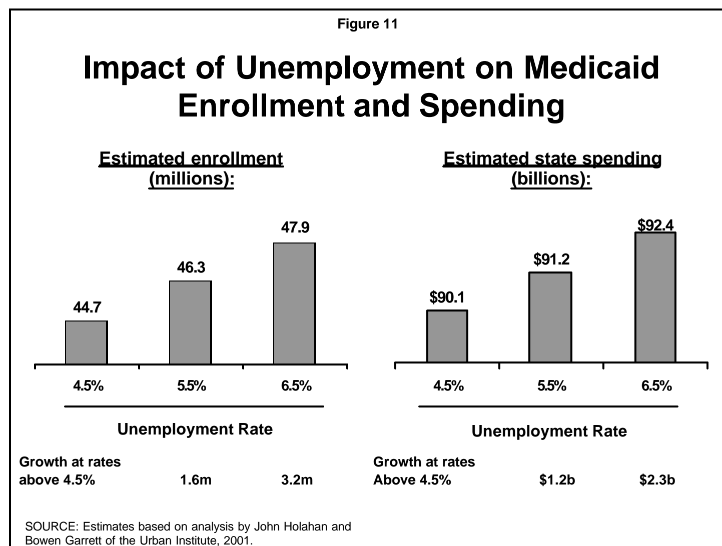
Welfare reform implementation, together with the 1997 enactment of the State Children's Health Insurance Program (SCHIP), focused state and national attention for the first time on streamlining Medicaid eligibility and enrollment, especially for children. Many states focused on the significant numbers of children who were eligible for Medicaid but had not enrolled.[8] States began simplifying the Medicaid application process, streamlining renewal procedures, and increasing outreach to eligible individuals. A number of states also expanded eligibility for children. Largely as a result of these efforts, Medicaid enrollment began to increase in 1999.

The other major factor contributing to increasing Medicaid enrollment is the economy. The Urban Institute estimates that, starting from a base unemployment rate of 4.5 percent, every 1 percentage increase in the unemployment rate adds about 1.6 million people to Medicaid enrollment (Figure 11). The unemployment rate as of August 2002 was 5.7 percent. Medicaid enrollment increased 3.5 percent in 1999 and increased 4.9 percent in 2000. Based on monthly enrollment data gathered through September 2001 from the states, the Kaiser Commission and

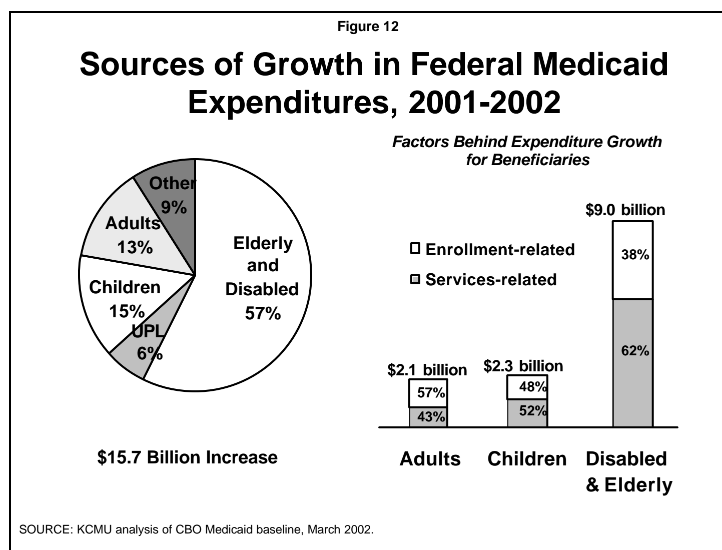
[7] Jocelyn Guyer, Matthew Broaddus, and Michelle Cochran, "Missed Opportunities: Declining Medicaid Enrollment Undermines the Nation's Progress in Insuring Low-Income Children." Center on Budget and Policy Priorities, October 20, 1999.

[8] In 1998, according to estimates from the Urban Institute, there were 8.9 million uninsured children in the United States; 4 million of these were eligible for Medicaid but not enrolled, and an additional 1.8 million were eligible for SCHIP but not enrolled.

HMA have estimated that in 2001 Medicaid enrollment increased 8.7 percent in 2001. In September 2001, total U.S. Medicaid enrollment reached 35.5 million.[9]



The Medicaid population, in large part because it includes the elderly and the disabled, also uses health care services more intensively than the population as a whole. The elderly and the disabled, who tend to use more expensive services, account for 67 percent of all Medicaid spending, despite representing only one-quarter of Medicaid enrollees. The impact of increases in the cost of hospital, nursing home, and other services, as well as prescription drugs, is therefore magnified in state Medicaid budgets, where elderly and the disabled individuals use so many of these services. Using CBO estimates of Medicaid spending, KCMU has estimated that the majority (57 percent) of the $16 billion in federal Medicaid growth between 2001 and 2002 was due to spending on the elderly and disabled (Figure 12). Another 28 percent of the spending growth was attributable to spending on children and families, and 15 percent was related to other factors, including states' use of upper payment limit arrangements.



[9] E. Ellis, V. Smith, D. Rousseau, "Medicaid Program Enrollment Data Update: September 2001," Kaiser Commission on Medicaid and the Uninsured, June 2002."

By the program's design, Medicaid costs can be expected to increase when the economy weakens and causes more people to enroll in the program. Because Medicaid is means-tested, more people qualify for Medicaid when incomes fall. Times of falling incomes also often coincide with falling state tax revenues. The federal Medicaid matching rate, or FMAP, is designed to change in response to changes in a state's per capita income, but because of data lags of up to three years, it does not keep pace with states' changing economic conditions. These factors create an inevitable tension for the state legislators, governors, and program administrators who oversee Medicaid: the resources needed for the program increase at the same time that many states have the most difficulty financing their share of the program.

The 2002 Survey of Medicaid Officials in 50 States and the District of Columbia

To identify state Medicaid spending trends and how states are responding to these trends and their overall fiscal conditions, the Kaiser Commission on Medicaid and the Uninsured asked Health Management Associates (HMA) to conduct a survey of Medicaid officials in all 50 states and the District of Columbia. The survey was conducted in May and June 2002, so states could describe specific actions taken in FY 2002 and their plans for FY 2003.[10]

Survey Methodology

This study was based on a survey of Medicaid officials in all 50 states and the District of Columbia. The survey was created to gather information for state fiscal years 2002 and 2003 about:

- Rates of growth in Medicaid spending,
- Factors driving expenditures, and
- Measures that states are using or planning to use to control rising Medicaid expenditures.

The survey also examined levels of state Medicaid funding. The 2002 survey instrument was adapted from the one used for a similar survey conducted in 2001.[11] To the extent possible, survey questions were structured so the data would be consistent across years and across states. The survey instrument is attached in Appendix A.

We sent the survey to all Medicaid directors in May 2002. The cover letter to the survey indicated that we were asking two things. First, we asked that the seven-page survey be completed and returned to us. Second, we asked to schedule an interview to go over their survey responses, using the completed survey as a guide, and to discuss further their budget situation and how they were responding. The personal interview with the Medicaid director or other Medicaid and budget officials was completed in all but three states. In those three instances the state officials believed their written survey responses were sufficient to describe their situation and preferred not to schedule a separate telephone interview. Telephone interviews with Medicaid and budget officials were conducted in May and June, beginning with states where the legislature had completed its session and the budget for FY 2003 (Appendix B contains a schedule of state legislative sessions). To ensure accuracy, the phone interviews included two or more members of the HMA research team. On the state side, the interview discussions usually included the Medicaid director and persons responsible for the Medicaid budget or Medicaid policy. Survey responses were received from all 50 states and the District of Columbia. The data were compiled and analysis completed in July and August of 2002.

As was the case for the 2001 survey, we relied on each state's definition of what was included in its Medicaid expenditures. For state budgeting and program purposes, a common definition of Medicaid expenditures does not exist across states. To facilitate responses to this survey, we asked states to provide us with the data on Medicaid spending that corresponded with the

[10] States fiscal years run from July 1-June 30 in 46 states. The state fiscal year begins on April 1 in New York, on September 1 in Texas, and on October 1 in Alabama and Michigan.
[11] 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.

definition they use for their budgeting purposes or for legislative appropriation purposes. To do otherwise would have made responding to our request extremely difficult and burdensome for state officials. With this convention, every state responded to the survey questions about Medicaid spending and rates of growth in Medicaid spending. Almost every state responded to questions related to enrollment growth in both FY 2002 and FY 2003, and the likelihood of a shortfall in FY 2003. In providing information about growth in Medicaid spending, some states included and others excluded Medicaid-financed services provided through other agencies such as public health, mental health, education or long-term care. However, we emphasize that the definition of Medicaid expenditures was not consistent across states, and for this reason we did not attempt to add across states the dollar values for Medicaid expenditures. We do report annual percentage changes in Medicaid expenditures, based on expenditures as they were reported by each state.

It is also important to note that survey results reflect the responses that were accurate at the time of the survey. This is particularly relevant for cost containment initiatives, for which information was compiled on a state-by-state basis for both FY 2002 and FY 2003. The results for FY 2002 reflect actions that were implemented during FY 2002, since the survey was administered at the end of FY 2002. The actions for FY 2003 represent legislative decisions to implement or proposals awaiting final legislative approval. The serious budget situations that most states faced made it difficult for some state legislatures to complete their work on state budgets for FY 2003. When legislative approval of the Medicaid budget had not yet been finalized, Medicaid officials described the policy proposals they believed would be adopted, but they could not respond with complete certainty. This report may therefore not reflect state budget actions or policy changes approved by states after the survey date for FY 2003.

In addition to presenting aggregate national trends, this report contains profiles of four states (Iowa, Oklahoma, Missouri and Mississippi), the situations they faced with their Medicaid budgets, and how they resolved them. These profiles appear at the end of the report.

State Medicaid Appropriations and Budgeting Procedures: What is a Medicaid Budget Shortfall?

In an increasing number of states in recent years, legislatures have provided supplemental funding for Medicaid when actual spending exceeded the originally authorized amounts. A "Medicaid budget shortfall" is said to occur when actual Medicaid expenditures exceed the original funding level authorized by the legislature. The routine nature of authorizing additional funding for Medicaid midyear in some states raises the issue of how to interpret a Medicaid shortfall and the increasing numbers of states with a shortfall.

The entitlement nature of the Medicaid program means that a state is obligated to pay for services the state has defined as covered for persons who meet state-defined eligibility criteria. As an entitlement program, it is difficult to control Medicaid spending with the precision that other state programs can be managed. At the same time, because the program is an entitlement, the federal government matches at least half of a state's costs with open-ended federal financing. To a certain extent, Medicaid expenditures are defined by economic conditions and other factors beyond the control of the state legislature or program administrators. This makes budgeting for Medicaid a difficult exercise in forecasting, and controlling Medicaid spending a challenge. In many states, an accepted pattern has emerged, in which the state budget office and the legislature

projects the Medicaid financial obligation as best it can, with a plan to monitor spending trends through the year. The legislature then returns to authorize funding of the full-year obligations near the end of the year, when the actual need is more certain. Medicaid is such a large item in the budget that budgeting additional funds beyond the exact amount that is needed for Medicaid would tie up a significant amount of funds, potentially denying funding for other programs. As a result, supplemental funding for Medicaid has become commonplace. In many states, general revenue funds, rainy day funds, tobacco settlement funds, Medicaid trust funds or transfers from other programs have routinely been used to cover shortfalls.

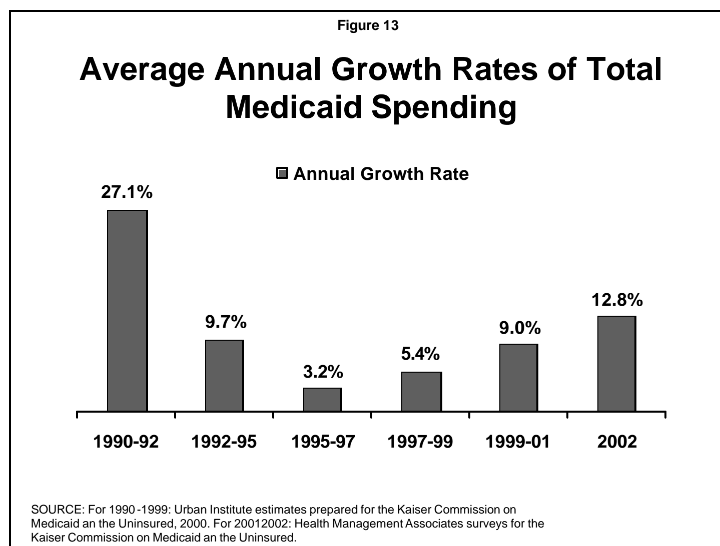
What distinguishes FY 2002 from other years is the increasing number of states where the need for supplemental funding was unexpected, and where the amount needed was much larger than expected. The outlook for FY 2003 suggests that while the need for supplemental funding has already been anticipated, far more states expect to need additional funding than in previous years.

Survey Results

Fiscal Year 2002

Expenditure Growth

In FY 2002, state officials indicated that total Medicaid spending (state, local and federal funds) increased by almost 13 percent, and state (i.e., non-federal) spending on Medicaid increased by almost 11 percent. Medicaid spending has grown at increasingly higher rates each year since 1996, following a period of declining rates of growth in the first half of the decade of the 1990s (Figure 13). Medicaid spending growth in FY 2002 was the highest it has been since 1992.

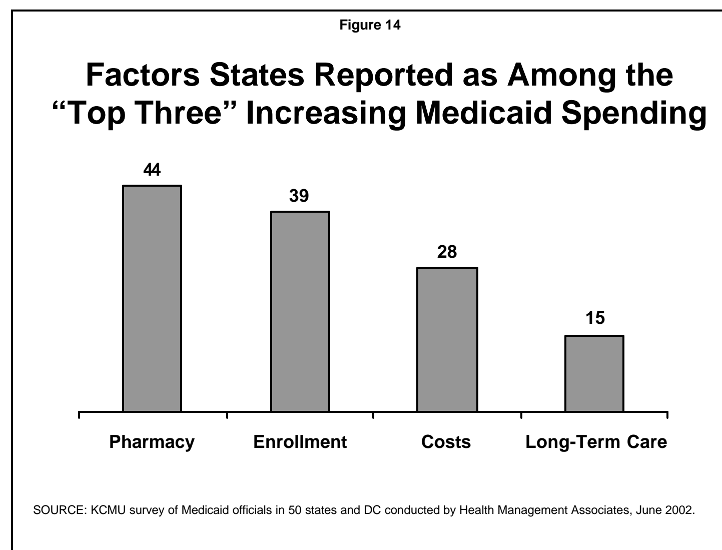


Factors Increasing Medicaid Expenditures

States reported that the most significant factor contributing to higher Medicaid spending in FY 2002 was the increasing costs of prescription drugs. The second most significant factor states cited was increasing enrollment in the program (see Appendix C for individual state responses).

State Medicaid officials were asked to describe, in their own words, what they considered to be the *most significant factor*, the *second most significant factor*, and *other factors* that contributed to the increase in Medicaid expenditures for FY 2002. The factors driving Medicaid cost growth were not selected from a list; this was an open-ended question and respondents were free to list any factors[12].

In 44 states, Medicaid officials listed prescription drugs among the three most significant factors driving expenditure growth in their state (Figure 14). Medicaid officials in 39 states mentioned enrollment increases among the top three driving factors of spending growth. Twenty-eight states reported that the increase in the cost of health care services was among the top three factors contributing to increased Medicaid costs, and fifteen states reported that spending on long-term care was among their top three most significant cost factors.



Pharmacy costs were also the factor most frequently listed as the number one driver of Medicaid costs in FY 2002: 25 states indicated that the cost of prescription drugs was the most significant factor in Medicaid cost growth in their state (Table 2). On average, about 10 percent of states' total Medicaid spending is on prescription drugs. After prescription drugs, the increase in Medicaid enrollment was listed as the most important factor in 18 states.

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[12] The responses were analyzed and grouped into categories. The categories were enrollment, pharmacy, costs, long-term care, hospital, and other. In most situations, the factors as state officials listed them were easy and logical to categorize. (e.g., pharmacy includes increases in total prescription drug costs, increases in drug utilization, drug inflation or price growth). The enrollment category includes terms mentioned as enrollment growth and expansion of eligibility. Some factors were not so easily categorized, such as FMAP changes, UPL for hospital inpatient services or managed care. Some factors fell into one or more groups (e.g., pharmacy provider rates). Those factors were categorized based on the larger context in which they appropriately fit (in this case, into pharmacy).

Table 2

Primary Driver of Medicaid Expenditure Growth	Number of States Reporting
Pharmacy	25
Enrollment Growth	18
Growth in Costs of Medical Care	3
Long Term Care related factors	3
Other	2

Increasing costs of medical care, including provider rate increases, was the most significant factor listed in three states, and three states listed long term care as the most significant factor. Finally, one state described increasing costs of behavioral health care and another described the impact of an intergovernmental transfer with nursing homes as increasing costs.

***Prescription Drugs**:* As in 2001, prescription drugs were reported as the main driver of Medicaid expenditures. Half the states listed it as the primary factor and 13 states as the secondary factor. Almost all states (44) listed pharmacy as any one of the top three factors contributing to Medicaid spending growth. More specifically, states mentioned that pharmacy costs were increasing due to:

- Increased utilization—i.e., more prescriptions per beneficiary. State officials mentioned that increasing utilization was related to increased advertising, increased consumer awareness, and increased usage in outpatient facilities in place of inpatient settings;
- New more expensive medicines;
- Price inflation for existing products; and
- Pharmacy driven capitation rate increases for managed care organizations (MCOs).

Enrollment Growth: Enrollment growth averaged 8.6 percent in FY 2002, and was listed second to prescription drugs as the primary driver of Medicaid expenditure growth. Eighteen states reported enrollment growth as the number one reason for the growth in Medicaid expenditures in their state. Officials identified the causes of enrollment growth as including the downturn in the economy, eligibility expansions, administrative simplifications aimed at increasing enrollment in previous years, and successful outreach as part of state SCHIP programs. The survey did not ask about eligibility expansions in 2002, but increases in Medicaid enrollment in 2002 were generally attributed to eligibility expansions undertaken in previous years. On average, states indicated that their Medicaid enrollment increased 8.6 percent from FY 2001 to 2002[13].

[13] State officials reported Medicaid annual enrollment increases averaging 8.6% for FY2002, compared to FY2001. Nationally, Medicaid enrollment declined in 1996, 1997 and 1998, a decline generally attributed to the effects of welfare reform and the delinking of cash assistance and Medicaid in 1996. Medicaid enrollment increased at successively higher rates in 1999, 2000 and 2001.

For FY 2003, Medicaid enrollment is expected to increase significantly again, although at a somewhat slower pace. State forecasts for FY 2003 on average are for Medicaid enrollment increases of 6.2 percent (Figure 15).

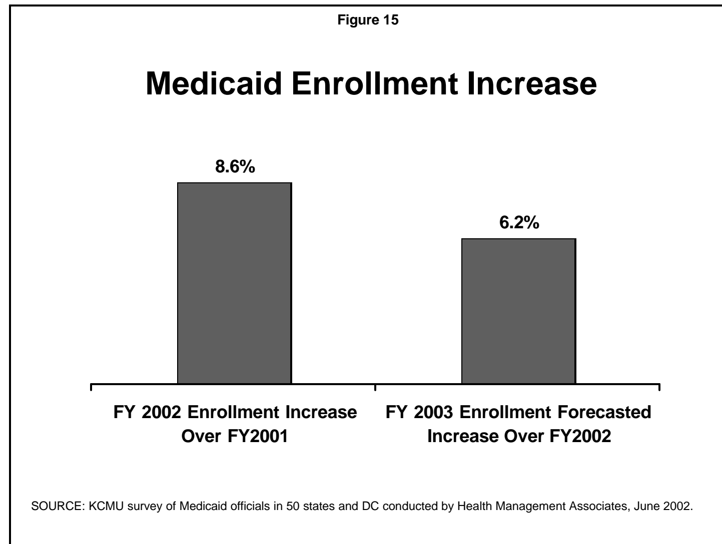


Table 3: Medicaid Enrollment Growth Rates 1997 to 2001

Calendar Year	Annual Percentage Change in Total Medicaid Monthly Enrollment*
1997	-2.8%
1998	0.0%
1999	3.5%
2000	4.9%
2001	9.7%

*Percentages reflect changes in monthly enrollment from December to December of the indicated year for 1998, 1999, and 2000. 1997 is an annualized value based on the period from June to December 1997, and 2001 is an annualized value based in December 2000 to September 2001.

Source: State Medicaid enrollment reports provided to Health Management Associates for Kaiser Commission on Medicaid and the Uninsured, 2002. See: Eileen Ellis, Vernon Smith and David Rousseau, Medicaid Program Enrollment Data Update: September 2001, Kaiser Commission on Medicaid and the Uninsured, June 2002.

State officials in 36 states attributed the majority of the FY 2002 growth in caseload to increased enrollment of children and adults. Enrollment growth was slower for the elderly and disabled, but a number of states listed growth in these categories as a factor in overall enrollment growth, and since these individuals are generally more expensive to treat, even modest enrollment growth in thes groups can translate into significant Medicaid costs. State officials attributed enrollment growth to the downturn in the economy and to the Medicaid case-finding effect of SCHIP outreach.

Medical Inflation and Utilization: Increased medical costs and/or increased utilization were cited as among the top three reasons for the increase in Medicaid spending in 28 states, and described as the main reason for the increase in Medicaid expenditures in three states. Some of the reasons reported in this category include increased utilization, managed care, technology, provider inflation, rate increases, and increased medical costs.

Long Term Care: Long-term care was cited as among the top three causes of expenditure growth in fifteen states and was described as the primary cause of expenditure growth in three states. Long-term care includes nursing home costs, home health, and home and community based services (HCBS) waivers[14]. One state reported that nursing home expenditures increased due to a special payment to a governmentally owned nursing facility as part of an intergovernmental transfer arrangement.[15] The transfer of funds from a governmental provider to the state is commonly used to claim federal funds that support provider rate increases or other Medicaid services.

Exhibit 1

Increases in Pharmacy Costs and Enrollment: Comments of State Medicaid Officials

"Almost the entire growth in our managed care rates is due to pharmacy."

"We expected enrollment growth, but nothing like what occurred."

"We are seeing lots of increases in welfare rolls and more kids going to Medicaid instead of SCHIP. It confirms our belief that it is the economy that is driving the caseload."

"We're bringing in more people and keeping them longer."

Cost Containment Measures

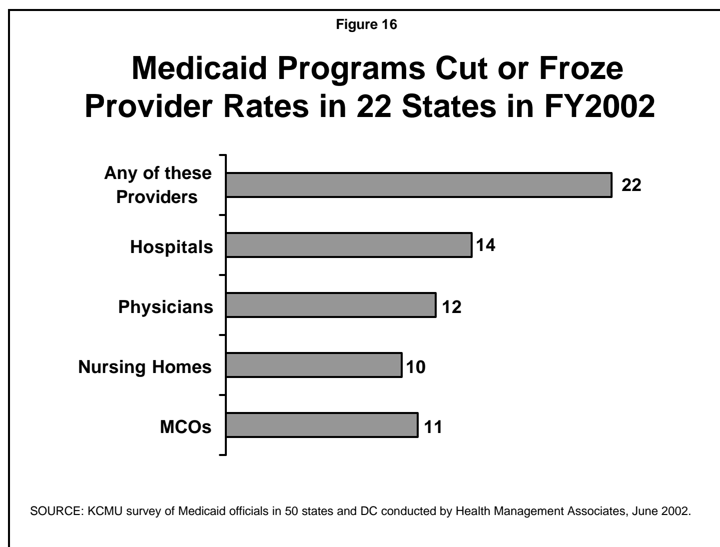
Due to unexpectedly high rates of growth in Medicaid spending in FY 2002, a total of 45 states implemented cost containment measures aimed at controlling spending growth in FY 2002. Cost containment measures were defined to include any provider rate reductions and freezes, cuts in eligibility and benefits, pharmacy cost containment actions, and any other restrictions and cuts made to Medicaid service or administrative budgets.

Specific cost-containment measures that states undertook in FY 2002 are detailed in Appendix D. The cost-containment strategies included those listed below:

[14] HCBS waivers afford states the flexibility to implement Medicaid-financed programs to provide services in the home or in other community settings as an alternative to placing Medicaid-eligible individuals in hospitals, nursing facilities or intermediate care facilities for persons with mental retardation (ICF/MRs). States may request waivers of certain federal requirements relating to statewideness, comparability of services and community income and resource rules for the medically needy. HCBS waiver services may include case management, homemaker/home health aide services, personal care services, adult day health, habilitation, respite care and other services needed by waiver participants to avoid being placed in a medical facility.

[15] An intergovernmental transfer (IGT) refers to a transfer of funds made from one governmental entity to another. In the case of Medicaid, governmental entities like public hospitals or nursing homes make transfers to the state Medicaid agency. The state then uses that money as part of the total state general fund for Medicaid expenditures.

- **Provider Rate Cuts or Freezes:** Twenty-two states implemented provider rate cuts or freezes. Provider rate cuts or freezes are defined as any policy related changes (distinct from inflationary adjustments), reductions in crossover payments[16], or other provider payments reductions related to hospitals, physicians, managed care organizations and nursing homes (Figure 16).



Rate Increases: The emphasis in FY 2002 was clearly on cost containment. Nevertheless, in FY 2002 a total of 45 states (of 49 responding) indicated that they increased payment rates for some providers. The rate increases were sometimes less than originally expected or planned. Most frequently, rates were increased in FY 2002 for nursing homes (41 states), inpatient hospitals (30) and managed care organizations (27).

- **Pharmacy**: A wide range of pharmacy related cost-containment actions were implemented by 32 states during FY 2002. The most common were prior authorization of selected brand name products and reductions in payments for drug products through application of greater discounts or a Maximum Allowable Cost (MAC) list for generics. The number of states implementing specific

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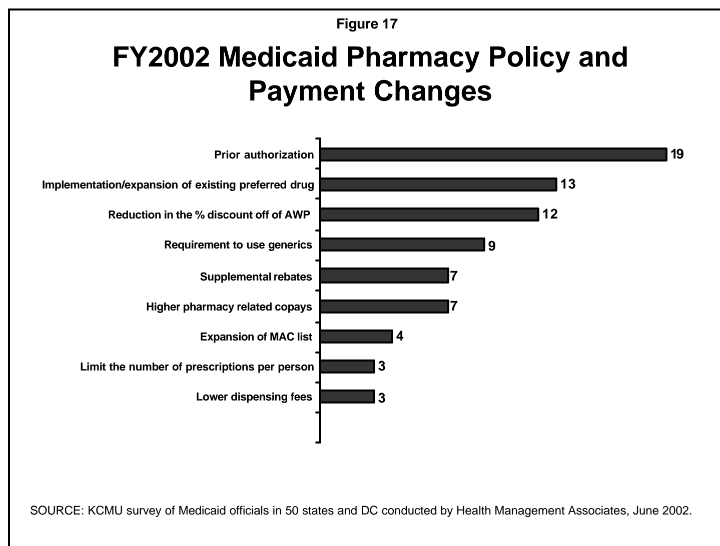
[16] "Cross-over payments" or "Medicare cross-over claims" refer to payments by Medicaid for services that are covered by both Medicaid and Medicare for a client who is enrolled in both programs. For dual Medicare-Medicaid clients, the Medicaid program pays amounts that are not covered by Medicare, including deductible amounts for inpatient services and coinsurance for ambulatory services. Many states pay the provider directly for the amount of the Medicare deductible or coinsurance. However, Medicaid programs may limit their payment to the difference between the Medicare payment and 100% of that state's Medicaid rate for the service. As an example, Medicare pays a provider $80 which is 80% of the Medicare recognized fee of $100 for a particular procedure. If the Medicaid fee for the same service is $90, the state only needs to pay the provider $10, the difference between the Medicaid rate and the amount paid by Medicare, rather than the full $20 coinsurance amount. The provider must accept this amount as payment in full and cannot bill the enrollee if he/she participates in the Medicaid program. Several states are modifying the way they make cross-over payments as part of their cost containment strategies.

policies is shown in Figure 17.[17] As one state official mentioned, "No matter how much we budget, pharmacy costs seem to always exceed expenses."



- **Benefit reductions**: Nine states implemented benefit reductions in FY 2002. Five of the nine states cut or reduced dental benefits for adults. Other reductions included limiting benefits for vision and psychiatric counseling.

- **Eligibility cuts:** Eight states implemented eligibility restrictions or cuts in FY 2002. Cuts included limits on the number of individuals that could be enrolled in Home and Community Based Services (HCBS) waiver programs, delays in program expansions, and as of June 15, 2002, New Jersey stopped accepting applications from parents for Family Care and changed how it treats income under Section 1931 for parents applying for Medicaid[18].

Exhibit 2

Cost Containment: Comments of State Medicaid Officials

"We're going after pharmacy with a vengeance."

"Everything is back on the table [in FY 2003]."

"There will be changes in benefits, increases in cost sharing and benefits limitations in some manner."

"One of our goals right now is to save managed care. Otherwise we'll have another hit on our costs."

"We may have cut back more than we should have [in FY 2002]. I don't know where to go from here."

[17] AWP refers to Average Wholesale Price. MAC refers to Maximum Allowable Cost, and is, on average, 60% less than the Average Wholesale Price.
[18] New Jersey's Family Care program provides Medicaid coverage for parents with incomes up to 200% of poverty under a federal Medicaid 1115 waiver. Section 1931 of the Social Security Act allows states to "disregard" part of the earned income of families in determining eligibility for Medicaid.

Fiscal Year 2003

Factors Increasing Medicaid Expenditures

In general, Medicaid officials expect Medicaid cost growth in FY 2003 to be driven primarily by prescription drug costs and by Medicaid enrollment increases, followed by medical inflation and long term care costs. These are the same factors identified as driving costs in FY 2002. Specifically, state officials in 48 states indicated that they expect Medicaid cost growth to be driven by exactly the same factors in FY 2003 as in FY 2002.

Officials indicated that these factors might impact the program in a slightly different way in FY 2003,and there was some concern that these factors might contribute to more serious budgetary pressures. For example, officials expressed concern that the economic slowdown might translate into further increases in enrollment and utilization. There was concern also that pressure might increase for provider rate increases, or for increasing the number of slots under a waiver program, thereby increasing the number of persons enrolled in the Medicaid program.

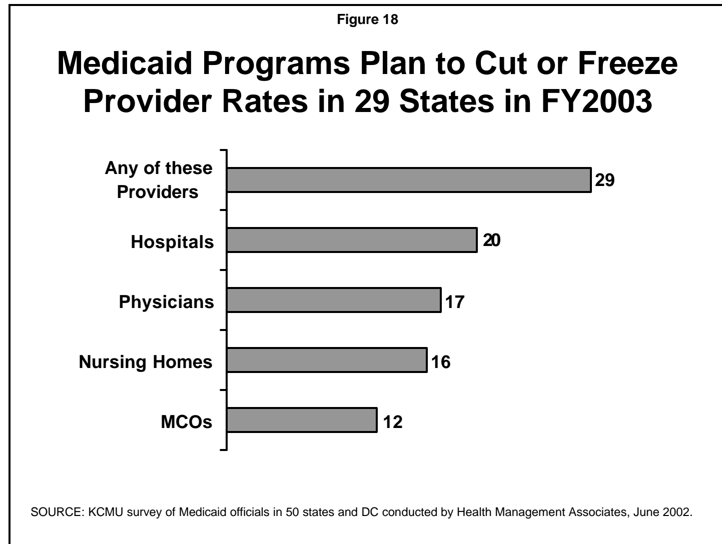
A few state officials indicated that they expect these factors to have a diminishing impact in FY 2003 because they are expecting a turnaround in the economy and slower enrollment growth for Medicaid and for SCHIP. They also thought that their cost containment actions would have time to be implemented and to begin realizing savings in FY 2003.

In three situations, officials believed that the factors driving Medicaid cost growth would change in FY 2003. In Michigan, for example, the primary driver in FY 2003 is expected to be pharmacy, and the second factor would be enrollment; in FY 2002, these two factors were listed in reverse order. Officials in the District of Columbia indicated that enrollment instead of rate increases would likely be most significant in FY 2003. Oklahoma officials indicated that rate increases were the key factor in FY 2002, but there would be no rate increases in FY 2003. Instead, enrollment increases, utilization increases and pharmacy are expected to drive Medicaid expenditures in FY 2003.

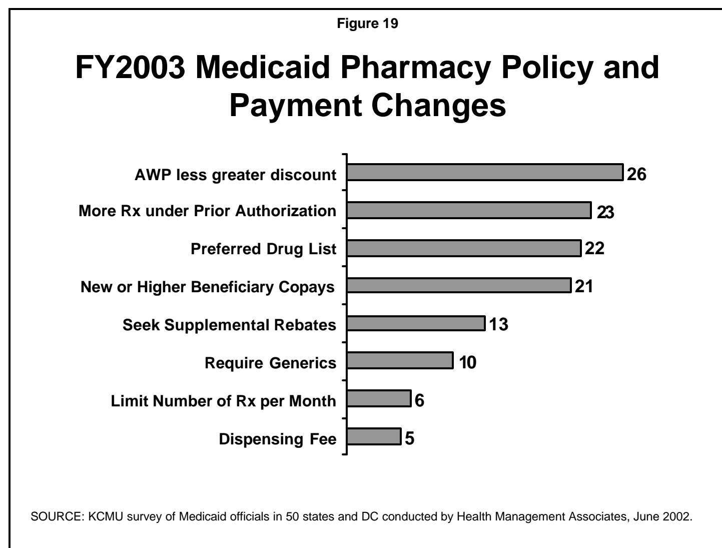
Cost Containment Measures

Medicaid officials said they expect FY 2003 to be a tougher budget year than FY 2002. At the time of the survey, further cost-containing actions were planned in at least 41 states for FY 2003 (Appendix E lists individual state responses). The actual number will be greater, quite possibly exceeding the 45 states that took cost containing actions in FY 2002, when mid-year actions are undertaken in FY 2003. The current count also does not fully consider all actions in states where the legislature had not completed the Medicaid budget for FY 2003 at the time of the survey. Nevertheless, it is clear that Medicaid cost containment is a major focus in almost every state in FY 2003, as indicated in the following actions:

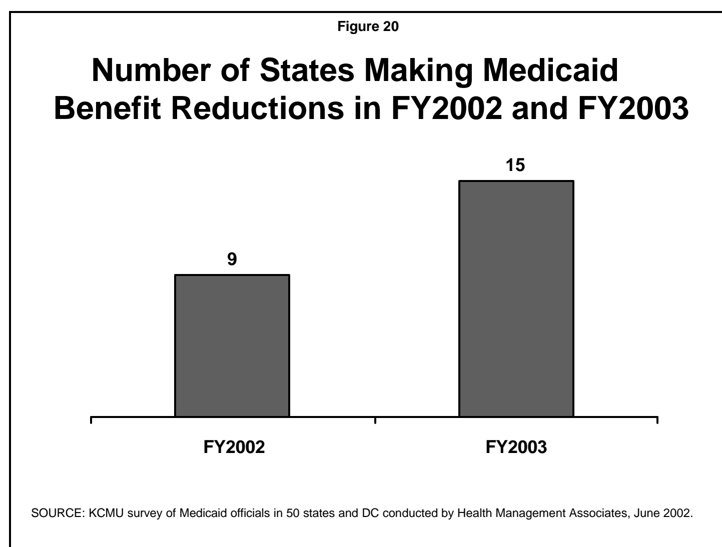
- **Provider Payments**: A larger number of states (29) plan to cut or freeze provider payments in FY 2003 as compared to 22 in the previous fiscal year (Figure 18). Compared to 45 states in FY 2002, only 34 states indicated there would be increases in any provider rates. Most frequently, these were automatic cost increases tied to an economic price index for hospitals or nursing homes.



- **Pharmacy**: A total of 40 states planned some type of pharmacy control in FY 2003 (Figure 19). While the types of controls planned have not changed much from the previous year, the frequency in which states have planned to undertake these control mechanisms have increased significantly from the previous year.



- **Benefit reductions**: Fifteen states passed benefit reductions, eight of which cut or reduced dental benefits for adults (Figure 20). Other benefit reductions include restrictions on home health, podiatry, chiropractic services, eyeglasses, psychological counseling and translator services. Nine states reduced benefits in FY 2002.

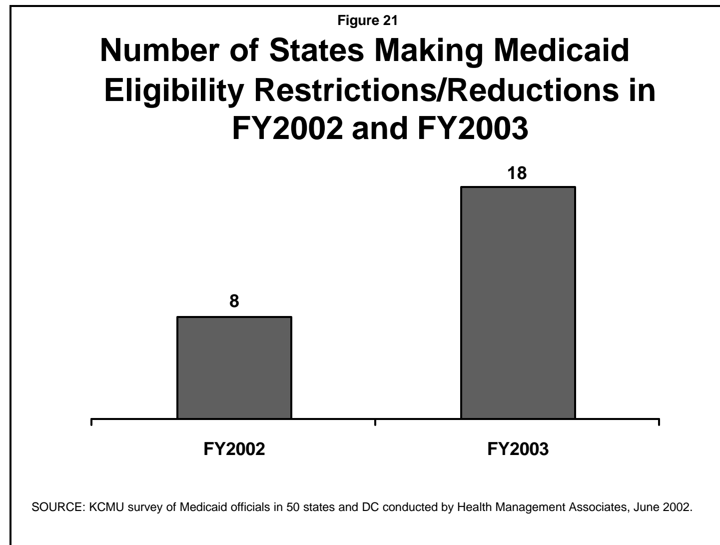


- **Long Term Care**: Thirteen states proposed long term care cuts. Examples of cuts include changing the facility bed hold policy[19] instituting new reimbursement methodologies, shutting down nursing homes and requiring that long term care facilities have dual Medicare and Medicaid certification.
- **Copayments for non-pharmacy services**: Fifteen states proposed copays or increased cost sharing for Medicaid enrollees[20]. Copays were imposed for transportation services, doctor visits, non-emergency emergency room (ER) visits, waiver populations, and for certain fee-for-service (FFS) ambulatory services. Rhode Island began charging a 5% copremium for households above 150% of the federal poverty level (FPL).
- **Managed care expansions**: Twelve states proposed managed care expansions. Examples include introducing populations that were previously enrolled in FFS into managed care (e.g., enrolling people in higher levels of poverty, enrolling the SSI population, SSI children and other children with special health care needs), expansion of primary care case management (PCCM) statewide, mandatory enrollment into PCCM, and expansion of risk based managed care throughout the state.
- **Disease and Case Management Programs**: An increasing number of states appear to be turning to disease management and case management programs hoping that providing more appropriate and timely care will result in higher quality care and lower costs. Eleven states reported that they had implemented

[19] When a nursing home resident goes to a hospital for inpatient care, the nursing home often cannot afford to reserve the bed of that resident (or even guarantee that there will be any available bed for that individual) unless the home receives a payment from the state to "hold" the bed. Most states' Medicaid programs have a "bed-hold" policy to pay the nursing home at a reduced rate while the Medicaid enrollee is in the hospital.

[20] When Congress created Medicaid in 1965, it prohibited beneficiary cost-sharing. Since then, it has given states more latitude to impose cost-sharing, although cost-sharing must be nominal (generally $3 or less or five percent of the payment for the service received) and cost-sharing is not permitted for children or pregnant women. Cost-sharing for the low-income population is a controversial issue, because some studies of the effect of cost-sharing have found that low-income individuals whose care is subject to cost-sharing are less likely to seek health care services (see Hudman and O'Malley, "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations," forthcoming, Kaiser Commission on Medicaid and the Uninsured, 2002).

disease management or case management programs in FY 2002 and 21 states reported that they planned to implement such programs in FY 2003. Specific disease management programs mentioned included programs for asthma, diabetes, congestive heart failure (CHF), hypertension and chronic obstructive pulmonary disease (COPD).



- **Eligibility Cuts**: Eighteen states, compared to eight states in FY 2002, planned eligibility cuts or restrictions for FY 2003 (Figure 21). Three states enacted cuts that will eliminate coverage for large numbers of persons on Medicaid.
  - Missouri cut 32,600 people from Medicaid in July by lowering the threshold at which parents become eligible from 100 percent of the poverty level (under $15,000 per year for a family of three) to 77 percent of the poverty line (about $11,000 per year for a family of three), reducing transitional coverage for people moving from welfare to work, and changing the period of allowable medical expenses for the medically needy.[21] (For more detail, please refer to the Missouri case study presented in the next section.)
  - Nebraska legislature passed a number of measures to reduce eligibility, including reducing continuous eligibility, changing income disregards, and changing the methods by which income is calculated. The changes will result in more than 25,000 people (12,750 adults and 12,600 children), or 12 percent of the state's total Medicaid enrollees, losing eligibility.
  - Massachusetts enacted a FY 2003 budget that eliminates Medicaid coverage for approximately 50,000 long-term unemployed individuals effective April 1, 2003. [22]

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[21] A judge issued a temporary restraining order on the Missouri cut in eligibility near the end of July 2002. See further description in the brief case study on the following page.

[22] FY 2003 Budget Update: Health Issues, Massachusetts Law Reform Institute, July 22, 2002.

Massachusetts and Nebraska's eligibility changes passed after the formal survey was completed, and Health Management Associates augmented the survey results to include these two significant changes.

In addition, states have also enacted additional eligibility reductions, including:

- Reducing the period of coverage for transitional medical assistance (TMA) or post-partum pregnancy-related care,
- Tightening eligibility by restoring asset and income reporting requirements for families and medically needy individuals,
- Restricting spend-down,
- Reducing eligibility levels,
- Reducing Medicaid coverage from two years to one year for those transitioning from Temporary Assistance for Needy Families (TANF) to work.

Exhibit 3

Eligibility Restrictions and Reductions: Comments of State Medicaid Officials

"We are facing a much larger battle than we've ever seen to maintain current levels of eligibility."

"We had planned to eliminate the asset test for pregnant women and to implement expedited eligibility, but they are postponed for now."

Table 4 displays the number of states that implemented cost-containment measures in FY 2002 compared with the number of states that planned the same cost-containment measures in FY 2003.

Table 4: Comparison of Cost Containment Efforts in FY 2002 and FY 2003

	Number of States	
Cost Containment Actions	**Implemented in FY 2002**	**Planned and/or Implemented FY 2003**
Provider payment rate freezes or decreases	22	29
Pharmacy-related actions (including pharmacy copays)	32	40
Benefit reductions	9	15
Eligibility reductions	8	18
New or higher copays (not including pharmacy)	4	15
Expansion of managed care	10	12
Implementation of disease/case management	11	21
Enhanced fraud and abuse	16	19
Long term care	7	13

Exhibit 4

Medicaid Budgets: Comments of State Medicaid Officials

“It's pretty grim here when you kind of see the black cloud of gloom that's coming."

“The budget situation next year (FY 2004) will be more difficult. It will be hard to avoid cuts next year.”

“It's pretty grim here when you kind of see the black cloud of gloom that's coming."

“The budget situation next year (FY 2004) will be more difficult. It will be hard to avoid cuts next year.”

“ I don’t think there’s any light at the end of the tunnel yet. Our biggest problem is that a large part of the budget is funded by one-time funds.”

“We are a big player in the state budget. Medicaid is the 800-pound gorilla. It’s the irresistible force hitting a brick wall, and something’s gotta give.”

“We won't find the needed savings on the margin. We'll have to take a chain saw.”

“We have been given a budget [for FY 2003]. We will make every effort to come in within in the budget.”

“The proposed cuts would be costly to the health care system in our state. When you look at the economic impact, it would be devastating.”

SCHIP

The State Children’s Health Insurance Program (SCHIP) enrollment continues to grow at a steady pace. SCHIP, a matched block grant to states, serves approximately 3.5 million children under age 19 with family incomes below 200 percent of poverty who are not eligible for Medicaid or covered by private insurance. The federal government will provide $3.15 billion in funding for the program in fiscal year 2002.

In addition to Medicaid related cost-containment measures, a few states have implemented cost containment measures for their SCHIP program in hopes of curtailing enrollment growth in Medicaid and/or SCHIP. In FY 2002, five states (Iowa, New Jersey, Montana, North Carolina and Utah) capped enrollment in the SCHIP program. In FY 2003, an additional two states (Florida and Oregon) included an enrollment cap for SCHIP on a list of possible budget control actions for all or part of the year. In addition to enrollment caps, outreach has also been reduced. State officials indicated one rationale for curtailing SCHIP outreach is that children applying for SCHIP are often instead found eligible and enrolled in Medicaid.

Exhibit 5

SCHIP outreach: Comments of State Medicaid Officials

" [SCHIP] is really a success story. But if enrollment continues to grow, we may have to institute a waiting list."

"We are continuing to do outreach, but we are taking our foot off the gas."

Administrative Budgets

As states cut administrative spending for programs across the board, Medicaid administrative budgets have also been cut. In FY 2002, 34 states had some sort of cut in the total Medicaid administrative budget, and/or a freeze imposed upon them by the legislature. Across the board budget cuts were in the range of two to fifteen percent. Hiring freezes, layoffs, decreases in the number of full time equivalent (FTE) positions, as well as other freezes (e.g., reduced office supplies and out of state travel) were most common. For FY 2003, Medicaid officials in at least 27 states indicated that they were subject to some sort of administrative cost reductions. This number includes five states subject to an administrative cutback for the first time in FY 2003. Given that many states are facing more serious budget pressures in FY 2003 than in FY 2002, it is likely that states will face additional administrative budget restrictions during the fiscal year. In any case, administrative restrictions make it more difficult for Medicaid programs to accomplish their missions at a time of increased demands and expectations.

Exhibit 6

Administrative Budgets: Comments of State Medicaid Officials

"We are very thin."

"It is very difficult for us to do our jobs. Morale is not good."

Implementation of the Breast and Cervical Cancer Treatment Option

Several states began implementing the Breast and Cervical Cancer Expansion program in FY 2002. By mid-2002 a total of 44 states had received federal approval to implement this special coverage. States indicated that while per person costs for individuals covered by this program were often significant, the total numbers of women enrolled was small and therefore, costs for this coverage were not regarded as a significant driver of Medicaid expenditures in FY 2002 or 2003. In FY 2002, 20 states reported that they had implemented a program. Three states indicated that they planned to implement this coverage in FY 2003 or FY 2004.

Implementation of State Olmstead Plans

The survey also asked about whether the 1999 Supreme Court Olmstead[23] decision was increasing Medicaid spending. Clearly, the issue of Olmstead as a potential cost driver was known, and Medicaid officials were familiar with and able to discuss the Olmstead plans that had been developed in their state. However, in most states (but not all), Olmstead implementation was not regarded as a significant factor increasing Medicaid spending in FY 2002. This conclusion was sometimes expressed with some surprise, because many officials had been (and still are) wary of Olmstead lawsuits and the potential for substantial costs of implementing Olmstead plans. However, the picture that emerged from discussions with Medicaid officials was that in most states the costs of Olmstead compliance was not yet a cost issue, but that it could yet be a significant issue in the near future.

Exhibit 7

Question: Is Olmstead a factor contributing to expenditure growth in your state?
Comments of State Medicaid Officials

"We think it will be a factor; we're getting a lot of pressure from advocacy groups."

'We have a [Olmstead] lawsuit, but we can't say it has driven any cost increases so far."

"It is a pressure. More a pressure than a factor."

"One would think so, but it hasn't been."

Waivers

During the past 13 months, the Centers of Medicare and Medicaid Services (CMS) has announced two new waiver initiatives. In August 2001, President Bush announced the Health Insurance Flexibility and Accountability (HIFA) waiver initiative. HIFA waivers are intended to provide states with enhanced flexibility to expand Medicaid and SCHIP coverage within existing resources, generally by restructuring benefits for some existing beneficiaries or using unspent SCHIP allocations to help finance expansions. State and federal financial constraints mean that these waivers could be used to reduce benefits, limit enrollment, or impose higher cost-sharing for some beneficiaries, beyond what is permitted under federal Medicaid rules. In some cases, states are trying to help relieve fiscal pressures by using HIFA waivers to obtain federal Medicaid matching funds for health programs that are currently funded entirely with state or local funds.

Seventeen states reported that they are developing or considering HIFA waivers in FY 2003.

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[23] In June 1999, the Supreme Court ruled in Olmstead versus L.C. that states were required to provide services to persons with disabilities in community settings rather than institutions for individuals for whom institutional case is inappropriate. Olmstead is not a Medicaid case, however the decision has implications for the Medicaid program and how states use Medicaid to provide care for persons with disabilities.
Source: Kaiser Commission on Medicaid and the Uninsured, "The Olmstead Decision: Implications for Medicaid"

In January 2002, CMS approved an Illinois 1115 waiver request to expand Medicaid with a single benefit -- prescription drug coverage for low-income seniors. At the same time, CMS also announced the "Pharmacy Plus" model waiver guidelines to encourage other states to adopt senior drug programs similar to the Illinois program. Eighteen states reported that they are developing pharmacy waivers (either under the "Pharmacy Plus" model or under an alternative waiver strategy first employed by Maine beginning in June 2001[24]). Because 34 states[25] have implemented state funded pharmacy assistance programs for seniors, Medicaid pharmacy waivers are an attractive way for states to refinance existing state-only expenditures and use the savings to expand coverage and/or address other budget shortfalls.

In all, state officials in 27 states reported that they expected to submit a waiver request to CMS in FY 2003.

Outlook

By a wide margin, Medicaid spending growth exceeded the rate of growth for total state budgets in FY 2002, and Medicaid officials indicated it would do so again in 2003 (Table 5). In FY 2002, state officials reported that total Medicaid spending increased by about 13 percent, a rate of growth over six times greater than the 2 percent growth for all state programs (including Medicaid).

Table 5: Medicaid Spending Growth in FY 2001, 2002 and 2003

State Fiscal Year	Medicaid Spending Increase (State Dollars Only)	Medicaid Spending Increase (Total Dollars)	Total State Budget Spending Increase (State dollars Only)
2001	10.6%	11.6%	8.3%
2002	10.8%	12.8%	2.0%
2003 (appropriated)	3.7%	4.8%	1.8%

Note: Percentages are unweighted means of changes in state Medicaid and total budgets.
Source: Medicaid spending growth for FY 2002 and FY 2003: Health Management Associates State Medicaid Survey for Kaiser Commission on Medicaid and the Uninsured, June 2002.
FY 2001 from NASBO, Fiscal Survey of the States, May 2002. FY 2003 Total Budget Appropriations from NCSL Survey, July 2002.

In FY 2003, Medicaid officials indicated that the legislative total appropriations for Medicaid would increase by 4.8 percent, with the state share increasing 3.7 percent (Figure 22). This rate of increase will almost certainly be less than actual total spending growth for Medicaid turns out to be in FY 2003. The growth in legislative authorizations for Medicaid for FY 2003 seems unrealistically low, particularly in the context of FY 2002's actual total spending growth that averaged 12.8 percent. Medicaid's appropriated growth rate, however, is more than double the average 1.8 percent increase in FY 2003 appropriations across all programs in state budgets.[26]

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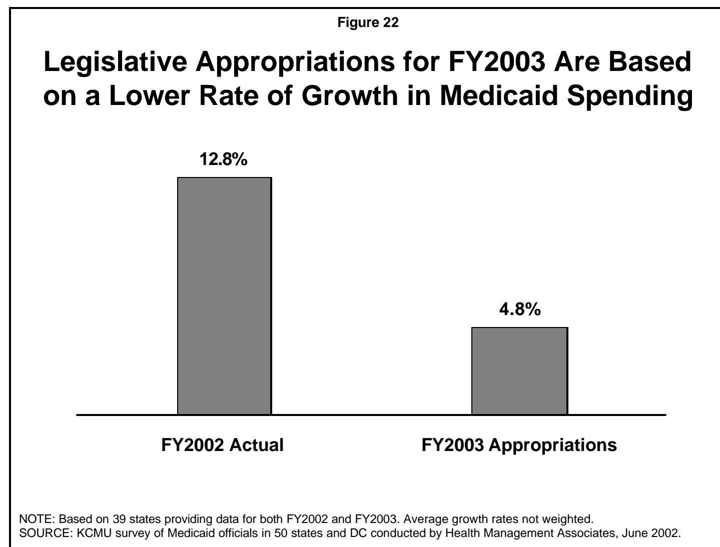
[24] Prior to the approval of the Illinois pharmacy waiver, both Maine and Vermont also had pharmacy-only 1115 waivers. Maine has over 100,000 enrollees and Vermont about 11,000 enrollees under its waiver.
[25] NCSL website, http://www.ncsl.org/programs/health/drugaid.htm.
[26] NCSL Survey, July 2002



For FY 2002, 36 states received additional funds in order to finance Medicaid expenditures for that fiscal year. In many states, general revenue funds, rainy day funds, tobacco settlement funds, Medicaid trust funds or transfers from other programs covered FY 2002 shortfalls. State officials indicated they expect the situation to be far more serious in FY 2003.

Exhibit 8

Likelihood of FY 2003 Shortfall: Comments of State Medicaid Officials

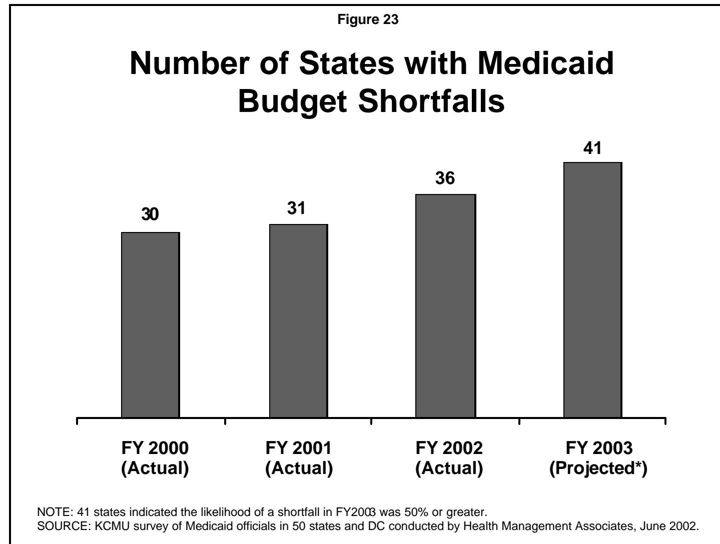
"I don't see how we can avoid it. It is highly likely unless the economy improves and enrollment drops. That's not likely."

"The '03 deficit is vast. Some combination of program cuts and a supplemental is certain."

“We’ll undergo further cuts before a supplemental appropriation is allowed.”

“It is 100 percent likely. I am already over my budgeted caseload for ’03.”

When asked the likelihood of a Medicaid budget shortfall and the need for supplemental funding in FY 2003, officials in 41 states predicted a 50-50 chance or greater that a budget shortfall will occur. State officials also suggested that FY 2004 would be more difficult than FY 2003 since states have drawn down most of the one time funding sources that might be used.



Since FY 2000 (Figure 23), states have been increasingly likely to experience a budget shortfall and to need supplemental funding to pay the full-year costs of Medicaid. Shortfalls can be attributed to many factors, one of which is that state legislatures have funded the program assuming rates of growth that are much lower than observed growth rates. For example, FY 2003 appropriations anticipate an annual growth in Medicaid state fund expenditures of an average of 3.7 percent. By comparison, growth rates in state fund expenditures exceeded 10 percent for both FY 2001 and FY 2002. On average, officials projected growth in Medicaid enrollment alone at 6.2 percent for FY2003. In other words, the assumptions on which appropriations are based for FY 2003 are unlikely to be realized. This helps explain why officials in 41 states projected a shortfall as likely as FY 2003 began, and why at least that many states are undertaking significant cost containing measures.

Exhibit 9

Outlook for Medicaid Budget: Comments of State Medicaid Officials

"This next go around the revenue will be a lot leaner. It will be a tougher year."

"I have a feeling we are in for a very bumpy ride."

"The outlook is pretty grim. We are trying to hang on to all of the good things achieved in the last 8 years."

"We are one of the states that solved the current year problem with rainy day funds so I don't know what we will do next year."

"FY 2003 is going to be incredibly ugly. To get through FY 2002 we kicked a lot of things into '03. We are going to have a tough time. I don't think it can get done in an election year…Who knows what will happen when the true scope of the shortfall becomes public."

"It's the old sorry story. When revenues go down, that's when Medicaid goes up."

"Everything is in chaos now. I haven't seen anything like this in over a decade."

"We are trying to stem the tide. I don't see any expansions for the next two years."

"We expect budget debates for FY 2004 to be as tough as they were for FY 2003. The budget will be constructed in an environment where the state is broke."

"We are coming to the realization that it will be a tough pull to get us back to where we were. It is going to take us maybe 4 to 5 years."

Adding to state fiscal stress are the recent restrictions placed on upper payment limits (UPLs)[27]. The restrictions on the use of UPL strategies are phased in and affect each state differently depending no their UPL arrangement. States did not list these restrictions as a factor driving Medicaid budget shortfalls, but several states indicated they would be significantly affected by the recent regulations. When state officials were asked what effect the recent UPL restrictions would have on their Medicaid budgets, officials in 16 states mentioned that the impact would be substantial, because lost federal funds would leave a serious hole in their budget. In New York, for example, officials indicated that due to UPL restrictions, nursing home IGTs would be phased-down at a cost of $80 million in one year.[28] In addition, ending the 150 percent UPL for inpatient and outpatient hospital reimbursement will cost New York $336 million annually. In Michigan, an *annual* benefit from IGT restrictions of $700 million will be lost, primarily in FY 2004 and 2005. Because the phase out period ends in 2006 for states like Michigan that relied heavily upon IGTs and UPLs, these states will feel the bulk of the effect in FY 2004 and 2005. States that pass all the money along to providers will not themselves be harmed directly--Medicaid providers will bear the largest burden in the form of reduced payments--but in these states decreased payments for hospitals and nursing homes will undoubtedly translate into pressures for provider rate increases.

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[27] Recent federal regulations place additional restrictions on state calculations of the upper limits on Medicaid payments to government-owned entities, including hospitals, clinics, nursing homes, and intermediate care facilities for the mentally retarded. For states that had federal approval for payments that exceed these new limits a phase-out period has been instituted. The phase-out periods vary by state.

[28] States frequently use intergovernmental transfers (IGTs) from public providers as part of their upper payment limit arrangements.

Summary and Conclusion

The picture that emerges from this look across all 50 states and the District of Columbia is that Medicaid officials in every state are under great pressure to control and reduce the rate of growth in Medicaid spending. This pressure was building before FY 2002, but intensified considerably midway through the fiscal year when Medicaid costs – driven by increases in pharmacy costs and enrollment -- increased faster than expected, and at about the same time, state revenues dropped dramatically. The expenditure growth experienced in FY 2002 was largely unforeseen by Medicaid officials in most states.

Because the urgency to reduce Medicaid spending growth developed well into FY 2002, Medicaid officials were pressed to offer options to control growth both for FY 2002 and for FY 2003. However, even under the pressure of looming budget shortfalls, the public policy process by which Medicaid cost containing policies are adopted take time, and more time still is required to implement the policies. In many states there simply was not enough time to develop and implement strategies that would achieve the needed cost savings in FY 2002. As a result, a common solution to resolving the Medicaid shortfalls at the end of FY 2002 was the use of one time funding sources and Medicaid reserves such as rainy day and tobacco settlement funds. In some cases, these sources are now largely exhausted.

States adopted numerous strategies in FY 2002 to control Medicaid spending. Actions to control the high rates of growth for prescription drugs were the most common strategy, followed by limits or reductions in provider payment rates. In a few states, actions were taken to restrict eligibility or benefits, but these strategies were less prevalent. States began to look more closely at long-term care and also at additional ways to control provider fraud and abuse. In a number of states, new or higher copayments were adopted for prescription drugs and other services such as eyeglasses.

As Medicaid budgets for FY 2003 were adopted by legislatures in the spring of 2002, Medicaid officials were directed to implement more aggressive cost controls. More states will cut payments for prescription drugs, will adopt a preferred drug list, require prior authorization for more drugs and drug classes, and seek supplemental pharmacy rebates. More states will cut or freeze provider rates. More states are planning to restrict eligibility. More states are planning to cut benefits, with the most prevalent being dental services for adults. Significantly, in more states adult beneficiaries will bear a greater share of the costs through new or higher copayments for prescription drugs and other services such as eyeglasses or services provided by dentists, chiropractors or podiatrists.

The SCHIP program, which serves 3.5 million people, making it significantly smaller than Medicaid, has been subject to less cost pressure than Medicaid. With the exception of a few of states that have adopted enrollment caps and other states that are scaling back outreach, states continue to give priority to enrolling children into this popular program.

The outlook for FY 2003 and beyond is for a continued high rate of Medicaid cost growth and with it increasing pressure to control Medicaid costs. Medicaid officials spoke of their belief that the immediate future was one of increasing and even extreme pressure to reduce Medicaid cost growth. They described the prospect of needing to develop proposals for significant cost

reduction as they managed the program in FY 2003 and developed their budgets for FY 2004. Unless Medicaid spending growth slows or state fiscal situations improve, state Medicaid officials expect they will likely face difficult choices for the next several years.

State Profiles of Medicaid Cost Containment Policies

Profile of Medicaid Cost Containment Policies: Iowa

Shortly after FY 2002 began, Iowa state revenue growth slowed significantly while Medicaid expenditure growth increased above expectations. The Medicaid shortfall alone was estimated at $30 to $40 million in state funds (which equals between seven and a half percent and ten percent of the FY 2002 general fund appropriation for Medicaid). FY 2003 Medicaid general fund needs were expected to grow by an additional $60 million. To address the immediate FY 2002 state budget shortfall, Governor Vilsack issued an executive order for an across-the-board 4.3 percent budget cut for all state programs that amounted to a $17 million cut in general fund dollars for Medicaid (with federal funds, a reduction of total spending of $45 million). This was in addition to the $30 to $40 million Medicaid shortfall. A two-day "Medicaid Summit" was held in November 2001 specifically to address the immediate Medicaid budget shortfall.

Notwithstanding the resolve and urgency, the task of choosing a strategy proved almost impossible. Policy makers considered many possible approaches (including benefit reductions, eligibility cuts and other utilization control strategies), only to rule them out. The option of eliminating the "Medically Needy" group (an eligibility category that includes persons with large medical bills) continued to arise due, in part, to certain restrictions in the Iowa Code. (The Iowa Code provides that if eligibility groups are to be eliminated, the Medically Needy group must be the first group cut.) Subsequent to the Medicaid Summit, a reluctant recommendation was submitted, as required, to the Department of Human Services Council to eliminate the Medicaid Medically Needy coverage for adults. The Council rejected the recommendation. In January 2002, a new recommendation was submitted that would address the $17 million Medicaid shortfall by taking $5 million from tobacco settlement funds, another $5 million from a Senior Living Trust Fund, and achieved the remaining $7 million in savings by reducing eligibility for the Medically Needy eligibility category. This strategy, too, was rejected. Resolution on the immediate Medicaid budget shortfall was finally reached in March 2002 when the legislature adopted a new budget for FY 2002. The legislature appropriated an additional $57 million in supplemental funding for Medicaid, using tobacco settlement funds and borrowing from the state's hospital trust fund. With these funds, the proposed elimination of the Medically Needy coverage was set aside.

Disagreement, however, continued over the state budget for FY 2003. Dissatisfied with the FY 2003 budget passed at the end of the regular session in mid April, Governor Vilsack called a special session for April 22, 2002 and urged the legislature to restore cuts made to education, human services and public safety by diverting $60 million in road-use taxes. The Legislature adjourned without acting on the Governor's proposal. On May 7, 2002, the State's Revenue Estimating Committee released new projections showing a further decrease in general revenues of $205.5 million in FY 2002 and $220.1 million FY 2003. As a result of this dramatic change in the state's general revenue picture, Governor Vilsack called another special session for May 28, 2002. The legislature acted to close the FY 2002 gap by further drawing down the rainy day fund and other reserves and transferring fund balances from other areas. The revised FY 2003 budget also included more fund transfers as well as additional spending cuts to state programs, including over $18 million of state fund reductions for Medicaid. The Medicaid reductions included $10 million attributed to further pharmacy savings efforts, $3 million attributed to the elimination of continuous eligibility, $2 million attributed to savings from higher drug copayment requirements and $3.7 million in "general" reductions. (Governor Vilsack vetoed the drug copayment increases and the continuous eligibility provisions. While Iowa had previously eliminated the monthly income reporting requirement for Medicaid beneficiaries and moved to an "exception" reporting system, the state did not actually provide continuous eligibility.) Iowa Medicaid staff reported the following cost containment efforts:

Provider Rates:

- 3% across the board provider rate reductions in '02 (except nursing home and pharmacy)
- Across the board rate freeze (except nursing home and pharmacy) in FY '03. Nursing

<table>
<tr><td>homes received a 6.2% increase in ’02 and a 3.1% increase in ’03.
Nursing facility bed-hold day policy[29] changed based upon facility occupancy level
Intermediate Care Facility for the Mentally Retarded (ICF/MR) provider “participation fee” to be imposed in ‘03</td></tr>
<tr><td>Prescription Drug Controls and Limits (under consideration for ’03, but not finalized at the time of the survey):</td></tr>
<tr><td>Subjecting more drugs to prior authorization
Developing a preferred drug list
Expanding retrospective Drug Utilization Review (DUR) activities
Undertaking greater utilization management activities and expanding pharmacy lock-in program
Implementation of a state MAC program</td></tr>
<tr><td>Benefit/Service Reductions:</td></tr>
<tr><td>Selected cuts in adult dental (including denture replacement)
Considering new beneficiary copayment requirements in selected areas in ‘03</td></tr>
<tr><td>Eligibility Reductions: None</td></tr>
<tr><td>Other:</td></tr>
<tr><td>Policy development on dual certification (Medicare/Medicaid) for nursing homes in ‘03
Plan to enhance disease management programs in ‘03
2 ½ unpaid furlough days for state employees in FY ‘02
State employee reduction in force in FY ’02 has resulted in 25% fewer central office staff at the Department of Human Services
In 2003, administration budget reflects 12 half furlough days in FY ’03. (In lieu of these furlough days, the Department plans to employ a number of strategies including reductions in force, leaving vacancies unfilled and perhaps some furloughs that will be determined at a later date.)</td></tr>
</table>

[29] When a nursing home resident goes to a hospital for inpatient care, the nursing home often cannot afford to reserve the bed of that resident (or even guarantee that there will be any available bed for that individual) unless the home receives a payment from the state to “hold” the bed. Most states’ Medicaid programs have a “bed-hold” policy to pay the nursing home at a reduced rate while the Medicaid enrollee is in the hospital.

Profile of Medicaid Cost Containment Policies: Oklahoma

In the fall of 2001, the Oklahoma Health Care Authority (OHCA) projected a $21 million (or 5 percent) shortfall in its FY 2002 state Medicaid appropriation. A list of cost containment measures was developed designed to keep Medicaid spending closer to appropriated levels. The list of cost containment measures formally approved by the OHCA in January 2002 included a number of dramatic eligibility reductions, including the elimination of the Medically Needy program (that provides coverage for persons with high medical expenses), and the reduction of income eligibility standards for pregnant women and children from 185% of the federal poverty level to federal minimum standards. In all, approximately 10 percent of all Medicaid enrollees would lose Medicaid coverage under these proposed measures. Other measures designed to produce immediate savings included provider rate cuts, delays in scheduled rate increases, cuts in pharmacy reimbursements, subjecting more drugs to prior authorization, elimination of denture and eyeglass coverage for nursing home residents and elimination of dental coverage for all adults. In February 2002, however, an agreement was reached with the Oklahoma legislature providing $16.5 million in supplemental appropriations that allowed the rescission of many of the cuts before they were scheduled to take effect, including all of the eligibility reductions. Other cuts, however, were allowed to move forward.
Provider Rates:
• Rates frozen in ’02 for hospitals, nursing homes, physicians and other practitioners. Ten percent rate cut for behavioral health services provided in a long term care setting • Rates frozen in ’03 for all providers (The state is currently looking for ways to lift the rate freeze.) • Nursing facility bed-hold day reimbursement reduced in ‘02 • Medicare cross-over claims reduced in ’02 for services provided under part B as well as skilled nursing under part A
Prescription Drug Controls and Limits:
• Increased discount taken from AWP from AWP-10.5% to AWP-12% in ‘02 • Expanded the preferred drug list in ’02 and plan to further expand it in ‘03 • Expanded the State MAC list in ‘02 • Plan to implement prescriber profiling in ‘03 • Considering implementation of provider profiling in ‘03
Benefit/Service Reductions:
• Reduced maximum allowable behavioral health counseling services in LTC facilities
Eligibility Reductions:
• Suspended TEFRA (Tax Equity and Fiscal Responsibility Act) coverage (“Katie Beckett” children) • Canceled implementation of breast and cervical cancer coverage expansion • Delayed implementation of TWIAA (Ticket to Work and Work Incentives Improvement Act)
Other:
• Disease management pilots for asthma and depression underway in ’02; intention to expand in the future • Enhancing fraud and abuse detection and recoveries through a contracted vendor in ‘02 • Enhancing Third Party Liability (TPL) recoveries through a contracted vendor in ‘02 • Hiring and purchasing freeze to meet a 5% administrative budget cut in ‘02

Profile of Medicaid Cost Containment Policies: Missouri

On May 10, 2002, with just one week left in the regular session of the 2002 Missouri General Assembly, the legislature approved a budget for FY 2003 that Governor Bob Holden found to be $167 million out of balance. With just two days left in the session, Governor Holden urged the General Assembly to act to close the budget gap or he would be forced to call a special session. Hours before the mandatory adjournment, a package was pieced together that relied on a myriad of revenue measures (including a pharmacy provider tax) combined with bond revenues based on securitizing Missouri's tobacco settlement to plug the gap. The General Assembly, however, failed to give Governor Holden access to revenues in the state's rainy day fund to address the state's FY 2002 budget shortfall, forcing the Governor to make $230 million in cuts that significantly impacted higher education, nursing homes and state workers. Tapping the Rainy Day Fund requires a two-thirds vote of the legislature. The last time this occurred was the Flood of 1993.

On June 26, 2002, the Governor signed into law an FY 2003 budget that is $372.9 million smaller than the FY 2002 budget, marking the first time since 1982 that the total Missouri budget had shrunk from one year to the next. Ten of fourteen departments received less general revenue funding. (Only Elementary and Secondary Education, Agriculture, Corrections and the Office of Administration received funding increases.) Transportation, Natural Resources and Economic Development's general revenue budgets were reduced by more than thirty percent. As a result of the reductions in the FY 2003 state budget, the Medicaid program has undertaken a number of cost containment efforts intended to produce $145.3 million in state savings. These efforts include provider rate freezes, pharmacy reductions, some benefit cuts and significant eligibility reductions for low-income adults (described below). Also, one of the most controversial cuts in the FY 2003 budget involved changes made to the Medicaid spend-down program that would result in ending the long-time practice of the state paying recipients' incurred expenses when those expenses were on the day they actually met their spend down amount.

At least three of the Medicaid cuts have now come under legal attack. Nursing homes filed a lawsuit in June over $20 million of FY 2002 funding withheld by the Governor to partly address the state's FY 2002 budget shortfall. A lawsuit challenging the adult dental cuts was filed in July. 0n August 21, 2002, the St Louis City Circuit Court issued a preliminary injunction order requiring the state to continue adult dental benefits. Also, on July 26, 2002, a federal court issued a temporary restraining order requiring the State to restore Medicaid eligibility to approximately 17,000 of the 32,000 adults that lost coverage as of July 1, 2002. A preliminary injunction was later issued in August. Also, since November 2001, the state and CMS have continued to negotiate a proposed federal Medicaid disallowance of over $2.2 billion relating to the state's nursing home and hospital provider taxes. State Medicaid Director Greg Vadner believes the proposed disallowance to be the largest in the history of the Medicaid program.

Provider Rates:

- Most provider rates frozen in '02 and '03
- Planning to cut Medicare cross-over claims in '03
- Nursing homes will lose IGT/UPL funded add-on payments beginning in '04

Prescription Drug Controls and Limits:

- Reduced ingredient cost reimbursement from AWP-10.43% to the lower of AWP- 10.43% or WAC+10% in '02
- Added more drugs to the state maximum allowable cost ("MAC") list in '02
- Subjected more drugs to prior authorization beginning in '01 and continuing in '02 and '03
- Plan to develop a preferred drug list in '03
- Increasing dispensing fee in '03 from $3.95 to $8.04

Benefit/Service Reductions:

- Eliminated adult dental coverage, except dentures, in '03. *(Benefit reinstated by court order.)*
- Eliminated eyeglasses for adults in '03
- Eliminated coverage for circumcisions unless medically necessary

Profile of Medicaid Cost Containment Policies: Missouri

Eligibility Reductions*(all in '03)*:
• Reduced eligibility for low-income parents from 100% FPL to 77% FPL. (*Currently partially enjoined by court order requiring the receipt of transitional Medicaid coverage for approximately 17,000 working parents.)* • Eliminate coverage for non-custodial parents • Reduced eligibility for those transitioning off TANF from 300% to 100% FPL and from 2 years to 1 year • Reduced post-partum coverage from two years and 60 days to one year and 60 days • Changed spend-down process (monthly instead of quarterly, with option of premium payment.)
Other:
• Implement disease management programs for asthma, diabetes, congestive heart failure and COPD in '03 • Implement pharmacy case management for recipients with more than 9 scripts in '03 • Contracted with a vendor to enhance fraud and abuse detection and recovery efforts beginning in March '02 • Departmental staffing cuts (through attrition), travel restrictions and other administrative reductions in '02 and '03

Profile of Medicaid Cost Containment Policies: Mississippi

During the 2002 legislative session in Mississippi, the legislature and Governor Musgrove grappled with how to deal with projected state Medicaid budget shortfalls of $158 million in FY 2002 and $120 million in FY 2003. Governor Musgrove signed House Bill 1200 that raised copayment requirements, reduced reimbursement rates for providers and required other cost containment measures to help cover the FY 2002 shortfall. Later, however, the Governor clashed with the Mississippi legislature over how to close the FY 2003 shortfall. The Governor vetoed the Medicaid appropriation bill for FY 2003 saying that it was insufficient to meet the program's funding needs. He also warned legislators that if they did not appropriate more money for the program, 13,000 beneficiaries would no longer be able to receive care in nursing homes and thousands more would lose their prescription drug benefits. The legislature overrode the Governor's veto three days later. The Governor and lawmakers later met to discuss the FY 2003 shortfall and agreed, in part, to require the implementation of a number of cost containment measures and to create an oversight committee that would "monitor and reexamine" the Medicaid program. They also agreed to hold off until September calling a special legislative session to deal with the anticipated shortfall. (The legislature later eliminated a quarterly Medicaid budget "cap" making a special session in September unnecessary.) As of August 20, 2002, Mississippi Medicaid officials continue to face a FY 2003 state Medicaid budget shortfall estimated at $75 million. Mississippi Medicaid officials reported the following cost containment measures:

Provider Rates:

- Most provider rates (excluding institutional providers) cut by 5% effective June '02
- In '02 and '03, provider taxes on nursing homes, intermediate care facilities for the mentally retarded (ICF/MRs) and psychiatric residential treatment facilities (PRTFs) increased; new provider tax imposed on hospitals in '02
- Eliminated transportation reimbursement for attendant riders in '02

Prescription Drug Controls and Limits:

- In '02, reduced ingredient cost reimbursement from AWP- 10% to AWP-12% in '02 and reduced dispensing fee from $4.91 to $3.91
- Require use of generic drugs when available and the return of unused drugs in tamper-resistant packaging originally dispensed for a nursing home patient
- Original plan to opt out of federal drug rebate program and establish a closed formulary that includes only drugs with the lowest and best price as determined through a bidding process was not approved by CMS. State now moving to adopt a preferred drug list.
- In '02, reduce the maximum number of prescriptions per month from 10 to 7 with prior authorization required after 5
- In '02, limit the quantity dispensed to a 34 day supply
- In '02, required that all Medicare covered drug claims for dual eligibles be submitted first to Medicare before submitting to the state

Benefit/Service Reductions:

- Reduce coverage for eyeglasses from one pair every three years to one pair every five
- Limit benefits for pregnant women to pregnancy related services only in '02
- Reduce detoxification treatment days from 14 to 5-7

Eligibility Reductions:

- Eliminated declaration of income eligibility determination option in '02

Other:

- Maximum copays imposed on all possible services (ambulance, dental, Federally qualified health center, rural health center, home health, hospital inpatient and outpatient, drugs, physician, eyeglasses, durable medical equipment), except for non-emergency transportation, in '02
- Plan to implement disease management programs for asthma, diabetes, and hypertension '03
- Eliminated the primary care case management program (HealthMACS) in '02
- Looking at new fraud and abuse software and picture IDs for recipients in '03
- Implement in '02 emergency room diversions for non-emergency care
- Departmental staffing freeze, travel restrictions and other administrative reductions in '02 and '03

APPENDIX A: SURVEY INSTRUMENT

Medicaid Budget Survey
for Fiscal Years 2001, 2002 and 2003

State of: ________________ Name: ____________________________ Date:__________

Phone: __________________ Email: ____________________________

Section A. Medicaid Expenditures for State Fiscal Years 2001, 2002 and 2003

Below, please indicate Medicaid expenditures, and the source of funds. "Medicaid expenditures" is intended to mean payments for medical services, including capitation payments, DSH payments, supplemental payments and any other payments that qualify for federal matching funds as medical services. This definition would not include Medicaid administrative costs. Please indicate if the State's definition includes other payments: _______________________________

Are these amounts for Medicaid services in ALL state agencies, or just the Medicaid agency?

	Source of Funds			
	State Funds	Local or Other Funds	Federal Funds	Total: All Fund Sources
FY 2001				
a. Medicaid Expenditures (Actual)				
FY 2002				
a. Original Medicaid Appropriation				
b. Current Projected Medicaid Expenditures				
c. Current Projected Medicaid Expenditures: Percentage Change from FY2001				
FY 2003				
a. Legislative Appropriation for Medicaid (If adopted; otherwise expected)				
b. Percentage Change: FY 2003 Medicaid Appropriation over FY 2002 Expenditures				

Will the restrictions on IGT / UPLs affect your state? How? _____________________________

Notes:
____
____

Section B. State Fiscal Year 2002

1.a. What would you consider *the most significant factor* contributing to the increase in Medicaid expenditures in FY 2002? ____________________

b. What would be the second most significant factor? ____________________

c. Other significant factors? ____________________

2.a. Provider payment rates: For each provider type, please describe any rate increases, rate freezes or rate cuts in FY 2002:

Pharmacy ____________________
Inpatient hospital ____________________
Outpatient hospital ____________________
Doctors ____________________
Dentists ____________________
Managed care organizations ____________________
Nursing homes ____________________
Home health providers ____________________
Home and community-based waiver providers ____________________
Other providers ____________________

b. Expansion or reduction of benefits (describe) ____________________
____

c. Enrollment increases in FY 2002: Overall % growth from FY 2001 ____________________

To what extent is each eligibility group contributing to enrollment growth and costs?

-- children? ____________________
-- adults? ____________________
-- pregnant women? ____________________
-- elderly? ____________________
-- disabled? ____________________
-- other eligibility categories? ____________________

To what factors do you attribute the growth in Medicaid enrollment?

--Eligibility expansions? ____________________
--Outreach? ____________________
--Simplification of application or eligibility process? ____________________
--Downturn in economy? ____________________
--Other factors in enrollment growth? ____________________

d. Are there other factors contributing to expenditure growth in your state?

-- Breast and cervical cancer expansion? ____________________
-- Olmstead? ____________________
-- Others? ____________________

3. What program or policy actions were *proposed or taken* during FY 2002 to slow the growth in Medicaid expenditures? Please briefly describe those that apply. If possible, indicate the general fund dollar savings for FY 2002.

Program or Policy Actions: Medicaid	Proposed	Implemented	GF Savings?
a. Provider payment rate reductions or freezes			
i. hospitals?			
ii. physicians or other practitioners?			
iii. managed care?			
iv. nursing homes?			
v. others?			
b. Prescription Drug Controls and limits:			
i. Payment for Rx @ AWP less a greater discount			
ii. More drugs subject to prior authorization			
iii. Preferred drug list			
iv. Supplemental rebates			
v. Requirements to use generics			
vi. Limits on the number of Rx per month			
vii. New or higher copays			
c. Other benefit or service reductions or limits (other than Rx):			
d. Eligibility cuts or delays in planned expansions			
g. New or higher beneficiary copays (other than for Rx)			
d. Expansion of managed care			
f. Disease management or case management			
e. Enhanced fraud and abuse controls			
j. Long-term care changes?			
k. Changes in Program Administration?			
l. Other actions:			

Notes on above actions: ____
____
____
____
____

4. Were additional funds made available to Medicaid after the original appropriation for FY 2002? Yes?_____ No?_____ Please indicate the source of additional funds, and the amounts.

Source of Additional Funds (Indicate all that apply in FY 2002	Used in FY 2002? (Yes or No)	Amount ($millions)
a. Legislative Supplemental appropriation		
i. State general revenues / general funds		
ii. Rainy Day Funds		
iii. Tobacco Settlement funds		
iv. Other source:		
b. Transfer of funds from Medicaid trust fund		
c. Transfer of funds from other programs		
d. UPL or DSH funding		
e. Tax increases (describe)		
f. Other:		

Section C: State Fiscal Year 2003

5. Next, let's talk about Medicaid for next year, FY 2003:

Do you expect the factors that will contribute to Medicaid expenditure growth in FY 2003 will be the same as or different from those that contributed in FY 2002?

a. Same factors as in FY 2002 ______
b. Different in FY 2003, in this way:
____
____
c. What is Medicaid enrollment growth projected to be in FY 2003? ________%
d. Will provider payment rates be increased in FY 2003? __________________________
____

6. What program or policy actions are now planned (or are likely) for FY 2003 to control the growth in Medicaid expenditures? Please describe those that apply.

Program or Policy Actions	Planned or Likely in FY 2003 (X=Yes)	Proposed Savings for FY 2003 (General Fund)
a. Provider payment rate reductions or freezes		
i. hospitals?		
ii. physicians or other practitioners?		
iii. managed care?		
iv. nursing homes?		
v. others?		
b. Prescription Drug Controls and limits:		
i. Payment for Rx @ AWP less a greater discount		
ii. More drugs subject to prior authorization		
iii. Preferred drug list		
iv. Supplemental rebates		
v. Requirements to use generics		
vi. Limits on the number of Rx per month		
vii. New or higher copays		
c. Other benefit or service reductions or limits (not Rx):		
d. Eligibility cuts or delays in planned expansions		
g. New or higher beneficiary copays (other than for Rx)		
d. Expansion of managed care		
f. Disease management or case management		
e. Enhanced fraud and abuse controls		
j. Long-term care changes		
k. Changes in Program administration		
l. Other actions:		

Notes on above actions: (Were policies proposed by Governor or Legislature but not adopted?)
____

What, if any, constraints are you facing in your Medicaid administrative budget?

7. When you look now at the amount appropriated (or that you expect to be appropriated) for FY 2003 for Medicaid, how likely do you believe it is that your state will experience a Medicaid budget shortfall in FY 2003?

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

8. **S-CHIP**:
a. What factors have contributed to increases to spending growth in your State Children's Health Insurance Program?
____
____

b. What actions did you take in FY 2002, or do you expect to take in FY 2003, to change S-CHIP?

Action to Change S-CHIP?	Actions in FY 2002	Planned for FY 2003
a. Cap enrollment		
b. Eliminate benefits		
c. Reduce provider payments		
d. Increase premiums		
e. Change cost-sharing		
f. Change eligibility levels		
g. Reduce outreach		
h. Change application procedures		
I. Other actions:		

9. **1115 Waivers**: Do you expect to submit to CMS a new Medicaid or SCHIP 1115 waiver (or modification to an existing waiver)………….…………. Yes ____ No ____
--Would this be a HIFA waiver? ……….…………………Yes ____ No ____
--Would this be a prescription drug waiver?………………..Yes ____ No ____
Can you briefly describe how the waiver would:

a. Modify benefits covered? ____
b. Change eligibility? ____
c. Change provider reimbursement?____
d. Change cost-sharing policies? ____
e. Expand managed care? ____
f. Other changes? ____

Can you briefly describe how the requirements for budget neutrality (or allotment neutrality) are to be met? ____
____

g. Do you have materials that describe the waiver that you could send?
Yes_____ No_____

10. a. Do you have any other comments about the Medicaid budget in your state, about other impacts of Medicaid expenditure trends, or about how Medicaid expenditures are affecting other program areas in your State?

____
____
____
____

b. 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?

Materials may be sent to:

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

Phone: 517-482-9236
E-mail: Vsmith@hlthmgt.com

Thank you very much.

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

Appendix B: 2002 Legislative Regular and Special Session Calendar

State	Regular		Special	
	Convenes	Adjourns	Convenes	Adjourns
Alabama	Jan 08	Apr 17		
Alaska	Jan 14	May 16	May 17	May 21
Arizona	Jan 14	May 23	Feb 04, Apr 01	Mar 20, May 23
Arkansas	---	---	Jun 10	
California	Jan 07	Aug 31		
Colorado	Jan 09	May 08		
Connecticut	Feb 06	May 08		
Delaware	Jan 08	June 30		
District of Columbia	Jan 02	*		
Florida	Jan 22	Mar 22	Apr 02, Apr 02	Apr 05, May 13
Georgia	Jan 14	Apr 12		
Hawaii	Jan 16	May 02		
Idaho	Jan 07	Mar 15		
Illinois	Jan 09	June 2		
Indiana	Jan 07	Mar 14	May 14	
Iowa	Jan 14	Apr 12	Apr 22	Apr 22
Kansas	Jan 14	Apr 13	May 1	
Kentucky	Jan 08	Apr 15	Apr 22	May 01
Louisiana	Apr 29	Jun 12	Mar 25	Apr 17
Maine	Jan 02	Apr 25		
Maryland	Jan 09	Apr 08		
Massachusetts	Jan 02	*		
Michigan	Jan 09	*		
Minnesota	Jan 29	May 20		
Mississippi	Jan 08	Apr 05		
Missouri	Jan 09	May 30		
Montana	---	---		
Nebraska	Jan 09	Apr 19		
Nevada	---	---		
New Hampshire	Jan 02	July 01		
New Jersey	Jan 08			
New Mexico	Jan 15	Feb 14	May 24	
New York	Jan 09	*		
North Carolina	May 28	July		
North Dakota	---	---		
Ohio	Jan 02			
Oklahoma	Feb 04	May 24		
Oregon	---	---	Feb 08, Feb 25, Jun 12	Feb 11, Mar 02
Pennsylvania	Jan 01	*		
Rhode Island	Jan 01	Late June		
South Carolina	Jan 08	Jun 06		
South Dakota	Jan 08	Mar 12		
Tennessee	Jan 08	Late June		
Texas	---	---		
Utah	Jan 21	Mar 06	Apr 24, Apr 24, May 22, Jun 26, Jul 6, Jul 8	Apr 24, Apr 29, May 22
Vermont	Jan 08	Jun 13		
Virginia	Jan 09	Mar 09	Apr 17	Apr 17
Washington	Jan 14	Mar 14		
West Virginia	Jan 09	Mar 14	Jun 9	
Wisconsin	Jan 07	*	Jan 22	
Wyoming	Feb 11	Mar 13		

* =Legislature meets throughout the year.
SOURCE: National Conference of State Legislatures, 2002 Legislative Session Calendars,http://www.ncsl.org/programs/legman/about/sess2002.htm. Accessed September 16, 2002.

Appendix C: Factors Contributing to Expenditure Growth in 2002—State Responses

State	Primary Factor	Secondary Factor	Other
Alabama	Enrollment	Pharmacy	Utilization
Alaska	Cost	Enrollment	Utilization
Arizona	Expansions	Enrollment	Increased Medical Costs
Arkansas	Mental Health	Pharmacy	Enrollment
California	Eligibility	Hospital	Pharmacy
Colorado	Pharmacy	Utilization	Managed Care
Connecticut	Enrollment	Pharmacy	Cost of Health Care
Delaware	Pharmacy	Utilization	
District of Columbia	Mandatory Rate Increases		
Florida	Pharmacy	Long Term Care	UPL for Inpatient Hospital services
Georgia	Pharmacy	Enrollment	Utilization
Hawaii	Enrollment	Pharmacy	
Idaho	Pharmacy	Aged and Disabled Waiver	Hospital
Illinois	Pharmacy	Enrollment	Hospital
Indiana	Pharmacy	Enrollment	Long Term Care
Iowa	Enrollment	Utilization	Pharmacy and continued reliance on nursing home placements
Kansas	Pharmacy	Home Health	Rate changes and enrollment
Kentucky	Eligibles	Pharmacy	Cost based payment methodologies
Louisiana	Pharmacy	Hospital	Waiver Program
Maine	Pharmacy	Behavioral Health	Enrollment
Maryland	Enrollment	Nursing Home	Pharmacy
Massachusetts	Pharmacy	Long Term Care	Utilization
Michigan	Enrollment	Pharmacy	--
Minnesota	Home and Community Based Waiver	Cost	Enrollment
Mississippi	Enrollment	Pharmacy	FMAP[30]
Missouri	Pharmacy	Enrollment	--
Montana	Enrollment	Utilization	Pharmacy
Nebraska	Pharmacy	Enrollment	--
Nevada	Enrollment	Medical Cost Inflation	Pharmacy
New Hampshire	Pharmacy	Outpatient Hospital	Enrollment
New Jersey	Pharmacy	Home Health	Other
New Mexico	Enrollment	Pharmacy	Cost Inflation
New York	Enrollment	Pharmacy	Expenditures
North Carolina	Enrollment	Utilization	Technology
North Dakota	Nursing Home	Pharmacy	Eligibles
Ohio	Pharmacy	Nursing Home	Growth in Caseload
Oklahoma	Rate Increases	Enrollment	Pharmacy
Oregon	Pharmacy	Economy	Medical Inflation
Pennsylvania	Pharmacy	Behavioral Health Services for Children	--
Rhode Island	Pharmacy	Managed Care	Services for children with special health care needs
South Carolina	Enrollment	Utilization	--
South Dakota	Pharmacy	Utilization	Long Term Care
Tennessee	Pharmacy	Enrollment	Hospital
Texas	Enrollment	Cost	FMAP changes
Utah	Eligibles	Pharmacy	Provider Inflation
Vermont	Pharmacy	Long Term Care	Hospital Outpatient
Virginia	IGT for Nursing Facilities	Pharmacy	Other
Washington	Pharmacy	Enrollment	--
West Virginia	Pharmacy	Nursing Home	Enrollment
Wisconsin	Nursing Home	Pharmacy	Enrollment
Wyoming	Pharmacy	Enrollment	Expansion

NOTE: Not all states provided responses for all three factors driving expenditure growth.

[30] FMAP refers to changes made to the method used to calculate the federal Medicaid match rate.

Appendix D: Cost Containment Actions Taken in Each of the 50 States and District of Columbia in FY 2002

State	Provider Payments	Pharmacy Controls*	Benefit Reductions	Eligibility Cuts	Copays **	Managed Care Expansions	DM/ CM	Fraud and Abuse	LTC
Alabama									
Alaska		X		X					
Arizona	X								
Arkansas	X	X					X		
California	X								
Colorado		X						X	
Connecticut									
Delaware		X						X	
District of Columbia		X							
Florida	X	X					X		
Georgia		X	X	X			X	X	
Hawaii									
Idaho	X	X	X			X	X		
Illinois	X	X			X			X	
Indiana	X	X				X			
Iowa	X		X						X
Kansas		X						X	
Kentucky	X	X				X			X
Louisiana		X				X	X		
Maine		X							
Maryland	X								
Massachusetts		X	X				X	X	
Michigan	X	X							X
Minnesota	X	X		X					
Mississippi	X	X	X	X	X				X
Missouri		X					X	X	
Montana	X								
Nebraska	X								
Nevada	X								
New Hampshire	X	X	X						
New Jersey				X		X		X	
New Mexico		X	X						
New York						X		X	
North Carolina	X	X							
North Dakota									
Ohio	X	X		X		X			
Oklahoma	X	X						X	
Oregon		X				X	X		
Pennsylvania									
Rhode Island									
South Carolina	X	X	X						
South Dakota									
Tennessee						X			
Texas		X						X	
Utah	X		X	X	X				
Vermont		X			X		X		
Virginia						X		X	
Washington		X		X				X	X
West Virginia		X					X	X	
Wisconsin		X					X	X	X
Wyoming		X						X	X
Total	**22**	**32**	**9**	**8**	**4**	**10**	**11**	**16**	**7**

*Pharmacy controls include states that began or increased beneficiary co-payments for prescription drugs.
**Co-payments category includes states that began or increased beneficiary co-payments for health care services other than prescription drugs.

Appendix E: Cost Containment Actions Taken in Each of the 50 States and District of Columbia for FY 2003

State	Provider Payments	Pharmacy Controls*	Benefit Reductions	Eligibility Cuts	Copays **	Managed Care Expansions	DM/ CM	Fraud and Abuse	LTC
Alabama									
Alaska	X	X						X	
Arizona		X	X	X	X				
Arkansas							X		
California	X	X	X	X	X		X	X	
Colorado	X	X		X			X	X	
Connecticut		X	X	X				X	X
Delaware	X	X	X	X	X	X	X	X	X
District of Columbia		X						X	X
Florida		X	X			X		X	
Georgia		X		X			X	X	X
Hawaii	X	X							
Idaho									
Illinois	X	X		X	X		X	X	X
Indiana	X	X	X	X		X	X	X	
Iowa	X	X					X		X
Kansas	X	X	X	X		X	X		
Kentucky	X	X			X			X	
Louisiana		X				X	X		
Maine									
Maryland	X	X							
Massachusetts		X		X	X		X	X	
Michigan	X	X		X	X				X
Minnesota									
Mississippi	X	X	X		X		X	X	X
Missouri	X	X	X	X					
Montana	X	X	X						
Nebraska	X	X		X					
Nevada	X	X				X	X		
New Hampshire		X		X	X		X		
New Jersey	X	X							
New Mexico		X						X	X
New York	X	X				X		X	
North Carolina		X	X	X		X	X		X
North Dakota				X					
Ohio	X	X			X	X	X	X	X
Oklahoma		X							
Oregon	X	X			X		X		
Pennsylvania				X		X		X	X
Rhode Island	X		X		X	X			
South Carolina									
South Dakota	X	X							
Tennessee									
Texas	X	X	X		X			X	
Utah	X	X	X		X				
Vermont		X							
Virginia	X	X					X		
Washington						X	X		
West Virginia	X	X	X	X	X		X	X	X
Wisconsin	X	X							
Wyoming	X	X					X	X	
Total	**29**	**40**	**15**	**18**	**15**	**12**	**21**	**19**	**13**

*Pharmacy controls include states that began or increased beneficiary co-payments for prescription drugs.
**Co-payments category includes states that began or increased beneficiary co-payments for health care services other than prescription drugs.

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