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The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005

Results from a 50-State Survey

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Kaiser Commission on Medicaid and the Uninsured

October 2004

THE HENRY J. KAISER FAMILY FOUNDATION

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

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The authors acknowledge with great appreciation the cooperation and assistance of Medicaid directors and their staff in all 50 states and the District of Columbia. Without exception, these officials graciously and generously offered their time to complete the survey on which this study is based, and to provide information about their programs and their plans for the future. Without their help the study could not have been carried out, and we truly appreciate their assistance.

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Executive Summary

For the fourth consecutive year, the Kaiser Commission on Medicaid and the Uninsured has worked with Health Management Associates to survey state Medicaid officials about their Medicaid spending growth and cost containment plans. This report describes the findings of the most recent survey that was completed in the summer of 2004 as most states were ending the 2004 fiscal year and entering the 2005 fiscal year. The report also looks at these changes in the context of Medicaid cost containment actions taken since 2002.

As states completed FY 2004 and enter FY 2005, they are faced with a mix of good and bad news. After more than three years of intense fiscal stress, FY 2004 marked a turning point for state revenues and for budget shortfalls. After sharp declines, state revenues started to improve and budget shortfalls started to shrink. States were also helped in FY 2004 by $20 billion in temporary federal fiscal relief including $10 billion directly for Medicaid. During FY 2005, revenues are expected to continue to grow, but FY 2005 also marks the end of the temporary federal fiscal relief. Many states are facing large budget shortfalls totaling about $40 billion. While smaller than in previous years, these shortfalls continue to place great stress on state budgets.

Throughout the period of fiscal stress, Medicaid, the nation's largest public health insurance program that provides insurance coverage and long-term care services to over 52 million low-income children, families, seniors and people with disabilities, faced competing demands. During periods of economic downturn, Medicaid plays an important safety-net role when enrollment grows as a result of increases in the number of people living in poverty. At the same time, Medicaid was under intense pressure to control costs because it is the second largest program in most state budgets and because Medicaid has been growing faster than other state programs. In response, states have implemented a series of measures designed to slow the rate of growth in Medicaid spending including reductions in Medicaid eligibility, benefits and provider payments. These measures have helped to constrain costs, but have also placed an additional burden on Medicaid beneficiaries and the providers who serve them.

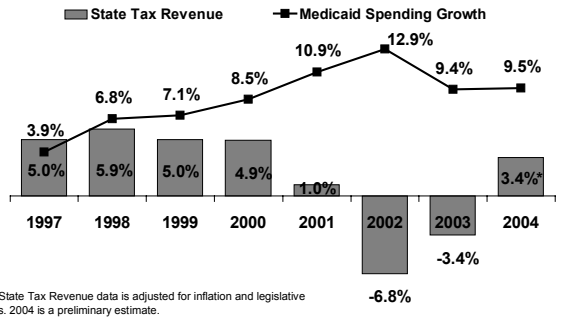
The key findings from the latest survey include the following:

Despite severe state fiscal stress, Medicaid enrollment grew by nearly one-third since the beginning of 2001 as the program maintained its role as a critical safety-net for low-income populations. Medicaid enrollment growth was 5.2 percent in FY 2004 and is expected to grow at the significant but somewhat slower rate of 4.7 percent in FY 2005. While these rates are slower than growth for the preceding years, the cumulative effect of enrollment growth since FY 2001 has been significant. New census data shows an increase in the numbers and percentages of people in poverty as well as those without private health insurance. Medicaid has served as a critical safety-net for many of these individuals, especially for children, who fell into poverty during the economic downturn. Without Medicaid, many of these individuals would have otherwise been uninsured.

Medicaid spending in FY 2003 and FY 2004 grew faster than other state programs, but slower than growth in private health insurance premiums. Over the past four years, every state and the District of Columbia has adopted budget-driven Medicaid cost containment policies and initiatives. However, even with the aggressive actions taken by states, Medicaid spending has been increasing at a rate that outpaces state expenditure growth and the annual growth in the state revenues that support the program at the state level. In FY 2004, overall Medicaid spending increased on average by 9.5 percent, virtually matching the 9.4 percent increase that occurred in FY 2003 (Figure 1). This is slower than the 11.9 percent growth for Medicaid over the period from FY 2000 to FY 2002. Reflective of rising health costs, private health insurance premiums grew by 11.2 percent from 2003 to 2004. Like private health insurance, prescription drug costs and overall health care costs have been key drivers of Medicaid spending growth. Unlike private health insurance that has eroded during the economic downturn, enrollment growth, driven by the large increase in poverty, was most frequently cited by states as the primary driver of Medicaid spending.

Figure 1

Underlying Growth in State Tax Revenue Compared with Average Medicaid Spending Growth, 1997-2004



NOTE: State Tax Revenue data is adjusted for inflation and legislative changes. 2004 is a preliminary estimate.

SOURCE: Analysis by the Rockefeller Institute of Government of data from the Bureau of the Census, Bureau of Economic Analysis and the National Association of State Budget Officers.

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Responding to pressure to control Medicaid costs, all 50 states and the District of Columbia implemented actions designed to control Medicaid spending growth in FY 2004 and all states planned to implement cost containment measures in FY 2005. The KCMU survey found that every state in the nation, including the District of Columbia, implemented at least one new Medicaid cost containment strategy in FY 2004 and then again in FY 2005.[1] According to the survey, 39 states were facing increased pressure and another 12 states were facing constant, but intense pressure to control Medicaid costs. For FY 2005, 47 states adopted plans to freeze or reduce provider payments, and 43 states planned pharmacy cost controls to reduce overall Medicaid spending growth (Figure 2). In addition, 15 states made plans to restrict eligibility, nine states planned to reduce or restrict benefits and nine states reported plans to increase co-payments in FY 2005. Some of the more dramatic eligibility reductions in FY 2005 were accomplished through the use of 1115 Waivers that are now being considered more

widely by states as a method of cost containment. Three important trends emerged in FY 2005:

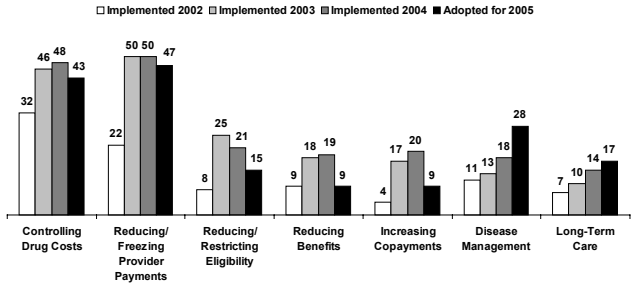
- Compared to FY 2004, fewer states in FY 2005 took new actions to control prescription drug costs, cut or freeze provider rates, reduce or restrict eligibility or benefits, or to increase beneficiary co-payments. After multiple years of cost containment, many state officials felt they could not cut any deeper in these areas. States are also now realizing the cost saving impact of prior year actions.

- More states plan to implement cost containment actions directed at the elderly and disabled through disease management programs and long term care initiatives in FY 2005. Many states may be turning to these strategies because these are high cost populations and because they have exhausted other options.

- After several years of Medicaid reductions, some states have plans to restore previous Medicaid cuts or actually expand programs in FY 2005.

Figure 2

States Undertaking New Medicaid Cost Containment Strategies FY 2002 – FY 2005



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003 and October 2004.

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Federal fiscal relief helped states meet Medicaid shortfalls in FY 2004 and helped to maintain Medicaid eligibility levels; however, states are expecting sharp increases in the state share of Medicaid costs in FY 2005 as they replace the loss of the enhanced federal support. The temporary 2.95 percent enhanced federal matching rate (FMAP), enacted as part of the Jobs and Growth Tax Relief Reconciliation Act of 2003, was in place for fifteen months but expired on June 30, 2004. States reported that the enhanced FMAP helped avoid or minimize Medicaid cutbacks that otherwise would have occurred in FY 2004. To be eligible for the federal fiscal relief, states were prohibited from making reductions to eligibility standards. This provision helped to protect Medicaid eligibility during the time that the fiscal relief was in place. The state share of Medicaid costs increased by 4.8 percent in FY 2004 and is expected to increase by 11.7 percent in FY 2005 as states return to the previous Medicaid matching rate formula and lose the temporary enhanced federal support. Several states indicated this caused added fiscal stress on development of their Medicaid budgets in FY 2005.

Implementation of the Medicare Prescription Drug Benefit will generate significant fiscal and administrative challenges for state Medicaid programs and only three states reported they have allocated resources in FY 2005 to meet these challenges. States have a number of concerns related to the Medicaid impacts of the Medicare Modernization Act. The most significant concern, raised by over three-fourths of states, related to the "clawback," a provision in the Medicare law that requires states to make payments to the federal government to help finance the Medicare drug benefit for dual eligibles. States expressed concern that the clawback will more than offset any potential savings, and states will face a net increase in costs when the Part D Medicare drug benefit begins in 2006. States will also be faced with new administrative requirements related to the determination of eligibility for subsidies for low-income beneficiaries eligible for both Medicaid and Medicare in the near term and general implementation of Medicare Part D beginning in FY 2006. Only California, New York and Rhode Island dedicated resources in FY 2005 budgets to meet these implementation challenges.

States are approaching FY 2005 with caution. While revenues are improving overall, many states still face budget shortfalls and pressure to control Medicaid spending growth will continue. On the positive side, state Medicaid officials expect lower growth rates for Medicaid spending and enrollment in FY 2005. States also anticipate that their revenues will continue to rebound, providing some relief from the intense budget stress that has characterized the past four years. However, initial state appropriations for Medicaid spending are low, some states already face budget shortfalls in FY 2005, and Medicaid spending is projected to increase faster than state revenues. As a result, the outlook as seen through the eyes of Medicaid officials is another year of significant efforts to control spending growth.

Meeting the challenges of rising numbers of uninsured Americans, who are low-income, as well as the implementation of the new Medicare prescription drug benefit puts additional strain on Medicaid and state budgets. Additional federal funding support for the Medicaid program could be necessary to address both the long-term care needs of the elderly and people with disabilities and expand coverage of the uninsured in an environment of limited state resources and rising health care costs. These efforts to contain Medicaid spending growth reflect the realities of state budgets and competing priorities, but leave gaps in the ability of Medicaid to meet its growing responsibilities as the nation's safety-net for health and long-term care.

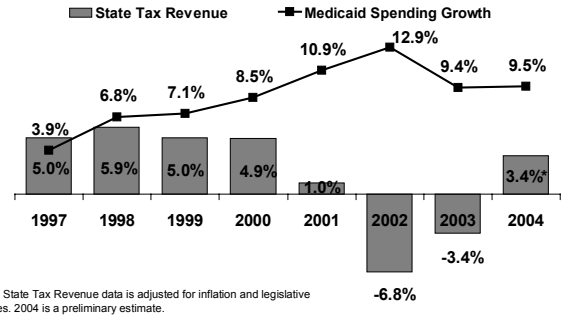
Introduction

The focus of this report is on current trends in Medicaid spending, enrollment, cost-containment and other policy-making during a time of significant, on-going state budget stress. When the economic downturn began in 2001, state revenues dropped dramatically and states experienced budget shortfalls of close to $200 billion from 2002 to 2004.[2] States implemented efforts to reduce spending across all state programs and every state adopted budget-driven Medicaid cost control policies to meet looming budget shortfalls. The federal government provided $20 billion in temporary fiscal relief in May 2003 to help address these difficult fiscal conditions.

After two years of decline, state tax revenue growth was positive in 2004 and is expected to continue to grow in FY 2005 (Figure 3). Despite this good news, revenue growth remains slow in many areas of the country, including states in the Great Lakes and Plains areas of the United States.[3] About 30 states face budget shortfalls totaling about $40 billion in FY 2005.[4] Meanwhile, pressure to control Medicaid growth remains strong. The program continues to experience strong growth attributable to growing enrollment, rising prescription drug costs and overall health care costs growth even though states have implemented aggressive cost containment actions over the last several years. In fiscal year 2004 states continued to focus on efforts to control Medicaid spending and have more plans to control costs in fiscal year 2005.

Figure 3

Underlying Growth in State Tax Revenue Compared with Average Medicaid Spending Growth, 1997-2004



NOTE: State Tax Revenue data is adjusted for inflation and legislative changes. 2004 is a preliminary estimate.

SOURCE: Analysis by the Rockefeller Institute of Government of data from the Bureau of the Census, Bureau of Economic Analysis and the National Association of State Budget Officers.

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[2] Center on Budget and Policy Priorities, *A Brief Update on State Fiscal Conditions and the Effects of Federal Policies on State Budgets*, September 13, 2004.
[3] Nicholas Jenny, The Nelson A. Rockefeller Institute of Government, *Strong Finish for Many States' Fiscal Years: Preliminary April-June Quarterly State Tax Revenue Data*, August 2004.
[4] Center on Budget and Policy Priorities, *A Brief Update on State Fiscal Conditions and the Effects of Federal Policies on State* Budgets, September 13, 2004.

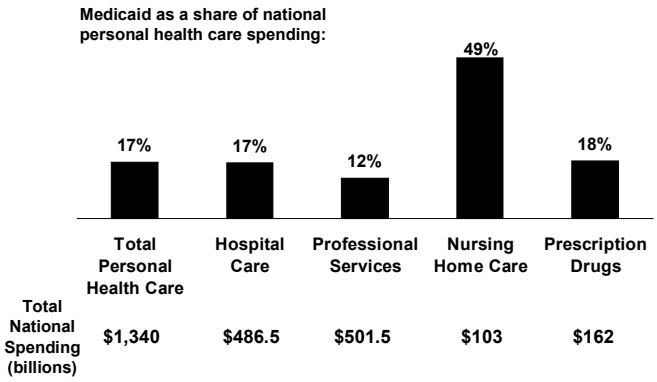
Since 2001, the Kaiser Commission on Medicaid and the Uninsured (KCMU) has worked with Health Management Associates (HMA) to survey the changes states are making to their Medicaid programs and budgets during a time of fiscal stress. This report focuses on changes in FY 2004 and FY 2005, but also places these changes into the context of all the changes that have occurred over the last few years. This report also includes a section on the outlook for Medicaid's role in the implementation of the new Medicare Part D prescription drug benefit, and the concerns articulated by Medicaid directors as they assessed their new role and the implications for Medicaid in this significant new federal policy.

Background: The Medicaid Program and State Budgets

Medicaid is the nation's largest public health insurance program providing health and long-term care coverage to 52 million low-income people in FY 2004. By comparison, Medicare serves 42 million individuals. Medicaid covers children, families, seniors, and people with disabilities, and fills in gaps in Medicare coverage for seniors, especially for prescription drugs and long-term care. On average, Medicaid covers about one in every nine Americans. To meet the broad needs of the population it serves, Medicaid covers a range of comprehensive services, including physician and hospital care, nursing home care and prescription drug coverage. Medicaid also plays a major role in our country's health care delivery system, paying for nearly half of all nursing home care and 18 percent of prescription drugs (Figure 4).

Figure 4

Medicaid's Role in the Health System, 2002



SOURCE: Levit, et al, 2004. Based on National Health Care Expenditure Data, Centers for Medicare and Medicaid Services, Office of the Actuary.

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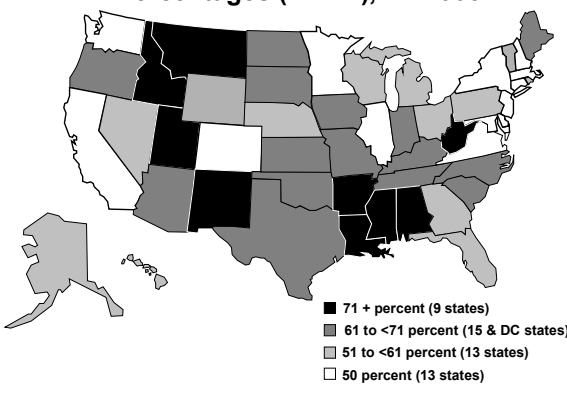
The Medicaid program is jointly funded by states and federal government. For FY 2004, total Medicaid expenditures will exceed $300 billion, an amount just slightly greater than total Medicare spending. The federal government matches state spending for the services Medicaid covers on an open-ended basis. The federal matching rate, known as the federal medical assistance percentage (FMAP) varies by state from 50 to 77 percent (Figure 5).

Figure 5

Federal Medical Assistance Percentages (FMAP), FY 2005



SOURCE: Federal Register: December 3, 2003

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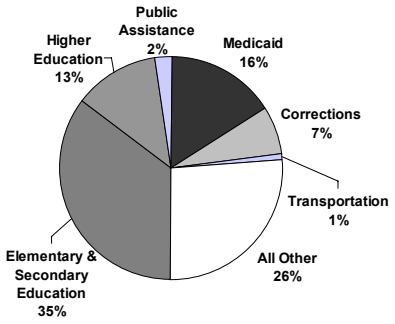
Because of the matching formula, state spending on Medicaid brings increased federal dollars to the state. For example, at a 50 percent matching rate, a state draws down an additional $1.00 for every dollar it spends. Likewise, at a 70 percent matching rate, a state draws down an additional $2.33 for every $1 it spends. Medicaid's matching formula provides an important incentive for states to increase funding for health and long-term care services because of the ability to access federal matching dollars. Medicaid is single largest source of federal grant support to states, representing 43 percent of all federal grants to states. On average, states spend about 16 percent of their own funds on Medicaid making it the second largest program in most states' general fund budgets (Figure 6).

Figure 6

State Medicaid Spending as a Percent of General Fund Expenditures, 2002



Total State General Fund Spending = $496 billion

SOURCE: National Association of State Budget Officers, 2002 State Expenditure Report, November 2003.

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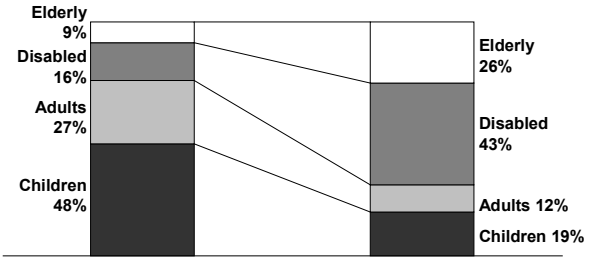
States have the responsibility to design and administer their Medicaid program within the federal rules that define the terms and conditions under which a state can earn federal matching funds. Within the federal structure, states enroll beneficiaries using their own eligibility criteria, decide which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

Medicaid expenditures vary by the population being served. Low-income children and their parents represent about three-fourths of Medicaid beneficiaries, although their health coverage is less expensive as they account for just 30 percent of Medicaid spending (Figure 7). Most of Medicaid's costs are directed towards persons with disabilities and the elderly. The elderly and persons with disabilities represent just one-quarter of Medicaid enrollees, but they account for 70 percent of Medicaid spending, reflecting their intensive use of acute and long-term care services. Medicaid also plays a

significant role in supplementing Medicare coverage for 7 million seniors and people with disabilities who are enrolled in both programs. For these people, Medicaid covers services Medicare does not, most notably prescription drugs and long-term care, and assists with Medicare premiums and cost sharing.

Figure 7

Medicaid Enrollees and Expenditures by Enrollment Group, 2003



Expenditure distribution based on CBO data that includes only federal spending on services and excludes DSH, supplemental provider payments, vaccines for children, administration, and the temporary FMAP increase. Total expenditures assume a state share of 43% of total program spending.
SOURCE: Kaiser Commission estimates based on CBO and OMB data, 2004.

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Beginning in 2001, as the national economy worsened and growth in state tax revenue slowed, states were forced to scale back state spending for all services, from education to health care. The severity of state fiscal conditions forced states to consider difficult options that have affected health coverage for millions of low-income people in every state. Over the past few years, every state has implemented measures to limit prescription drug costs and cut or freeze provider payment rates.

In response to extraordinary state fiscal pressures, in May 2003, Congress passed the Jobs and Growth Tax Relief Reconciliation Act of 2003 that provided $20 billion in temporary federal fiscal relief to the states to ease budgetary pressures. $10 billion of the fiscal relief was provided through a temporary increase in the federal share of Medicaid spending, and an additional $10 billion was provided in temporary grants for states to use for Medicaid or other state programs. This fiscal relief proved instrumental in helping states to meet Medicaid and state budget shortfalls, avoid making potentially larger Medicaid program cuts, and to preserve eligibility.

As states enter fiscal year 2005, revenue has been growing for the last three quarters and is expected to continue to grow. However, many individual states are expecting large budget shortfalls for FY 2005 and Medicaid costs will continue to grow. These factors will continue to exert enormous pressure on Medicaid programs to reduce or control costs.

Additionally, state budgets and Medicaid programs will face a number of new challenges. First, federal fiscal relief ended on June 30, 2004 and the state share of Medicaid expenditures is expected to increase significantly in FY 2005 over FY 2004 levels. Second, states will also face a number of challenges as they move forward to implement their responsibilities for the Medicare prescription drug benefit. Third, Medicaid will

continue to be pressured by increasing poverty and eroding employer sponsored health coverage. The latest census data show that there were increases in the number and percentage of Americans living in poverty and as well as the number and percentage of Americans without health insurance. Finally, CMS has imposed higher scrutiny over how states finance their Medicaid programs that could have the effect of limiting federal resources for the program.

As a result, states will continue to look for new ways to control the growth of spending in their Medicaid programs. Some states have turned to Medicaid 1115 Demonstration Waivers in an attempt to control Medicaid costs. While Medicaid 1115 Waivers are not new, some of the waivers recently approved or under review include features such as enrollment caps, reduced benefits and increased premiums or cost sharing. Some of these design features have serious implications for beneficiaries such as eliminating the guarantee for coverage and limiting access to care. Additionally, these waivers shift the risks of higher than anticipated costs to the states, providers and beneficiaries. The role of 1115 Waivers as well as discussions about restructuring the Medicaid program will continue to play out through the FY 2005 year ahead.

Methodology

This report is based on a survey of Medicaid officials in all 50 states and the District of Columbia conducted by Health Management Associates (HMA) for the Kaiser Commission on Medicaid and the Uninsured (KCMU). This is the fourth annual KCMU/HMA survey designed to track trends in Medicaid spending and policy making during a time of significant state budget pressures. In addition to the annual surveys, mid-year update surveys were conducted for fiscal years 2001, 2003 and 2004 to provide further information as states continued to implement additional budget-driven cost containment actions after the beginning of those fiscal years.

The current survey was designed specifically to document the actions states took in state fiscal year 2004 and that they are implementing or expect to implement in state fiscal year 2005.[5] The survey for this report was conducted in July and August of 2004 to reflect the fact that the fiscal years for most states begin on July 1.[6] In most cases, state legislatures had completed their sessions or their decisions on the FY 2005 Medicaid budget at the time of the survey. In seven states, the state legislature had not yet adopted the FY 2005 budget at the time of the survey.[7] In these cases HMA finalized the state survey as late as mid-September as Medicaid budget decisions were made.

The 2004 survey instrument was designed to provide information that was consistent with previous surveys. However, as with previous surveys, specific questions were added to reflect current issues. For this survey, questions were included to understand the impacts of the end of the enhanced federal Medicaid match on June 30, 2004 and of the Medicaid implications of the new Medicare prescription drug benefit.[8]

The data for this report was provided directly by Medicaid directors and other Medicaid staff. The survey instrument was sent to each Medicaid director in mid-June 2004. Then, personal telephone interviews were scheduled during July and August 2004. The purpose of the telephone interview was to review the written responses or to conduct the survey itself, if the survey had not been completed in advance. These interviews were invaluable to clarify responses and to record the nuances of state actions. Generally, the interview included the Medicaid director along with policy or budget staff. In a limited number of cases the interview was delegated to a Medicaid budget or policy official. Responses were received from and interviews conducted for all 50 states and the District of Columbia.

With regard to FY 2005, the survey asked state officials to report only new policy changes that were already implemented for FY 2005 or for which a decision had been made to implement during FY 2005. In some cases these actions were put in place on

[5] For previous survey results, see the following links: http://www.kff.org/medicaid/7001.cfm; http://www.kff.org/medicaid/kcmu4137report.cfm; http://www.kff.org/medicaid/4082-index.cfm

[6] Fiscal years begin on July 1 for all states except for four: New York on April 1, Texas on September 1, Alabama, Michigan and the District of Columbia on October 1.

[7] Alaska, California, Kentucky, Massachusetts, Michigan, Mississippi and Rhode Island were the seven states that had not adopted their budgets at the time the survey was originally completed.

[8] The survey instrument is included as Appendix L to this report.

July 1. In other cases, actions were to be implemented during the year when the necessary systems changes and notice requirements were completed. Often, these actions involve complex administrative changes, computer system updates or specific advance notice requirements. Sometimes, policy changes prove too difficult or complex to be implemented within the original timelines. In other instances, policies still under consideration are not recorded in this survey even though they may be implemented in FY 2005. Thus, the actions reported here for FY 2005 are those that Medicaid programs had been directed to implement and which they expected to implement as they began the fiscal year.[9] The actions reported here for FY 2004 are those actually implemented in that year.

Where possible, data from previous surveys are referenced to provide trends, context and perspective for the results of this survey. In particular, this was done to describe selected state Medicaid cost containment activities over a four-year period from fiscal years 2002 to 2005, in addition to showing the number of states implementing these actions in FY 2004 and FY 2005.

[9] For this reason, this survey identified some changes in the number of states carrying out changes in a given fiscal year. For example, in our January 2004 survey update, 43 states indicated plans to implement measures to control drug costs. In the current survey, 48 states reported that they implemented drug cost controls in FY 2004. Similarly, in January 39 states planned on reducing or freezing provider payments, but this survey showed that 50 states implemented some provider reduction or freeze. In January 2004, 18 states planned on eligibility restrictions, 17 planned on benefit reductions and 21 planned on increasing co-payments. This report showed that 21 states implemented eligibility restrictions, 19 states implemented benefit reductions and 20 implemented increasing co-payments in FY 2004. The overall number of states taking undertaking cost containment plans remained at 50 states and the District of Columbia.

Survey Results: State Medicaid Policy Changes for Fiscal Years 2004 and 2005

This recent survey found that despite an improving fiscal situation, states continued to focus on Medicaid cost containment and other actions designed to slow the rate of growth in Medicaid spending. Every state in the country implemented some form of Medicaid cost control measure during FY 2003 and FY 2004. Again, as policymakers made decisions for FY 2005, they once again were under great pressure to rein in Medicaid spending. As of September 2004, all 50 states and the District of Columbia had adopted plans to implement at least one new measure to control the growth in Medicaid spending for FY 2005.

For FY 2005, state officials reported a continued focus on measures to slow the rate of growth in Medicaid spending; however, fewer cost containment initiatives were adopted in FY 2005 compared to FY 2004 in some areas such as reductions in provider payments, eligibility and benefits while states implemented additional cost containment initiatives in other areas such as disease management and long term care. Several reasons for this behavior include the following:

- Some state officials indicated that they had virtually exhausted available options for cost control or had gone as far as they could in some areas and needed to turn to new initiatives.

- State officials indicated that they were just beginning to see the cost saving impacts of measures adopted in FY 2004, and they did not have the administrative capacity to begin implementation of a new set of cost containment strategies.

- Other states indicated that the enhanced federal matching funds in FY 2004 had provided sufficient fiscal relief to allow the state to avoid further Medicaid cutbacks, or that an improving state revenue situation had reduced the pressure for more intensive cost cutting.

Nevertheless, the 2004 survey documented a wide range of initiatives that were implemented in 2004 and those that are scheduled to be implemented in 2005.

The 2004 survey results are presented below in the following order:

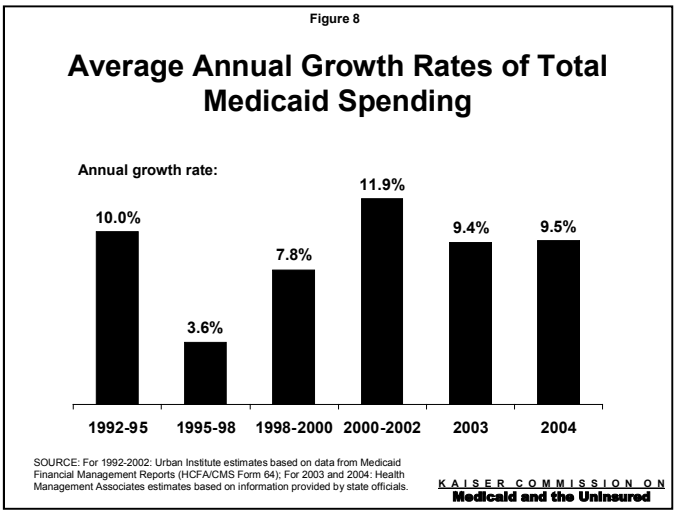
1. Medicaid Spending Growth Rates;
2. Medicaid Enrollment Growth;
3. Factors Contributing to Increasing Medicaid Expenditures;
4. Medicaid Cost Containment Measures;
5. Provider Taxes;
6. Impact of 2003-2004 Federal Fiscal Relief;
7. Impact of Increased Scrutiny of Special Financing Arrangements;
8. Impact of the Medicare Prescription Drug Benefit, and
9. The Outlook for FY 2005

1. Medicaid Spending Growth Rates

The survey asked states to report their total Medicaid spending growth from FY 2003 to FY 2004. Total Medicaid spending reflects actual Medicaid payments to medical providers for the services they provide to Medicaid beneficiaries. Total Medicaid spending also includes special payments to providers such as Disproportionate Share Hospital (DSH) payments, but does not include Medicaid administrative costs. Total Medicaid spending includes all funding sources, including the state, local and federal funds that finance Medicaid spending.[10]

In FY 2004, total Medicaid spending increased on average by 9.5 percent. The increase in total Medicaid spending in FY 2004 was slightly higher than the 9.4 percent growth rate reported for 2003,[11] but lower than the 11.9 percent average annual rate of growth that occurred over the 2000-2002 period (Figure 8). [12]

Figure 8



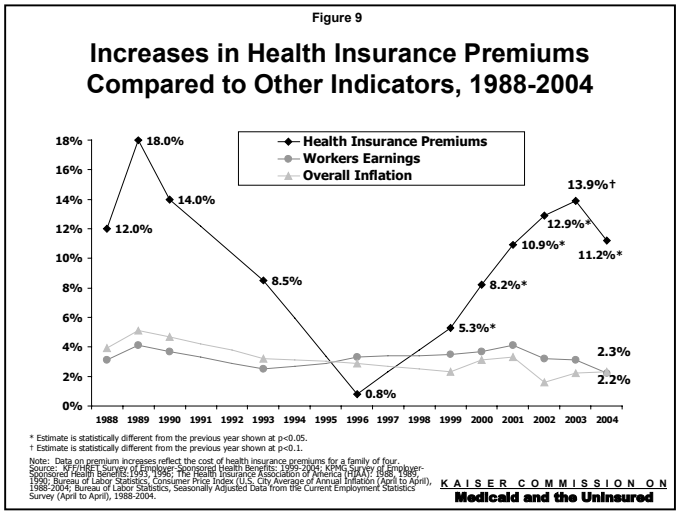
[10] Due to differences in the placement of the Medicaid agency across states, there is variation in what is included in the growth trends. For example, programs administered by other state agencies such as Medicaid funded mental health services are not included for every state. However, data is consistent over time for a particular state, so the trends are accurate.

[11] Average spending for FY 2003 and FY 2004 was calculated across all 50 states on a weighted basis, using total Medicaid spending by states as reported by the National Association of State Budget Officers, *State Expenditure Report,* to be released in October 2004. Prior to the January 2004 report, spending averages have been reported on an unweighted basis.

[12] Medicaid spending is often described in periods to reflect significant events occurring over that time. From 1992 to 1995, Medicaid spending growth dropped considerably compared to growth from 1990 to 1992 due to Congressional efforts to control DSH expenditures, slower enrollment growth, and slower growth of spending per enrollee. From 1995 to 1998, annual Medicaid spending grew at some of the lowest rates in the history of the program. Restrictions on DSH payments and declining enrollment were the key factors limiting growth. Total enrollment of adults and children fell by 1.5 million people from 1995 to 1997 as a strong economy and state and federal welfare reform efforts decreased participation in cash assistance programs. Total enrollment of aged and disabled people continued to increase but much slower than the rate of growth from 1990 to 1995. From 1998 to 2000 states controlled Medicaid growth by limiting provider payment rates and using managed care; however, spending per enrollee grew faster from in this period than in the previous period. Medicaid growth accelerated in the 2000 to 2002 period due to the economic downturn and overall increases in health care costs.

In FY 2002 total Medicaid spending had grown at the highest rate in a decade. FY 2003 marked a turning point, in that it was the first year since 1995 that the rate of growth in Medicaid spending was less than the previous year. As described below, Medicaid spending growth was lower than the growth in private health insurance premiums but higher than the growth rate for other state programs.

Medicaid spending growth can also be compared to the growth of private health insurance premiums. Both Medicaid and the private insurance market face similar cost pressures from changes in the health care market place such as higher costs for prescription drugs and hospital services and new technology. These factors have caused costs to grow much faster than the rate of inflation both for Medicaid and the private sector. Both sectors have also worked to contain health care costs by implementing various strategies such as disease management programs. However, unlike the private sector, Medicaid coverage has expanded during the economic downturn as more people fell into poverty and became eligible for the program while employer sponsored coverage has eroded as employers dropped coverage or rapidly increasing premium costs made it unaffordable for employees to participate. In 2004, the overall Medicaid growth of 9.5 percent reflects growth in per capita costs and the increasing number of persons enrolled in the program. This aggregate Medicaid spending increase of 9.5 percent was lower than the per capita rate of growth in premiums for employer-sponsored health insurance that was 11.2 percent. 2004 marked the fourth consecutive year of double-digit growth for private insurance premiums (Figure 9).[13]



A key consideration when states make their spending and policy decisions for Medicaid is the state share of total Medicaid costs. In FY 2004, the state share of Medicaid spending was affected by federal legislation that temporarily increased the federal share and reduced the state share of Medicaid spending. The Jobs and Growth Tax Relief

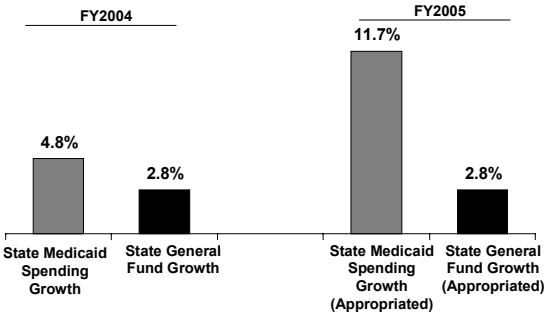
[13] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, "2003 Annual Employer Health Benefits Survey, September 2003, http://www.kff.org/insurance/7148/index.cfm

Reconciliation Act of 2003, enacted in May 2003, included a temporary increase of 2.95 percentage points in the federal Medicaid matching rate (the "Federal Medical Assistance Percentage," or FMAP) for all states for the 15-month period from April 2003 through June 2004. As a direct result, the state share of Medicaid spending grew at a much slower rate than total Medicaid expenditures over this period. In FY 2004 total Medicaid spending grew by 9.5 percent, but the state share of Medicaid spending increased only 4.8 percent. With the end of the fiscal relief, state spending is expected to increase faster than total spending in FY 2005.

Even Medicaid state spending growth of 4.8 percent was greater than the growth for other state programs in FY 2004. State expenditures for all programs grew only by an estimated 2.8 percent in fiscal year 2004 and legislative spending authorizations for FY 2005 increased again by 2.8 percent again (Figure 10).[14] While 2.8 percent growth for state expenditures is higher than growth of less than one percent in 2003, these recent growth rates are far below average growth over the 1979 to 2005 period of 6.2 percent.[15]

Figure 10

State Spending Growth for Medicaid vs. Nominal State General Fund Spending



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2003 and July 2004. NGA/NASBO Fiscal Survey of the States, April 2004

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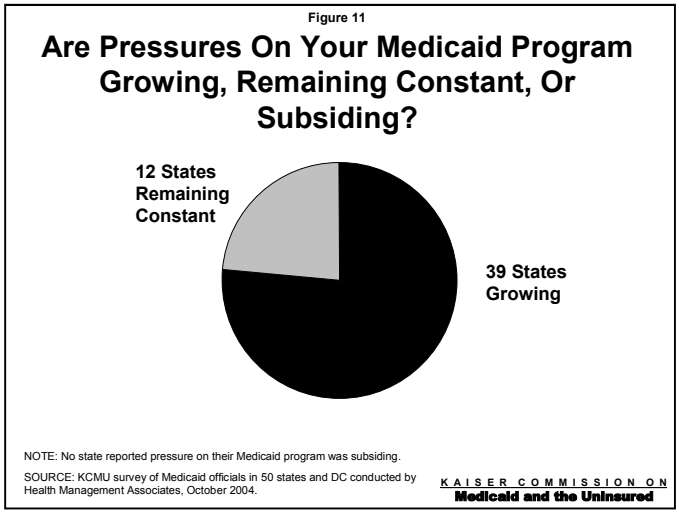
Given these growth rates in Medicaid spending compared to other state programs, it is not surprising that when asked whether pressures on the Medicaid program were growing, subsiding or remaining constant, Medicaid officials in more than three-fourths of states (39 states) responded that pressures were "growing." Twelve states said that pressures were remaining constant and no state reported their pressure was subsiding (Figure 11). Even in these states, officials sometimes commented that pressure on Medicaid remained intense. State officials indicated that the fact that Medicaid continues to command a greater share of state spending, growing at the expense of education or other state programs, has meant increasing pressure to find a way to slow the rate of growth in state Medicaid spending.

[14] National Governors Association and National Association of State Budget Officers, Fiscal Survey of States, June 2004

[15] NGA/NSBO Fiscal Survey of the States, April 2004.

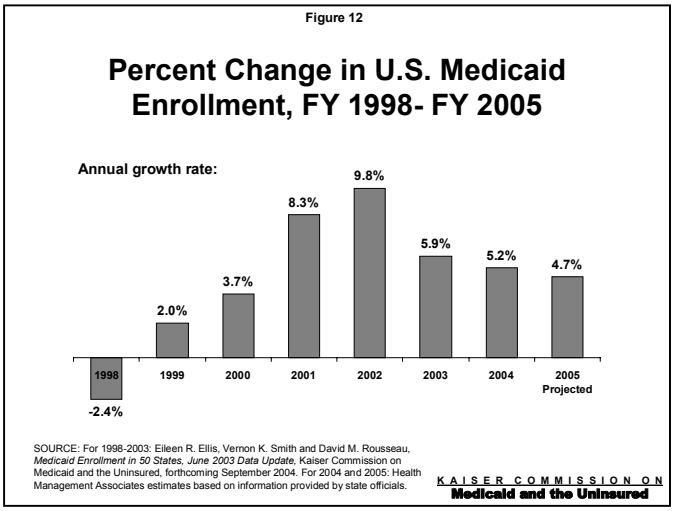
Figure 11



2. Medicaid Enrollment Growth

The number of persons enrolled in Medicaid continued to grow at a significant pace in FY 2004, but at a slower rate than occurred in the previous three years. State Medicaid officials reported total Medicaid enrollment growth averaged 5.2 percent for FY 2004, down from 5.9 percent in FY 2003 (Figure 12). For FY 2005, state officials projected Medicaid enrollment growth that would average 4.7 percent.[16] Medicaid enrollment has increased each year since 1999, with the average rate of growth peaking in FY 2002 at 9.8 percent.[17]

Figure 12



[16] Percentage changes for enrollment growth in this report reflect weighted averages across states. Those averages are calculated on a weighted basis by total enrollment in June 2003, as reported in: Eileen R. Ellis, Vernon K. Smith and David M. Rousseau, *Medicaid Enrollment in 50 States, June 2003 Data Update,* Kaiser Commission on Medicaid and the Uninsured, forthcoming October 2004.

[17] Eileen R. Ellis, Vernon K. Smith and David M. Rousseau, *Medicaid Enrollment in 50 States, June 2003 Data Update,* Kaiser Commission on Medicaid and the Uninsured, September 2004.

When asked to identify the most significant factors contributing to enrollment growth in their state in FY 2004, Medicaid officials responded:

- The economic downturn and an associated increase in the number of low-income uninsured persons newly eligible for Medicaid.[18] (listed as the most significant factors by 23 states)

- Impact of previous or current eligibility expansions and restorations (listed as the primary factor by 10 states)

- Demographic changes especially among the disabled and elderly categories (listed as the primary factor by 3 states)

- Increased outreach for other programs such as, the State Children's Health Insurance Program or food stamp program (listed as the primary factor 3 states)

Most Medicaid officials mentioned children and families, the groups most affected by the economy, as having the biggest impact on Medicaid enrollment growth in FY 2004. However, seven states identified the aged and disabled as contributing most to enrollment changes in FY 2004 (and nine states mentioned these groups as contributing most to enrollment growth in FY 2005). Because elderly and disabled beneficiaries are so much more expensive to cover on average than children and families, some Medicaid officials indicated that their cost growth was primarily due to the elderly and disabled even though enrollment growth was less dramatic for these eligibility groups.

Medicaid enrollment changes are often based on economic circumstances in that year and policy changes implemented in the prior years. In FY 2004, Medicaid enrollment continued to increase in almost all states. Three states reported specific enrollment decreases that occurred in FY 2004:

- Massachusetts reported a 2.0 percent decrease. This decline can be attributed to a reduction in coverage for long-term unemployed individuals from April 2003. While this program was restored in October 2003, enrollment is still significantly lower than before due to tightened eligibility processes.

- Oregon reported a 9.9 percent decrease. In FY 2003, Oregon eliminated its Medically Needy program and imposed new premium requirements in its "OHP (Oregon Health Plan) Standard" Medicaid waiver program resulting in a decline in enrollment in FY 2004.[19]

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[18]The Urban Institute has estimated, for example, that a one percent increase in the unemployment rate adds 1.5 million people to the Medicaid program, at a cost of $1 billion in state Medicaid spending. "Medicaid Coverage During Rising Unemployment, Kaiser Commission on Medicaid and the Uninsured," December 2001, http://www.kff.org/content/2001/4026/4026.pdf

[19] For a discussion of the impact of these changes on enrollments and access to care, see Cindy Mann and Samantha Artiga, *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program,* The Kaiser Commission on Medicaid and the Uninsured, June 2004, Publication No. 7100.

- South Carolina reported an 8.0 percent decrease.[20] This decrease is the result of actions taken in FY 2003 that tightened some of their eligibility processes for families and children in FY 2003. One of the changes was "elimination of passive review" of eligibility for Medicaid children, which resulted in a significant decrease in the number low-income children enrolled in Medicaid.

For FY 2005, two states projected enrollment decreases. Oregon projected a further 9.6 percent decrease as a result of its decision to close enrollment in the Oregon Health Plan (OHP) Standard Medicaid program. Michigan indicated that its Medicaid budget for FY 2005 is based on an assumption that lower unemployment will lead to a 2.0 percent enrollment decrease. The impact of eligibility reductions planned for FY 2005, such as those discussed later for Mississippi, may not be evident until FY 2006.

3. Factors Contributing to Increasing Medicaid Expenditures

State Medicaid officials were asked to identify the factors they believed had been most significant in causing Medicaid spending to increase in their state over the past year, FY 2004, and also for FY 2005. This was an open-ended, non-structured question. Responses were grouped into five categories: enrollment growth, growth in prescription drug costs, increasing health care costs, long term care and other.[21]

Three key factors emerged as the top drivers of Medicaid spending growth in FY 2004: Medicaid enrollment growth, prescription drug cost growth, and increasing costs of medical services. The factors contributing to expenditure growth in FY 2004 were similar to those identified in our previous surveys as top drivers of Medicaid costs. For FY 2005, Medicaid officials indicated in general that the same factors would continue to drive Medicaid spending.

Since FY 2002, the top three factors driving Medicaid spending have remained fairly constant; however, the factor most frequently listed as the most significant contributor to Medicaid spending has changed. In FY 2004 and again in FY 2005, enrollment growth was most frequently listed first as the most significant contributor to Medicaid spending growth followed by increasing costs of prescription drugs, the rising costs of medical care, and then long-term care. In FY 2002 and FY 2003, the increasing cost of prescription drugs was most frequently listed first followed by increasing growth in Medicaid caseloads.

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[20] South Carolina continued to see the impact of actions taken in FY 2003 that tightened some of their eligibility processes for families and children in FY 2003. Among the South Carolina changes was "elimination of passive review" of eligibility for Medicaid children, which resulted in a significant decrease in the number low-income children enrolled in Medicaid.

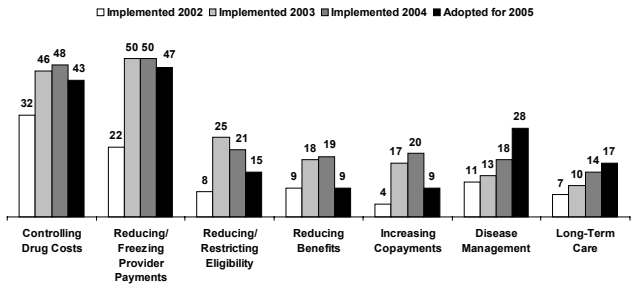
[21] For example, increasing enrollment included responses such as "higher caseloads," "more eligibles," or "higher numbers of recipients." Pharmacy cost growth included factors such as "increasing costs of drugs," "higher utilization of drugs," higher product costs for drugs." A group labeled "increasing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

4. Medicaid Cost Containment Measures

The survey found that every state in the nation, including the District of Columbia, implemented at least one new Medicaid cost containment strategy in FY 2004. This was the second consecutive year in which every state and the District of Columbia undertook Medicaid cost containment strategies. For FY 2005, all 50 states and the District of Columbia reported specific plans to undertake additional cost containment actions in their Medicaid programs (Figure 13).[22]

Figure 13

States Undertaking New Medicaid Cost Containment Strategies FY 2002 – FY 2005



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003 and October 2004.

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FY 2005 will be the fourth consecutive year that states have implemented significant Medicaid cost containment initiatives, and for some states, the fifth. Most states are implementing not just one action, but are simultaneously undertaking a comprehensive set of cost containment strategies. Fewer states restricted provider payments, benefits or eligibility in FY 2005 compared to FY 2004, but more states implemented disease management and long term care initiatives. It is noteworthy that during this period of budget-driven cost-cutting, not all Medicaid policy making has been directed at reducing costs, several states also adopted modest benefit and eligibility expansions.

This section outlines the cost containment strategies that states implemented in FY 2004 and adopted for FY 2005. State actions are discussed in the following order:

- Provider payment rate changes
- Pharmacy utilization and cost control initiatives
- Benefit changes
- Eligibility changes
- Copayment requirements

[22] For FY 2005, a provider rate freeze is the result of a continuation budget adopted by the legislature pending agreement of a new budget in Kentucky.

- Managed care initiatives
- Disease or case management programs
- Changes to fraud and abuse controls
- Long-term care initiatives

The cost containment actions described in this report are those adopted for implementation in FY 2004 and FY 2005. State actions adopted in previous years are not listed even though they may continue to be in effect. Specific cost-containment actions newly taken by states in FY 2004 are summarized in Appendix B. Actions adopted for implementation in FY 2005 are listed in Appendix C. Specific state-by-state actions on pharmacy, eligibility, benefits and disease management initiatives are listed in Appendices D through K.

Provider Payment Rate Changes

Medicaid payment rates are generally the lowest of any payer, and are sometimes below cost for delivering care. Even a freeze in provider payment rates, as health care costs continue to increase, can be a de facto cut in payments and can have an impact on the availability of providers who will accept Medicaid patients, provider satisfaction and beneficiary access to care. Still, when faced with fiscal pressure, constraining provider payment rates is a typical strategy for Medicaid programs to slow the rate of growth in spending.

In FY 2004, 50 states and the District of Columbia cut or froze Medicaid payment rates for at least one group of providers (i.e., for hospitals, physicians, managed care organizations or nursing homes). This includes 48 states that froze rates (i.e., neither increased or cut rates) for one or more provider groups and 21 states that cut payment rates for one or more groups. Still, even in this time of fiscal stress, almost all states also increased rates for at least one provider group. A total of 46 states increased rates for one or more provider groups reflecting increasing provider pressure for catch-up rate increases after several years of freezes or cuts. This was an increase from 39 states that increased provider rates in FY 2003.

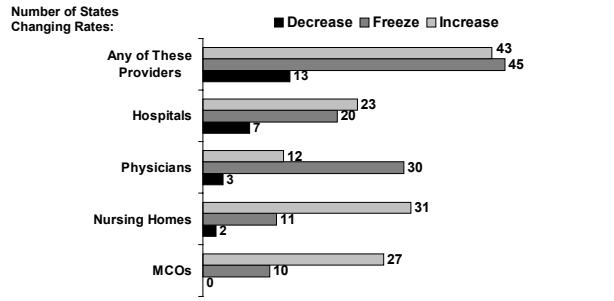
In FY 2005, a total of 47 states indicated they would be cutting or freezing Medicaid payment rates for at least one provider group, including 45 states that would freeze rates for one or more provider groups and 13 states that would cut rates (Figure 14). A total of 43 states indicated they would increase rates for one or more provider groups for FY 2005.

Comment of State Medicaid Official on Payment Rates:

"Rate increases occurred at the last minute in the legislative budget process, because revenues were equal to or better than expected."

"The pressure on the state budget is intense. We are getting to the rock bottom of what we can pay providers."

Figure 14



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2004.

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Among all provider groups, payment rates for physicians were most likely to be cut or frozen in FY 2004 and for FY 2005. Reimbursement methodologies for hospitals and nursing homes often include automatic adjustments based on an index relating to the cost of services so these provider groups are more likely than others to show increases. Additionally, some hospital and nursing home rate increases were tied to new or increased provider taxes; after netting out the cost of the provider tax, the rate increase may not be very large. Managed care payment rates became subject to requirements for actuarial soundness[23] in FY 2004, and this accounted for the significant number of rate increases for MCOs in FY 2004 and FY 2005.

- *Physicians*: Physician rates were cut or frozen in 42 states in FY 2004, including four states that cut and 38 states that froze physician rates. In FY 2005, physician rates were cut or frozen in 33 states, including three states that cut and 30 states that froze physician rates. Physician rates were increased in 9 states in FY 2004, and in 12 states in FY 2005.

- *Inpatient Hospitals*: Inpatient hospital rates were cut or frozen in 31 states in FY 2004 and in 27 states in FY 2005. In FY 2004, five states cut and 26 states froze hospital payment rates. In FY 2005, seven states cut and 20 states froze hospital payment rates. Hospital rates were increased in 21 states in FY 2004, and in 23 states in FY 2005. Payment increases for hospitals often reflect state statutory requirements to increase rates annually based on a specific index.

- *Nursing Homes:* Nursing home rates were cut or frozen in 18 states in FY 2004 and in 13 states in FY 2005. In FY 2004, four states cut and 14 states froze nursing home rates. For FY 2005, only two states cut and 11 states froze nursing

[23] According to Medicaid managed care regulations actuarially sound capitation rates must be developed with actuarial principles, be appropriate for the populations covered and the services furnished and be certified by actuaries.

home rates. Nursing homes were the provider group most likely to be granted a rate increase in both years, with increases in 32 states in FY 2004, and in 31 states in FY 2005. These increases often reflect longstanding state statutory requirements that provide annual rate increases based on a cost index.

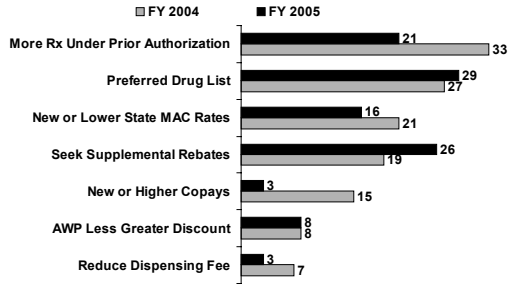
- *Managed Care Organizations*: Beginning in FY 2004, capitation rates for managed care organizations (MCOs) were subject to "actuarial soundness" requirements. These requirements impacted states decisions on rates for managed care in FY 2004 and 2005. Managed care organization capitation rates were cut or unchanged in 17 states in FY 2004, including six states that cut and 11 states that allowed no annual change in the rates. In FY 2005, rates were unchanged in 10 states. No states decreased capitation rates in FY 2005. MCO capitation rates were increased in 28 states in FY 2004, and in 27 states in FY 2005.

Pharmacy Utilization and Cost Control Initiatives

Cost-containment initiatives in the area of prescription drugs were implemented by 47 states and the District of Columbia in FY 2004. For FY 2005, a total of 43 states indicated that they would implement new or additional pharmacy–related initiatives. States continue to focus significant cost containment attention on prescription drugs, reflecting on-going efforts to slow the multi-year, double-digit cost growth. Compared to FY 2004, more states sought to control drug costs through preferred drug lists (PDL) and supplemental rebates than in FY 2004 (Figure 15). There was less of an emphasis on states setting new or lower Medicaid Maximum Allowable Costs (MAC)[24] and on reducing dispensing fees paid to pharmacists. In FY 2005, just one state reported that it increased its pharmacist dispensing fee.

Figure 15

Medicaid Prescription Drug Policy Changes FY 2004 and FY 2005



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2004.

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In addition, states continued to add new copayments or increase existing copayments for prescription drugs. In FY 2004, a total of 15 states adopted new or higher copayments

[24] State Maximum Allowable Cost Programs allow states to assign an upper limit to those generically available multi-source drugs for which a Federal Upper Limit (FUL) has not been set by the Centers for Medicare and Medicaid Services (CMS).

for prescription drugs. In FY 2005, the number of states adopting new or higher copayments for drugs dropped to three. Many of these states may be at the $3 per drug co-pay limit so they would not be able to increase pharmacy co-pays any higher without a waiver. See Appendix D for more detail on pharmacy cost containment actions for FY 2004, and Appendix E for FY 2005.

Benefits Changes

For FY 2005, state policymakers were less likely to cut benefits and more likely to expand or restore previously cut benefits, compared to the previous two years. For FY 2005, a total of nine states adopted benefit cuts or restrictions, a significant decrease from the total of 19 states in FY 2004, and 18 states in FY 2003. At the same time, in FY 2005, 14 states adopted benefit restorations and expansions, an increase from the 12 states that expanded benefits or restored previous benefit cuts in FY 2004, and the five states in FY 2003.

In general, the benefit reductions in 2004 and 2005 focused on restricting, reducing or eliminating "optional" services, which states offer at their discretion. These restrictions, reductions and eliminations focused primarily on Medicaid benefits for adults (including, in most cases, elderly and disabled beneficiaries). A few states implemented benefit limits that affected children, such as subjecting certain therapies to prior authorization.

In FY 2004, a total of 19 states cut or restricted benefits. Six of these states cut or restricted adult dental benefits and four states cut or restricted adult vision benefits and three states cut or restricted hearing services. Seven states eliminated or limited optional services for adults, including chiropractic services, podiatry services, psychological services, physical and occupational therapy and personal care services; 4 states eliminated some or all of these services altogether while the other 3 limited the amount of services that Medicaid would pay for.[25] In FY 2004, a total of 12 states expanded benefits or restored (fully or partially) previous cuts or restrictions.

In FY 2005, 9 states cut or restricted benefits. This included three states that reduced adult dental services. 14 states expanded benefits or restored (fully or partially) previous cuts or restrictions.

The following table highlights some of the benefit changes in FY 2004 and 2005:

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

FY 2004	FY 2005
Benefit Reductions	
19 states cut or restricted benefits • Cut or restricted adult dental benefits • Cut or restricted adult vision benefits • Cut or restricted hearing services • Eliminated or limited optional services for adults including chiropractic services, podiatry services, psychological services, physical and occupational therapy and personal care services • Limits on hospital lengths of stay for adults • New prior authorization for all Medicaid recipients • Reductions in non-emergency transportation • Limits on personal care hours for the aged and disabled • Limiting orthodontia to severe conditions for children • Eliminating coverage for circumcisions.	**9 states cut or restricted benefits**. • Reduced adult dental services • Eliminating or restricting podiatry, chiropractic, audiology, physical therapy, occupational therapy, speech, durable medical equipment, eyeglasses, transportation and psychological services • Limits on hospital lengths of stay for adults • Limiting orthodontia for children • Tighter hourly caps on personal care attendant services, brain injury rehabilitation and day health services • Limits on private duty nursing • Reducing physician office visit coverage for adults • Requiring prior authorization for children intervention services (occupational therapy, physical therapy and speech therapy).
Benefit Expansions	
12 states expanded or restored benefits • Restoration adult dental services • Restoration of eyeglasses and hearing aids for adults • Expansion of home and community-based waiver programs and services • Addition of long term personal care services for the elderly and disabled • Expansion of psychologist services to adults • Implementation of care management • Adding coverage of certain over-the-counter drugs • Increasing the annual limit for inpatient hospital days • Expanding or adding a hospice benefit.	**14 states expanded or restored benefits** • Restoration of podiatry, hearing aids, eyeglasses and chiropractic services • Expansion of home and community-based waiver programs and services • Extending substance abuse treatment for high risk pregnant women from 60 days to 12 months post-partum • Coverage for dentures for adults • Durable medical equipment coverage expansions • Expansion of school based services • Establishment of a PACE program ("Program for All Inclusive Care for the Elderly") • Increased access to mental health services for children • Expansion of dental services for children • Providing two annual authorized nurse visits (home health/HCBS type of services) • Addition of substance abuse treatment for adult populations through managed care • Enhanced community-based, mental health benefit package for qualified recipients • Limited exceptions to physician visit limits • Temporary restoration of physical therapy, audiology, emergency dental services for adults

Changes to Eligibility

Eligibility reductions are often difficult for states to implement because they impact vulnerable populations that usually would have no other access to health insurance or necessary health services. However, during the course of the recent economic downturn many states have turned to eligibility reductions to constrain Medicaid costs. Over the period from FY 2002 to FY 2005, a total of 38 states made restrictions or reductions to Medicaid eligibility in at least one of those four years.

In FY 2004, 21 states reduced or restricted eligibility for Medicaid, including nine states that only made changes to premiums and/or application and renewal procedures. Compared to prior years, these reductions were targeted narrowly, and were expected to affect relatively small numbers of people. In FY 2005, 15 states adopted plans to restrict or cut eligibility for Medicaid enrollees. (Included in this total are three states that imposed new or higher premium requirements and two states that changed application and renewal procedures that negatively affected the number of people on Medicaid.)

In both FY 2004 and FY 2005, a number of states made eligibility expansions. For example, several states that had previously not done so took up recently available options to offer coverage to the working disabled, to cover people under family planning waivers, and to provide coverage for uninsured women with breast and cervical cancer. Many of these expansions provide coverage for a limited set of benefits or to a targeted group of people. Some states undertook broader Medicaid expansions.

The following section describes eligibility changes in the following subsections:

- Eligibility rule changes
- Application and renewal process changes, and
- Premium changes

The changes for FY 2004 and FY 2005 are described in detail in Appendixes F and G.

Changes to Eligibility Standards

Fiscal Year 2004

As a condition of receiving the enhanced federal Medicaid matching rate (FMAP) for April 2003 through June 2004, the Jobs and Growth Tax Relief Reconciliation Act of 2003 required that states maintain eligibility through June 2004 at the levels that were in effect as of September 2, 2003. No state made eligibility changes that caused a loss of the enhanced FMAP during this period. Eligibility restrictions that did occur in FY 2004 were implemented on or before September 1, 2003 or were not changes to eligibility levels. States made reductions in income eligibility standards, eliminated continuous or presumptive eligibility, eliminated extended transitional medical assistance for parents and adults, increased the spend-down threshold for the aged, blind and disabled (ABD) population, and froze income standards.

However, even during the recent period of fiscal stress and cost containment, a number of states also undertook eligibility expansions. In FY 2004, ten states expanded eligibility. Eligibility expansions included income eligibility expansions for the aged and disabled, the elimination of TANF work requirements in determining Medicaid eligibility and two states implemented Medicaid buy-in for disabled workers.

Selected examples of states making changes to eligibility criteria in FY 2004 are described below:

FY 2004	
Eligibility Reductions	**Eligibility Expansions**
• **Kentucky** lowered the amount of income that could be retained for the community spouse of a long-term care resident, and eliminated long term care for the medically needy. • **Massachusetts** cut covered individuals with HIV from under 200% FPL to under 133% FPL. • **Nebraska** adopted eligibility reductions that cut coverage for 3,100 "Ribicoff"[26] children ages 19-20. • **Texas** discontinued coverage for medically needy adults with incomes above the TANF level and discontinued coverage for pregnant women age 19 and older with incomes above 158% FPL level.[27] These changes affected over 12,800 Texans. • **Utah** capped enrollment in the PCN (Primary Care Network) waiver program for "childless" adults and low-income uninsured parents at 19,900 in November 2003. In May 2004 enrollment was selectively reopened for adults with children.	• **Illinois** expanded income eligibility for children from 185 percent to 200 percent of the FPL; for parents from 49 percent to 90 percent of the FPL; and implemented a family planning waiver for women who lose Medicaid. Over 200,000 people were covered as a result of these expansions. • **Missouri** expanded Medicaid eligibility from 80 percent to 90 percent of the Federal Poverty Level to approximately 18,000 aged and disabled individuals.

[26] "Ribicoff children" are an optional eligibility category for states made up of children under 21 who are not receiving cash assistance but whose family incomes and resources meet the state's July 16, 1996 AFDC standards

[27] Texas reinstated coverage for pregnant women to 185% FPL effective September 1, 2004.

Fiscal Year 2005

While fewer states are undertaking eligibility cuts in FY 2005 compared to FY 2004, the eligibility cuts were broader and will affect a larger number of people. In FY 2005, twelve states planned some type of eligibility expansions. Many of these expansions are targeted to specific groups or for specific services. Three of these states plan to implement family planning waivers, one state plans to implement a breast and cervical cancer program and two states are planning Medicaid buy-in programs for the working disabled. Selected examples of planned changes to eligibility criteria in FY 2005 are described below:

FY 2005	
Eligibility Reductions	**Eligibility Expansions**
• **Mississippi** adopted a plan to eliminate coverage for the aged and disabled between 100% and 133% of the Federal Poverty Level. This would affect 65,000 individuals. 17,000 people would get coverage under a new 1115 Waiver. (See Box for more detail) • **Colorado** passed a law to remove legal immigrants from full Medicaid, expected to affect approximately 3,500 individuals and to be implemented in FY 2005. • **Georgia** reduced the Medicaid eligibility income limit for pregnant women and their infants from 235% FPL to 200% FPL, effective July 1, 2004, affecting 7,500 individuals. GA also eliminated coverage for medically needy persons in nursing homes affecting 1,700 individuals. • **Nebraska** adopted eligibility reductions that cut coverage for 3,100 "Ribicoff"[28] children ages 19-20. • **Oregon** closed enrollment for the Oregon Health Plan (OHP) Standard waiver program. State officials expected that enrollment would fall from 54,000 to between 25,000 and 30,000.	• **Illinois** adopted plans to increase eligibility for parents and adults in the FamilyCare program, covering an additional 56,000 adults. • **Maine** plans to increase eligibility for non-categorical adults from 100 percent to 125% of the FPL, covering 10,000 adults. The state also increased coverage for parents from 150 percent to 200 percent of the FPL, covering 25,000 parents. • **Missouri** plans to expand Medicaid eligibility from 90 percent to 95 percent of the FPL for the aged and disabled, covering approximately 12,000 people.

[28] "Ribicoff children" are an optional eligibility category for states made up of children under 21 who are not receiving cash assistance but whose family incomes and resources meet the state's July 16, 1996 AFDC standards.

Overview of the Mississippi Waiver

Mississippi to adopted a plan to eliminate coverage for a group of elderly and disabled beneficiaries with incomes between 100% and 133% of the Federal Poverty Level. This would affect 65,000 people. The state planned to help these people apply for the Medicare Drug Discount Card so that they would receive a discount on their prescription drug costs, including assisting their application for the $600 credit available for low-income beneficiaries with incomes below 135 percent of the FPL. The state received approval of a federal waiver to allow 17,000 of the 65,000 individuals to remain on Medicaid. The current waiver implementation date is scheduled for October 1, 2004. The waiver will cover 2 groups of individuals:

1. About 12,000 dual eligibles (covered by Medicare and Medicaid) will remain in Medicaid under the waiver because they need costly anti-rejection drugs after organ transplants, chemotherapy, kidney dialysis or anti-psychotic drugs and could not afford Medicare co-payments and deductibles.[29] For this group Medicaid coverage would end on January 1, 2006 when the new Medicare Part D prescription drug program begins. By reducing the number of dual eligibles enrolled in Medicaid, Mississippi lowers the amount that they will be required to pay the federal government under the "clawback" provisions of the Medicare prescription drug benefit.

2. The remaining 5,000 beneficiaries covered by the waiver are too young to qualify for Medicare and otherwise ineligible for Medicaid because their income is above poverty. This group would be covered under the Medicaid waiver until January 1, 2009.

Under this plan, 48,000 elderly and disabled beneficiaries would lose access Medicaid. The waiver has raised important policy questions about Medicaid coverage for low-income elderly and disabled Americans.

Application and Renewal Process Changes

Throughout the late 1990s and into 2001, states increasingly adopted measures intended to simplify and streamline the eligibility application and re-determination processes. However, in the face of budget shortfalls, fewer simplifications have occurred, and recently some states have reversed some of the previous simplifications or imposed changes that could make it more difficult for individuals to enroll and stay enrolled in Medicaid.

Ten states in 2004 and four states in FY 2005 made changes that could potentially decrease the number of people on Medicaid. Some of these changes include the:

- Implementation of more frequent re-verification periods than in previous years;
- Elimination of continuous eligibility for certain groups, and

[29] There are 13,000 individuals who would qualify for the waiver under this eligibility category, but the waiver caps enrollment for this group at 12,000.

- Elimination of the self-declaration of income that increases documentation requirements for Medicaid applications.

On the other hand, a total of 12 states made changes that streamlined or simplified their application and renewal procedures in FY 2004 and a total of 8 states made one or more positive changes to the application and renewal process in FY 2005.

Premium Changes

In a limited number of situations, state Medicaid programs are able to require premiums as a condition of coverage. In FY 2004, five states increased premiums, implemented new premiums or increased the number of people subject to paying premiums. Of the five states, two increased premiums for parents and children covered under expansion waivers (Massachusetts and Vermont). Three states implemented new or higher premiums on working disabled populations (Iowa, Louisiana and Minnesota).

Three states increased premiums in FY 2005. Two of these states increased premiums for the working disabled (Iowa and Nevada). One of these states also has a waiver pending to implement premiums on the Katie Beckett population (Maine).[30]

Copayment Requirements

Over the past several years, states have increasingly relied upon new or higher copayments as an important part of their cost containment strategies. In imposing copayments, states must comply with Federal Medicaid law, which specifies that copayments must be "nominal," generally defined as $3.00 or less per service. The law also provides exemptions so copayments cannot apply to certain services or certain eligibility groups such as children or pregnant women. Federal law requires that a provider must render a service regardless of whether the copayment is collected. A substantial body of research indicates that even nominal copayments can deter low-income individuals from receiving needed care.[31]

In FY 2004, a total of 20 states imposed new or higher co-payments. Pharmacy copayments were the most commonly added or increased with 15 states imposing new or increased copayments for prescription drugs. Five states imposed new or increased copayments for hospital visits (both inpatient and outpatient) and two states imposed copayments on non-emergency use of the hospital emergency room. States also applied new or higher co-pays to hearing, vision, dental and therapies, physician office visits and ambulatory services and home health.

For FY 2005, the number of states imposing new or higher copayments dropped to 9, down from 20 in FY 2004. Prescription drugs and emergency room copayments were

[30] Katie Beckett rules allow states the option to cover certain disabled children under age 19 under Medicaid if they meet the SSI standards for disability, the child would be eligible for Medicaid if he or she were in an institution and the child is receiving at home medical care that would be provided in an institution.

[31] Julie Hudman and Molly O'Malley, "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations," Kaiser Commission on Medicaid and the Uninsured, March 2003.

most commonly increased or added, with three states each for FY 2005. States also imposed new or higher copayments for hospital stays (one state), dental copayments (one state), and physician office visits (one state). One state eliminated all copayments that were previously in place.

Managed Care

In the previous recession in the early 1990s, managed care initiatives were the dominant strategies employed to control Medicaid spending growth. In the recent economic downturn, states have again used managed care as a component of their cost containment strategies, but not to the same extent as in earlier years. In FY 2004 and FY 2005, states continued to regard managed care as a significant vehicle for improving access and quality of care, but the costs of managed care have accelerated in many states making it a less attractive action for controlling spending growth. Common changes to Medicaid managed care include expanding service areas, enrolling new populations such as the elderly and disabled and implementing mandatory enrollment for certain eligibility groups or in certain geographic areas of the state.[32] The ongoing expansion of managed care by Medicaid is different from changing patterns of care in the private sector where the percentage of workers covered by managed care plans has declined since its peak in 1996.

In FY 2004, a total of 15 states made a change to their managed care program.[33] Nine of these states expanded their service areas for either primary care case management (PCCM) or for risk based managed care with four of the nine states expanding PCCM statewide and five of the nine states expanding risk-based managed care into additional counties. One state eliminated its PCCM program in FY 2004 (Alabama) and one state ended risk based contract in favor of expanding PCCM (Oklahoma). Three of the fifteen states enrolled new populations or restored coverage, through managed care, to Medicaid beneficiaries. One state enrolled TANF and ABD populations into managed care and another enrolled half the children with special health care needs into managed care as a cost containment measure. Finally, four of the fifteen states increased the number of people that were enrolled into managed care plans on a mandatory basis by either increasing the number of people that the state "auto assigns" into managed care or by moving from voluntary to mandatory managed care enrollment within certain counties of the state. [34]

In FY 2005, a total of 14 states expanded their managed care programs. Nine of these thirteen states expanded PCCM or risk based managed care into additional service areas

[32] Most of the states reporting changes to their managed care programs already had managed care programs in place in FY 2004 and FY 2005. States specifically focused on changes that increased the number of Medicaid enrollees service by managed care arrangements (both for PCCM and risk based programs).
[33] Managed care is defined as primary care case management (PCCM) and risk based managed care programs.
[34] Mandatory enrollment is defined as follows: new Medicaid recipients have a certain time period after joining the Medicaid program in which to choose a plan. If a recipient does not choose a plan in that time period, the state can assign the recipient to a managed care plan. The recipient has a period of time in which to opt-out of the plan and into another, or into fee-for-service. Specific details related to time period, opt-out, etc are determined and therefore vary by state.

within the state; five of these nine states expanded PCCM throughout the state and for additional populations (i.e. the aged, blind and disabled eligibility groups). Four of the 14 states expanded risk based managed care throughout the state. Four of the 14 states newly included dual eligibles and the SSI population into managed care, and six of the 14 states increased the amount of mandatory enrollment within the state.

Disease and Case Management

An increasing number of states are turning to disease and case management initiatives as cost containment strategies in FY 2004 and FY 2005. Disease management programs are generally seen as a relatively low-cost way to improve health care for people with chronic or disabling health conditions, including many adult Medicaid beneficiaries. While many states are turning to disease management, savings and quality results from these programs are promising, but not conclusive due to several barriers including voluntary participation, enrollee turnover, and low payment rates.[35]

These initiatives by state Medicaid programs parallel similar efforts in the private sector, although commercial disease management approaches often need to be adapted for Medicaid enrollees who then to be more difficult to contact and have a more complex array of problems than the privately insured population.[36] In the recent 2004 Employer Health Benefit Survey, 15 percent of firms responded that disease management strategies were very effective in containing costs.[37] This was a better rating than other initiatives including higher employee cost sharing (9 percent of firms rated very effective); consumer driven health plans (11 percent of firms rated very effective) or tighter managed care networks (9 percent of firms rated very effective).

For FY 2005, the number of states planning to undertake new or expanded disease or case management programs increased to 28, up from 18 in FY 2004. Five states responded that they would be piloting disease or case management programs on a limited basis within the state. A clear trend was toward more comprehensive care management programs, rather than strictly focusing on specific disease states. While asthma, diabetes, hypertension, depression and congestive heart failure continue to be a major focus, new programs were also implemented for mental and behavioral health and obesity. Between 2002 and 2005, 42 states began a disease or case management program.

Going forward, states may have a more difficult time implementing disease management programs as the duals move to get drug coverage under Medicare Part D. (See Appendix J and K for state-by-state detail for FY 2004 and FY 2005)

> ***Comment of State Medicaid Officials on MMA and Disease Management:***
>
> "The biggest issue is a loss of data, we have duals in disease management and duals in nursing homes."

[35] Claudia Williams, *Medicaid Disease Management: Issues and Promises.* Kaiser Commission on Medicaid and the Uninsured, September 2004.
[36] Ibid
[37] Kaiser Family Foundation and Health Research and Education Trust. Employer Health Benefits 2004 Annual Survey, http://www.kff.org/insurance/7148/index.cfm

Long-Term Care and Home and Community Based Services

Even though long-term care (LTC) represents over a third of total Medicaid spending in most states, states generally did not turn first to adopt major cost containment initiatives in this area throughout the recent period of fiscal stress. However, as states have exhausted other cost containment options, more states are now turning to long-term care initiatives for savings. The number of states focusing on LTC programs to control costs has increased from 10 states in FY 2003 to 17 states in FY 2005.

In FY 2004, eight states implemented cost controls related to nursing homes and 11 states planned for nursing home cost controls in FY 2005. Examples of these initiatives include: policies designed to reduce the number of nursing home beds, to reduce the number of hospital leave days, to tighten eligibility criteria, to reduce payments for bed holds, and to downsize the capacity of ICF/MR facilities. Other cost containment activities involved changes to nursing home reimbursement methodologies, such as adopting a case mix adjustment or reducing excess payment allowances.

In FY 2004 eight states and 11 states in FY 2005 had cost controls directed at home and community based services (HCBS) programs. Some of these states imposed a freeze on waiver slots. These recent reported reductions in HCBS programs is in contrast to state actions over the last five years to eliminate waiting lists for waiver services and expand access to community based long-term care services largely as a response to the United States Supreme Court decision in Olmstead V. L.C. from June 1999. This decision stated that the unjustified institutionalization of people with disabilities is a violation of the Americans with Disabilities Act (ADA). Other examples of cost controls include limiting the hours authorized for specific instrumental activities of daily living (IADLs), restricting private duty nursing hours, reducing budgets for high cost cases and utilization review program for all HCBS.

Fraud and Abuse

States continue to ensure program and fiscal integrity through new and ongoing fraud and abuse activities. In FY 2004, a total of 17 states indicated that they had implemented new or enhanced fraud and abuse activities. These actions are sometimes tied to new or enhanced support and MMIS systems, additional staff, and increased provider audits. For FY 2005, a total of 21 states planned new or enhanced fraud and abuse detection or prevention activities including recipient lock-in, establishment of a new Medicaid fraud unit within the state OIG, and greater focus on third party liability recoveries. Between 2002 and 2005 a total of 32 states have put at new fraud and abuse mechanisms in place in at least one of those years.

5. Provider Taxes

States use provider taxes to generate state and federal funds to support their Medicaid programs in a number of ways. Some states devote all the new resources to support their overall Medicaid budgets. Others use the funds to finance specific provider rate increases. In other cases the funds help address overall state budget shortfalls. Several

states implemented and plan to implement increases or new provider taxes to generate revenue in FY 2004 and FY 2005.

At the beginning of FY 2004, a total of 24 states had one or more provider taxes in place. Among those taxes already in place, the most common were assessments on nursing homes, ICFs/MR, hospitals, and MCOs. In 13 states, taxes or assessments applied to more than one category of provider tax. In FY 2004, a total of 21 states increased or imposed new provider assessments or taxes. New or higher provider taxes or assessments were most frequently imposed on nursing facilities, managed care organizations (MCOs), hospitals and intermediate care facilities for the mentally retarded (ICFs/MR).

While many states added or expanded provider taxes, in FY 2004, two states eliminated existing provider taxes: Oklahoma discontinued its MCO tax and Florida discontinued a tax on ambulatory surgical centers, mobile surgery facilities, clinical laboratories and diagnostic imaging as a result of a court ruling that the assessment violated the Florida constitution.

For FY 2005, 20 states increased or imposed one or more new provider assessments or taxes. Seven states added and three states increased a nursing home provider assessment, making it the most frequently imposed new provider assessment, as also had been the case for FY 2004. Eight states increased or imposed new assessments on ICFs/MR, four states imposed new assessments on MCOs and five states increased or imposed new assessments on hospitals.

Actions on Provider Taxes and Assessments in FY 2004 and FY 2005

Provider Type	In Place Prior to FY 2004	New in 2004	Increased in FY 2004	New in FY 2005	Increased in FY 2005	Total in FY 2005
Nursing Home	17	5	7	7	3	31
ICF/MR	13	3	2	6	2	21
Hospital	11	2	3	3	2	14
Managed Care Organization	3	3	2	4		10
Pharmacy	3					3
Home Health	2		1			2
Other	2		1	1		2

6. Impact of Federal Fiscal Relief

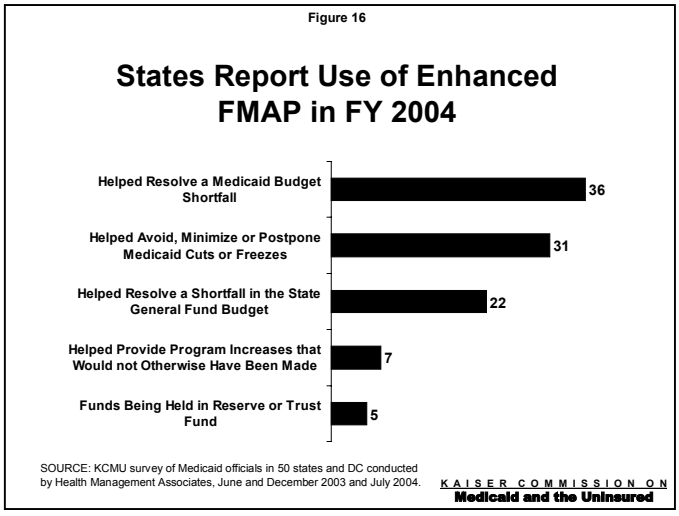
The Jobs and Growth Tax Relief Reconciliation Act of 2003, enacted in May 2003, contained two provisions that provided a total of $20 billion in fiscal relief to states in federal fiscal years 2003 and 2004.[38] The legislation provided $10 billion dollars in the form of a temporary 2.95 percentage point increase in each state's federal matching rate

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

for Medicaid programs (FMAP). The legislation also provided $10 billion in temporary grants for states to use for Medicaid or other state programs. A maintenance-of-effort provision dictated that only states that maintained eligibility at the levels that were in effect as of September 2, 2003 would receive the fiscal relief.

State Medicaid officials described how their state used the enhanced federal funding provided through the temporary FMAP increase. Officials indicated that states largely utilized the funds to address both Medicaid and overall budget shortfalls in 2004. This was exactly the outcome for which the fiscal relief was enacted. A total of 36 states reported that fiscal relief funds helped resolve an overall Medicaid budget shortfall and 22 states indicated that the funds were used to help resolve an overall state budget shortfall (Figure 16). In 31 states, officials indicated that the funds allowed the state to avoid, minimize or postpone Medicaid cuts or freezes that likely would have occurred, and in seven states officials reported the funds helped to finance program increases that likely would not otherwise have occurred.

Figure 16

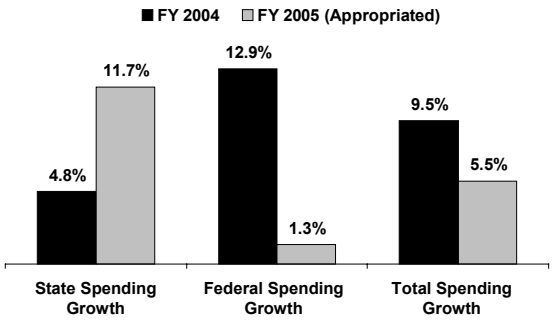


The expiration of the temporary enhanced FMAP on June 30, 2004 was expected to have a strong and direct impact on every state Medicaid program, since it caused states to experience exceptionally high FY 2005 state Medicaid spending growth that would be very difficult for states to absorb. Indeed, legislatures authorized spending growth in terms of state general funds of 11.7 percent in FY 2005, an amount 2.4 times greater than the 4.8 percent growth in state funds that actually occurred in FY 2004 (Figure 17).

Figure 17

Average Annual Medicaid Growth Rates

Federal Fiscal Relief Helped States in FY 2004 and Ended in FY 2005



SOURCE: Estimates based on KCMU analysis of CMS-64 data and KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2003 and July 2004.

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State officials described the impact of the expiration of the enhanced FMAP. The impact was seen by state officials in the first month after the enhanced FMAP ended. A number of states commented on the fiscal hardship that this would impose.

Comments of State Medicaid Officials on Expiration of Temporary FMAP:

"It puts enormous stress on our budget."

"The enhanced FMAP provided one-time temporary relief in FY 2004 for an otherwise severe general fund shortfall. Without similar funding in FY 2005, that structural deficit will continue."

"It is devastating to us."

"The expiration of the enhanced FMAP will increase the difference between the budget and expenditures. We just need more money. [We are] now facing a $225 million deficit. It may contribute to a need for more cost containment."

In at least 20 states, however, state officials indicated that the expiration of the enhanced FMAP had been anticipated and any specific identified impact in their state would be minimal, even though Medicaid continued to place significant stress on budgets in every state.

Officials in these states commented that the state budget for FY 2004 and FY 2005 had taken the temporary nature of the fiscal relief into account. In some states with biennial budgets, the funds generated by enhanced FMAP were carried forward from one fiscal year to address a budget shortfall in the following year. For these states, the impact of the expiration of the enhanced FMAP may be delayed until FY 2006.

More Comments of State Medicaid Officials on Expiration of Temporary FMAP:

"The budget people took it into account. It was regarded as one-time funding."

"Because the additional federal revenues were held in reserve for use in FY 2004-2005, the expiration of the enhanced FMAP had less of an impact than would have otherwise been expected. The impact will be felt in FY 2005-2006."

"No adverse effect of the Medicaid program. Didn't expect it to continue on forever."

"I don't think there will be an impact. Our estimates reflected the lower FMAP for'05. It won't make things easier, but I think our budget is pretty good overall."

"We had budgeted for it to end. It would be nice to have it back, because we are projecting a shortfall. But it was planned."

7. Impact of Increased Scrutiny of Special Financing Arrangements

As states have struggled in recent years to deal with state budget deficits and Medicaid budget shortfalls without undermining essential services to vulnerable populations, they have often turned to special financing arrangements to maximize the amount of federal Medicaid revenues flowing to the states. These special financing arrangements include the use of Intergovernmental Transfers (IGTs) and/or provider taxes to provide the non-federal share of Disproportionate Share Hospital (DSH) payments and/or Upper Payment Limit (UPL) reimbursements. CMS, in turn, has increased its scrutiny of these financing arrangements, often through the Medicaid State Plan Amendment (SPA) approval process, and has also increased the number of federal auditors assigned to monitor state Medicaid fiscal practices.

State Medicaid officials were asked to comment on how the recent enhanced federal scrutiny of special financing programs impacted their Medicaid programs. Not surprisingly, states that have not relied heavily on these special financing arrangements reported little or no impact. In contrast, states that have more aggressively pursued these arrangements reported greater impacts. In addition to the loss of federal revenues in some cases, states reported that the SPA approval process had become significantly slower – even for SPAs that did not involve or relate to special financing arrangements. State officials noted additional administrative burdens created by the enhanced scrutiny and uncertainties caused by SPA approval delays. The uncertainties make if difficult for states to budget appropriately for the program.

One state official commented:

> *"CMS scrutiny has not been limited to special financing programs, such as IGT funded payments. CMS has scrutinized and delayed approval on numerous state plan amendments that [the state] has submitted, regardless of whether the SPA relates to any IGT funded payment. This has created a situation in which [the state] is attempting to make changes to and improve the Medicaid program in the next fiscal year without knowing CMS's policies on changes we sought to implement last year. The scrutiny, which has resulted in deferrals and delays in*

SPAs, has created a level of uncertainty regarding [the state's] revenue collection--we are unable to draw down revenue associated with a pending SPA, thereby creating difficulties in calculating an accurate balance sheet. Additionally, the scrutiny, including that which has been placed on IGT-funded payments, has stressed administrative resources."

Other Comments of State Officials Regarding Enhanced Scrutiny of Special Financing Arrangements:

"That could drive us into bankruptcy! It's a big issue here. A very big issue."

"The time required to approve SPAs has been significantly extended and the process has been made substantially more difficult and unclear."

"So far, no impact financially. We have addressed all of their concerns. But we are concerned."

"There seems to have been a great deal of inconsistency. We have had to spend a great deal of time defending previously approved arrangements."

"It makes it challenging to do creative change. Just doing a simple State Plan change is a challenge. Who knows what the rules are? They keep changing."

8. Impact of the Medicare Prescription Drug Benefit

The 2004 survey included several questions asking state officials to assess the impact of the new Medicare prescription drug benefit on states as well as the impact of the interim Medicare drug discount card program.

Interim Drug Discount Card

Most state officials did not expect the interim drug discount card to impact the Medicaid program in a material way. While 22 states said there would be an impact, nine of those states said the impact would be minimal. For those states expecting an impact, state officials expressed concern regarding the coordination of benefits relating to the $600 transitional assistance discount card credit and also the ongoing impact of eligibility data exchanges with CMS. Some states also commented on the increased volume of calls and inquiries that they were receiving from Medicare beneficiaries seeking assistance. Finally, four states mentioned the possibility of a "woodwork effect" – that the discount card program might cause increased Medicaid enrollments, especially among those determined eligible for the $600 transitional assistance discount card credit.

States officials were also asked whether their state had a "state pharmaceutical assistance program" (SPAP) and, if so, whether any savings were expected by these programs attributable to the discount card program. Eight states indicated that savings were expected. Not surprisingly, the three states with the largest SPAPs in terms of enrollments and expenditures (New Jersey, New York and Pennsylvania) expect significant savings.[39] Other states reporting SPAP savings were Connecticut ($17

[39] New Jersey reported an expected $90 million in savings, New York reported $48 million and Pennsylvania responded that "significant savings [were] assumed."

million), Maine ($2.3 million), Michigan ($4.5 million), Minnesota ($2 million) and Rhode Island (amount not provided).

The New Medicare Part D

By far, states expressed the most concern over the expected impact of the implementation of the new Medicare Part D drug benefit that will take effect January 1, 2006. The states' chief concern related to the "clawback," a provision in the Medicare law that would require states to make payments to the federal government to help finance the Medicare drug benefit for dual eligibles. Just over three-quarters of the states expressed concern about the clawback. Fewer states expressed concerns about other critical areas related to the implementation of the Medicare drug benefit at the time of the survey that took place during the summer of 2004. This may be because the proposed regulations for the drug benefit were issued in August 2004, so states had not reviewed the regulations at the time of the survey. The proposed regulations also raised the possibility that states may be responsible for auto-enrolling over 6 million dual eligibles in Part D plans; this could place an additional unanticipated administrative burden on states. More states will undoubtedly focus on these issues more closely as the year goes on and as state responsibilities are more clearly defined when the final regulations are issued in early 2005.

When asked to identify the most significant issues that they expected to deal with relating to the Part D benefit, states reported:

- Concerns over the clawback (39 states)
- Concerns over the requirement for states to perform low-income subsidy determinations (16 states);
- Concerns that states would actually end up spending more for drug coverage for dual eligibles (through the clawback) than they would have in the absence of Part D (15 states);
- The adequacy of Part D plan formularies (12 states);

Other areas of concern identified include: concerns over other administrative costs and issues (12 states) including data exchange issues (8 states), and outreach and coordination of benefits with Part D plans (6 states); increased Medicaid enrollments due to the woodwork effect (9 states); loss of supplemental rebates (6 states); potential impacts on nursing home residents (3 states); and the fragmentation of the managed health care model (1 state).

Comments of State Officials Regarding Medicare Prescription Drug Benefit:

"We're very concerned about the clawback. The people are working with MSIS, trying to compile the data, but nobody believes it's accurate." "The states are going to be in the red on this issue for a long time." "It's going to cost the states."

"Eligibility, this will be an enormous problem for us. There won't be enough time to implement. It's a disaster waiting to happen."

"We think we are actually going to lose money. We are skeptical that the state will be given extra money. We think we are going to lose money because we will have to pay them back at what Medicare pays for the drug, and they can't negotiate rates."

"We don't have dollars to wraparound but we know the political pressures will be there to do it. We know beneficiaries expect their benefit to be the same and we know it won't be."

"We are very concerned about the change in January 2006. It's soon. I have a biennial budget, and the biggest issue is that we don't know what is expected of us."

"It will be huge. We have coordination issues, the beneficiary issues and the financial issues. I think we will be quite overburdened.. . . [The clawback]: Like handing your credit card to somebody else and hoping they'll be judicious."

Only three states (California, New York and Rhode Island) reported that they received new administrative resources in FY 2005 for preparing for the implementation of the Part D Medicare drug benefit in January 2006. However, all states will be expected to begin determining eligibility for the Part D low-income subsidies beginning in July 2005 and must somehow marshal the necessary resources in FY 2005 to accomplish eligibility systems changes, staffing readiness and other related administrative responsibilities in time.

9. The Outlook for FY 2005

The overall state budget picture is improving in many, but not all states. State revenue collections improved significantly in FY 2004 but are still below levels from before the onset of the economic downturn in 2001 (after adjusting for inflation and legislative changes). The expiration of the enhanced FMAP federal fiscal relief combined with continuing spending pressures in Medicaid will present a major challenge to many states in FY 2005 and will also impact budget development for the 2005-2007 biennium in others.

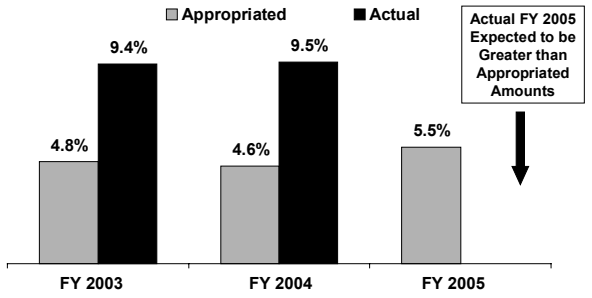
FY 2005 appropriation levels appear to be somewhat optimistic in light of on-going spending trends. This would be consistent with patterns for initial appropriations for previous years, as reflected in previous surveys. For FY 2005, legislatures adopted initial appropriations that authorized increases in total Medicaid spending that averaged 5.5 percent (Figure 18). This is similar to the 4.6 percent increase legislatures originally authorized for FY 2004 and the 4.8 percent increase originally appropriated for 2003.[40] In contrast, actual spending turned out to increase by 9.5 percent in FY 2004 and 9.4 percent in FY 2003. Recent history suggests that the original FY 2005 appropriation should not be interpreted as a projection of actual spending, even though it is the current

[40] See 2002 survey, September 2002 and 2003 survey, September 2003.

legal authorization for Medicaid spending.[41] Actual Medicaid spending growth could be higher.

Figure 18

Average Annual Growth Rates of Total (Federal and State) Medicaid Spending



NOTE: States appropriate both state and federal Medicaid spending.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2003 and July 2004.

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At the outset of FY 2005, Medicaid officials in 30 states believed the likelihood of a Medicaid budget shortfall in FY 2005 was at least 50-50. A "Medicaid budget shortfall" occurs when the original legislative appropriation is insufficient to cover expected actual expenditures. Given an average appropriated growth rate for total Medicaid spending of 5.5 percent, a significant number of states once again are likely to need additional funds or additional program cuts over the course of FY 2005.

In FY 2004, a total of 34 states experienced a Medicaid shortfall compared with 35 states in FY 2003. States closed their FY 2004 budget gaps through supplemental appropriations (in 13 states), from legislative transfers (six states), from savings from additional program reductions (five states), and from the temporary increase in the federal Medicaid matching rate (six states). Also, four states reported carrying a FY 2004 budget shortfall into FY 2005 and three states reported using FY 2005 appropriations to cover a FY 2004 shortfall.

Besides the now familiar and ongoing pressure to constrain Medicaid spending growth, State Medicaid officials must also look forward to the challenges of preparing for the implementation of the Part D Medicare drug benefit in January 2006.

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

Conclusion

The cumulative effect of these cost containment actions over the last several years had a critical impact on the 52 million children and families, pregnant women, the elderly and persons with disabilities who are enrolled in the program, as well as the doctors, pharmacies, hospitals, nursing homes and other providers who serve Medicaid patients, and the states who finance a significant share of program costs. However, even with cost containment actions, throughout this time of fiscal stress Medicaid did in fact play a critical safety-net role for many individuals, especially children, who fell into poverty or lost private insurance and would have otherwise been uninsured. The current financing structure of the Medicaid program, with federal matching dollars and guaranteed eligibility, for those who qualify, allowed Medicaid to play this critical role. Additional federal support, as well as requirements that states maintain eligibility also helped to preserve Medicaid's safety-net role in FY 2004.

State revenues improved in FY 2004 and are expected to continue to improve as states enter their 2005 fiscal years. This positive news allowed for fewer new cost containment actions to be planned for FY 2005 in critical areas such as reductions to benefits, eligibility and provider payments. In fact, many states were able to increase some provider payments and some states increased eligibility. However, as in FY 2004, FY 2005 marked another year where every state plans to implement at least one additional Medicaid cost containment initiative.

As states enter FY 2005, a number of significant new challenges lie immediately ahead: state general fund spending for Medicaid is expected to increase substantially with the end of the temporary federal fiscal relief; states will be challenged to implement their responsibilities for the new Medicare prescription drug benefit; and, trends of increasing poverty and eroding private insurance will continue to put pressure on Medicaid enrollment and spending growth as more people become eligible and enroll in the program. States have fallen under intense scrutiny from CMS related to special financing arrangements. This has put some Medicaid revenue into question and also placed additional administrative burdens on states.

State officials have indicated they will continue to search for new options and alternative mechanisms to control increasing Medicaid costs. In fact, many have already turned to Section 1115 Waivers to obtain flexibility to implement enrollment caps and benefit reductions to control costs. These waiver design features could undermine the critical support the program provides to vulnerable individuals and to their providers. At the same time, several states have begun to look at Medicaid as an effective vehicle to address the issue of the uninsured and have used the program to expand coverage. The recent period of fiscal stress has regenerated interest among states and at the federal level for the restructuring of the federal Medicaid law, particularly the way the program is financed and the relative role of states and the federal government. How the public policy discussion on these issues unfolds will have significant implications for state budgets, Medicaid beneficiaries and the ability of the Medicaid program to continue to serve as a critical safety-net program.

Profiles of Selected State Medicaid Policies:

- **Colorado**
- **Georgia**
- **Maine**

Profile of Medicaid Policy Changes: Colorado

While virtually all states have struggled with declining state revenues in recent years, Colorado's current budget constraints have been made more severe by a state constitutional amendment adopted in a statewide referendum in 1992. In addition to making all tax increases subject to voter referenda, the constitutional amendment (known as TABOR, for Taxpayer Bill of Rights) limits state government revenues and expenditures to the previous year's levels with adjustments only for inflation and population growth. Colorado must refund excess revenue to taxpayers and may not retain surpluses in good years to build reserves to hedge against future economic downturns. Thus, the Colorado Office of State Planning and Budgeting (OSPB) is currently projecting a FY 2005 TABOR refund of $53.1 million, but has also estimated that FY 2006 General Fund appropriations can be increased by only $79.5 million, or 1.4 percent, compared with FY 2005 appropriation levels. OSPB is also currently projecting a FY 2006 TABOR refund of $290.8 million due to expected improvement in General Fund revenue growth. A citizen-initiated referendum to increase tobacco taxes to help fund health care, including Medicaid and SCHIP, will appear on the November 2004 ballot.

Colorado already has one of the leanest Medicaid programs in the nation due to its tight income eligibility thresholds and limited coverage of optional services and populations. The state's ongoing budget challenges have nevertheless forced the state to continue to focus on Medicaid cost containment. Cost-containment actions implemented in Colorado in FY 2004 and FY 2005 are listed below.

Provider Rates:

- All provider rates were frozen in FY 2004 with the exception of managed care organizations, which received a slight increase and FQHCs, which received a decrease of approximately 5 percent.
- In FY 2005:
  - Rates were frozen for pharmacy, outpatient hospital, dentists, home health providers and home and community based waiver providers;
  - Rates were increased for physicians by approximately 1.3 percent;
  - Statutory increases were granted to managed care organizations and to nursing homes;
  - FQHC rates were restored and rates were increased for residential treatment centers, and
  - Rates were decreased by one percent for inpatient hospitals and by 1.5 percent for durable medical equipment. The $3 per member per month incentive fee for primary care physicians was eliminated.

Eligibility Changes:

- A law passed in FY 2003 to remove legal immigrants from Medicaid will be implemented in FY 2005.
- In FY 2005, the state is implementing a new automated eligibility system that is intended to facilitate enrollment in multiple programs.

Benefit/Service Changes:

- Funding for non-emergency transportation was reduced in FY 2004.

• Nursing Home Visitor services (targeted case management) were financed through Medicaid in FY 2004. • Substance abuse treatment services for high-risk pregnant women were extended from 60 days to 12 months post partum effective October 2004. • Private duty nursing hours were limited to 16 per day effective July 1, 2004. • Community transition services were added to the Home and Community Based Services Waiver program in October 2004. • Medicaid transportation changed from a Medicaid benefit to an administrative service effective July 1, 2004.
Prescription Drug Controls and Limits:
• State established prior authorization rules on drugs that previously did not require prior authorization in FY 2004. • New requirements to use generics imposed in FY 2004.
Other Actions in FY 2004 and 2005:
• The state continued its disease management pilots and began contracting with Administrative Service Organizations in FY 2004. • Copays increased for pharmacy, inpatient hospital, durable medical equipment, and lab/x-ray. All were increased to the federal maximum except for inpatient hospital.

Profile of Medicaid Policy Changes: Georgia

In the November 2002 elections, Georgia Republicans won the Governor's office and the state Senate (after a few Senators switched parties) for the first time in 130 years. The House of Representatives remained under Democratic control setting the stage for heated state budget debates during a time of slumping tax collections and rising health and education costs. During the 2003 legislative session, resolution of the FY 2004 state budget depended, in part, on the enactment of a tobacco tax increase proposed by Governor Sonny Perdue. Soon after FY 2004, began, however, Governor Perdue determined that state revenue collections were falling behind the assumptions upon which the FY 2004 budget was based. He therefore required state agencies to identify cuts in their FY 2004 budgets equal to 2.5 percent. Further, in developing their FY 2005 budget requests, agencies were ordered to plan for reductions of 7.5 percent.

In addition to submitting his budget recommendations for FY 2005, Governor Perdue delivered a supplemental FY 2004 budget request to the Georgia legislature in January 2004. The supplemental budget request reflected the 2.5 percent budget cuts that he had ordered state agencies to make, but also included $172.8 million in additional FY 2004 funding for Medicaid to cover a projected funding shortfall. The Governor noted that without the additional Medicaid appropriations, the state would run out of money to pay Medicaid claims in March 2004. As of the close of business on Wednesday, March 17th, the legislature had not yet acted on the supplemental Medicaid budget request and the state suspended Medicaid claims payments. On Monday, March 22nd, the legislature approved the additional Medicaid funds and Medicaid claims payments were resumed.

The FY 2005 Medicaid budget approved by the legislature rejected some cuts originally proposed by the Governor, but retained others. One of the more controversial cuts was the elimination of the Nursing Home Medically Needy program that provided Medicaid coverage for nursing home services for persons with incomes that otherwise would disqualify them for the Medicaid program but are too low to cover the cost of long-term care. On June 21, 2004, Governor Perdue announced that he intended to postpone the implementation of this cut from July 1st until September 30, 2004 to allow affected persons more time to find alternative coverage.

As state officials begin planning for FY 2006, efforts are underway to establish a statewide risk-based managed care program for families and children. Further Medicaid cuts are being considered as well. FY 2004 and FY 2005 cost containment measures are described below.

Provider Rates:
▪ In FY 2004, provider rates decreased for physicians (-5.5%), home health (-10%) and home and community-based services providers (-10%). Provider rates frozen for inpatient hospitals and increased for nursing home (+3.2%). ▪ In FY 2005, outpatient hospital rates reduced by 4.5 percent. All other provider rates frozen.
Eligibility Reductions:

▪ Georgia reduced the Medicaid eligibility income limit for pregnant women and their infants from 235% FPL to 200% FPL, effective July 1, 2004 (impacting approximately 7,500 persons). ▪ Coverage for medically needy persons in nursing homes eliminated effective September 30, 2004 (estimated to impact 1,700 persons).
Benefit/Service Reductions:
▪ Prior approval requirements added in FY 2004 for home health therapies. ▪ In FY 2004, dental services reduced for certain procedures (approximately a 7.5% reduction). ▪ Prior approval requirements added in FY 2005 for child intervention services (occupational therapy, Physical therapy and speech therapy).
Prescription Drug Controls and Limits:
▪ In FY 2004 prior approval and quality limits imposed for several drug classes ▪ In FY 2004, implemented supplemental rebates. ▪ In FY 2005, increased the discount taken from AWP to 11 percent from 10 percent. ▪ In FY 2005, increased generic incentive fee payment to shift utilization from brand to generic.
Other actions:
▪ Estate recovery authorized beginning August 2004. ▪ Nursing home provider bed tax implemented in FY 2004 and increased to maximum level for FY 2005. ▪ Implemented an enhanced case management program and an emergency room utilization management program in FY 2004. ▪ In FY 2004, non-custodial parents court ordered to buy commercial insurance when available.

Profile of Medicaid Policy Changes: Maine

On the day that Governor John Baldacci first took office in January 2003, he created the Governor's Office of Health Policy and Finance to fulfill a campaign commitment to make affordable, high quality health care coverage available to Maine residents. By June 2003, Maine had enacted the landmark "Dirigo Health" legislation – a comprehensive health reform initiative intended to achieve universal health insurance coverage for state residents by 2009. ("Dirigo" is the state motto, Latin for "I lead.")

As a result of the Dirigo Health legislation, Maine has plans to expand access to health care coverage through MaineCare, the state's Medicaid program, and through a new health insurance coverage option ("DirigoChoice") aimed primarily at employees of small employers or other uninsured individuals, with subsidies available to people with incomes below 300 percent of the FPL. The MaineCare expansions are tentative planned to take effect in late FY 2005 and would add coverage for 35,000 people. DirigoChoice will be administered by Anthem Blue Cross and Blue Shield of Maine and is expected to begin providing coverage in January 2005 and enroll 20,000 to 25,000 people in the first year of operation.

In FY 2004, as the state began the process of planning for the implementation of Dirigo Health. In FY 2005, a projected Medicaid budget shortfall led some state lawmakers to recommend delaying the planned MaineCare expansions. While the state did adopt a number of Medicaid cost containment measures, the planned MaineCare expansions were not abandoned. The cost containment measures included the creation of a preferred drug list and the collection of supplemental pharmacy rebates. Other FY 2004 and FY 2005 Medicaid changes are described below.

Provider Rates:
• Increased inpatient hospital rates by 5.35 percent in FY 2004. • Decreased outpatient hospital rates to total cost minus 23 percent in FY 2004. • In FY 2005, increased inpatient hospital by 3.785 percent and increased outpatient hospital to total costs minus 10 percent. • Rate caps imposed for providers of mental health and mental retardation services in FY 2005.
Planned Eligibility Expansions:
• In FY 2005, increase income eligibility for parents from 150 percent to 200 percent of the FPL, extending coverage to 25,000 people. • In FY 2005, increase income eligibility for non-categorical adults from 100 percent to 125 percent of the FPL, extending coverage to 10,000 people.
Benefit Changes:
• New prior authorization requirements for all population groups in FY 2004. • Limitations imposed on psychological services, physical therapy, occupational therapy, chiropractic services for MaineCare Basic (parents/adults) in FY 2004. • Tighter caps imposed on personal care attendant hours and brain injury rehabilitative hours for disabled in FY 2004.

• Tighter caps imposed on day health hours for the aged in FY 2004.
Prescription Drug Controls/Limits:
• Increased the discount taken off of AWP from 13 percent to 15 percent. • Implemented a PDL, prior authorization and supplemental rebates in FY 2004. • Five brand limit imposed on certain members in FY 2005. • Voluntary mail order program added in FY 2005. • State sponsored 340B enrollment/partnership initiative planned for in FY 2005.
Other Actions in FY 2004 and FY 2005:
• Pharmacy copayments increased for all non-exempt groups in FY 2004. • Rural Health Center and Federally Qualified Health Center copayments added for all non-exempt groups in FY 2004 and FY 2005, respectively. • State staff hiring restrictions in place for FY 2004. • Applied for waiver to implement premiums for the Katie Beckett population beginning in FY 2005. • Planned increased in Cub Care (SCHIP funded Medicaid expansion group) premiums in November 2004. • Case management to be implemented for high cost cases in FY 2005. • Will implement more intensive eligibility screens, prior authorization and utilization review on many services and high cost users for physical and behavioral health services in FY 2005.

Appendix A: Factors Contributing to Medicaid Expenditure Growth in 2004 – State Survey Responses

State	Primary Factor	Secondary Factor	Other
Alabama	Inflation in pharmacy and nursing home	Caseload	Utilization
Alaska	Cost containment efforts	Increased third party liability recoveries	Increased program oversight
Arizona	Medical inflation	Availability of state funds	
Arkansas	Growth in eligibles	Demand on services	Lack of management in mental health and prescription drugs
California	Caseload, especially the aged, blind and disabled	Cost of medical care, IP hospital and pharmacy	CMS funding issues
Colorado	Caseload	HMO lawsuit settlements	
Connecticut	Long Term Care	Prescription Drugs	
Delaware	The recession	Rebasing of nursing home rates	Increased utilization
District of Columbia	Enrollment growth	Increase in utilization of resources	Additional outreach efforts and increases in cost of purchased services
Florida	Increase in utilization and price of prescription drugs and hospital services	Growth in SSI population	
Georgia	Eligibility	Utilization	Price
Hawaii	Pharmacy	Higher enrollment in managed care (QUEST program)	
Idaho	Mental health	Prescription costs	Physician, hospital
Illinois	Drug costs	Enrollment	
Indiana	Enrollment	Home and Community Based Waivers	Pharmacy
Iowa	Waivers	Prescription drugs	Enrollment
Kansas	Prescription drugs	Enrollment in the aged, blind and disabled population	Home health and inpatient hospital
Kentucky	Economy and legislative actions driving increases	management initiatives to contain cost	
Louisiana	Pharmacy medical inflation	Enrollment	Waiver
Maine	Hospital costs	Drugs	TCM, NFS, PNMI
Maryland	Cost of services	Utilization of services	
Massachusetts	Enrollment	Utilization	Rates
Michigan	Overall caseload	Special financing phase-out	
Minnesota	Caseloads of home and community based services waivers and home care	Average cost of disabled basic care (especially prescription drug cost)	Average cost of coverage for children and parents, especially managed care rates
Mississippi	Medical Inflation	Increase in Eligibles	
Missouri	Pharmacy	Utilization increase	Caseload growth
Montana	Increase in number of eligible clients	Cost of pharmaceuticals	Utilization of services
Nebraska	Drug costs	Waiver services	Managed care capitation
Nevada	Increase in caseloads (greater aged, blind and disabled enrollment)	Provider rate increases	
New Hampshire	Enrollment	Price growth physicians and outpatient services	Utilization
New Jersey	Managed care capitation rate increase	Prescription drug utilization	Transportation

State	Primary Factor	Secondary Factor	Other
New Mexico	Recipient growth	Utilization increases prescription drugs and outpatient services	Waiver costs
New York	Pharmacy	Enrollment	
North Carolina	Prescribed drugs	Physicians	Inpatient hospital and mental health clinics
North Dakota	Utilization, hospital and physician	Pharmacy	
Ohio	Caseload growth	Rx price and per person utilization increases	Serving more people on waivers; higher utilization for durable medical equipment and nursing
Oklahoma	Increasing enrollment	Increasing rates	Benefit change for drugs
Oregon	Ballot measure decreased revenue	Tobacco tax	Hospitals
Pennsylvania	Eligibility	Pharmacy	Managed care
Rhode Island	Pharmacy	Nursing home	Hospitals
South Carolina	Pharmaceutical costs	Physician access and ambulatory related service increases (clinical, lab and x-ray)	Managed care rates
South Dakota	Costs and utilization (inpatient hospital, outpatient hospital, physicians and prescription drugs)	Growth in eligibles	
Tennessee	Pharmacy inflation	Pharmacy utilization	Enrollment growth
Texas	Volume (i.e. caseload) especially in vendor drug program		
Utah	Caseload growth	General inflation	Prescription drug growth
Vermont	FMAP rates	Pharmacy and long term care expenditures	General medical inflation
Virginia	General health care inflation, especially prescription drugs	Growth in waiver, LTC population	General growth in population
Washington	Pharmacy expenditures		
West Virginia	Pharmacy, prescription drug cost	Long term care-nursing home	
Wisconsin	Increase in caseload	Trends in pharmacy/prescription drugs	Increased cost for services of cost-based providers, such as FQHC's and long term care institutions
Wyoming	Long term care	Enrollment	Hospital utilization

Appendix B: Factors Contributing to Medicaid Expenditure Growth in 2005 – State Survey Responses

State	Primary Factor	Secondary Factor	Other
Alabama	Pharmacy	Eligibility	Utilization
Alaska	Rising health care costs	Insurance costs	
Arizona	Medical inflation	Utilization of emergency room and outpatient clinics	Prescription drugs and inpatient hospital
Arkansas	Growth in eligibles	Demand on services	Mental health and pharmacy expenditures
California	Caseload, especially aged, blind and disabled	Cost of medical care, inpatient hospital and pharmacy	CMS funding issues
Colorado	Increased Medicaid enrollment	Increased utilization of services	
Connecticut	Long term care	Prescription drugs	
Delaware	Renegotiated managed care contract rates	End of enhanced FMAP	Slow economic recovery
District of Columbia	Enrollment	Utilization of existing services	Increased managed care rates
Florida	Increased utilization and price of prescription drugs	Increase in utilization and cost of hospital services	Increase in diversion and transition from long term institutional care to community care; increased managed care
Georgia	Enrollment	Utilization of existing services	Price
Hawaii	Pharmacy	Eligibility growth	
Idaho	Prescriptions	Mental health	Hospitals
Illinois	Pharmacy	Enrollment	
Indiana	Loss of increased FMAP	Pharmacy	Enrollment
Iowa	Eligibility growth	Prescription drugs	Inpatient hospital and physician services
Kansas	Prescription drugs	Enrollment	Home health, ancillary services
Kentucky	Eligibility/utilization		
Louisiana	Rebasing of nursing home	Pharmacy inflation	Enrollment growth and utilization
Maine	Hospital costs	Drugs	TCM, NFS, PNMI
Maryland	Increasing cost of services	Projected, increased utilization	Shrinking funding resources
Massachusetts	Enrollment	Rates	Utilization
Michigan	Increasing caseload	Loss of one-time federal fiscal relief	Loss of special financing, actuarially sound HMO rates
Minnesota	HCBS waivers and home care caseloads	Average cost of disabled basic care, especially prescription drugs	Average cost of basic care for children and parents, especially managed care rates
Mississippi			
Missouri	Pharmacy	Utilization increase and caseload growth	Nursing facility rebasing

State	Primary Factor	Secondary Factor	Other
Montana	Pharmacy	Utilization	Eligibility
Nebraska	Waiver cost increases		
Nevada	Increase in caseloads	Provider rate increases	
New Hampshire	Enrollment	Physician and outpatient	Utilization
New Jersey	Managed care capitation rates	Prescription drug utilization and price/unit	
New Mexico	Recipient growth	Utilization	
New York	Pharmacy	Enrollment	
North Carolina	Increase in consumption rate	Increase in eligibles	Increase in cost per unit of services
North Dakota	Utilization controls in place	Enrollment flattened	
Ohio	Caseload growth	Prescription drug utilization and price	Durable medical equipment (DME), nursing and hospital; more waiver slots (category of community long term care supports-includes DME, nursing)
Oklahoma	Enrollment	Utilization	Uninsured
Oregon	Ending of OHP standard adults (expansion population)	Hospital costs	
Pennsylvania	Eligibility		
Rhode Island	Pharmacy	Hospital costs	Nursing home
South Carolina	Pharmaceutical costs	Physician access and hospital utilization	Eligibility issues
South Dakota	Costs of disabled	Utilization, increased per capita costs	Caseload
Tennessee	Pharmacy inflation	Implementation of reform plan	
Texas	Caseload	Costs	
Utah	Caseload	Inflation	Prescription drugs
Vermont	General medical inflation	FMAP changes (rates have gone down)	
Virginia	Funding initiatives increasing reimbursement rates	Funding initiatives increasing waiver slots	General health care inflation
Washington	Pharmacy expenditures		
West Virginia	Pharmacy benefits	Long term care	
Wisconsin	Increase in caseload	Trends in pharmacy/prescription drugs	Increased cost for services of cost-based providers, such as FQHCs and long term care institutions
Wyoming	Enrollment	Provider rate increases	FMAP drop

Appendix B: Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2004

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

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Copays	Managed Care Expansions	DM/ CM	Fraud and Abuse	LTC
Virginia	X	X		X	X				
Washington	X	X	X	X		X		X	
West Virginia	X				X	X			X
Wisconsin	X	X		X	X			X	X
Wyoming	X	X							
Total	**50**	**48**	**19**	**21**	**20**	**15**	**18**	**17**	**14**

Appendix C: Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2005

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

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Copays	Managed Care Expansions	DM/ CM	Fraud and Abuse	LTC
Virginia		X					X		
Washington	X	X			X		X	X	
West Virginia	X	X				X	X		
Wisconsin	X	X				X	X		X
Wyoming	X	X					X		
Total	**47**	**43**	**9**	**15**	**9**	**14**	**28**	**21**	**17**

Appendix D: Pharmacy Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2004

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

State	AWP	New or Lower State MAC	Reduction in Dispensing Fees	More Drugs Subject to Prior Authorization	Preferred Drug List	Supplemental Rebates
Texas				X	X	X
Utah				X		
Vermont					X	X
Virginia			X		X	
Washington		X		X	X	X
West Virginia						
Wisconsin	X	X		X		
Wyoming		X		X	X	
TOTAL	**8**	**21**	**7**	**33**	**27**	**19**

Appendix E: Pharmacy Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2005

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

State	AWP	New or Lower State MAC	Reduction in Dispensing Fees	More Drugs Subject to Prior Authorization	Preferred Drug List	Supplemental Rebates
Texas				X		
Utah						
Vermont				X	X	X
Virginia		X				
Washington		X			X	X
West Virginia		X				
Wisconsin	X	X		X	X	X
Wyoming				X	X	
TOTAL	**8**	**16**	**3**	**21**	**29**	**26**

Appendix F: Eligibility Related Actions Taken in the 50 States and District of Columbia in FY 2004

State	Eligibility Change
Alabama	
Alaska	**Children**: Reduced income standard for SCHIP Medicaid expansion group from 200% to 175%. Effective Date: 9/1/2003 **Parents/Adults**: Reduced eligibility standards for poverty level pregnant women from 200% to 175%. Effective Date: 9/1/2003 **Other**: The income standard for institutional group (300%) was frozen (i.e. will not be indexed for inflation).
Arizona	
Arkansas	
California	
Colorado	
Connecticut	**Children**: Eliminated continuous eligibility in August 2003. **Parents/Adults and Disabled**: Eliminated guaranteed eligibility in managed care (6 month) and eliminated new enrollments for adults with income between 100-150% FPL (potentially reducing enrollments by 17,000) in August 2003.
Delaware	
District of Columbia	
Florida	
Georgia	
Hawaii	
Idaho	
Illinois	**Children:** Expanded eligibility from 185% to 200% of FPL effective July 1, 2003 (20,000). **Parents/Adults**: Expanded eligibility from 49% to 90% FPL effective July 1, 2003 (65,000). **Other**: Family planning waiver added for women who lose Medicaid eligibility effective April 2004 (120,000).
Indiana	
Iowa	
Kansas	
Kentucky	**Aged and Disabled:** Lowered community spouse income and resource allowance and eliminated long term care for medically needy effective September 2003.
Louisiana	**Parents/Adults**: Eliminated consideration of TANF work requirements in determining Medicaid eligibility effective September 20, 2003. **Other**: Disregard cash surrender value of life insurance policies with combined face value up to $10,000 and increase burial fund exclusion to $10,000 for MNP, QMB, QI-1, SLMB, and TB infected individuals and special income level group effective August 20, 2003 (897).
Maine	
Maryland	**Children:** SCHIP: Reduced maximum income-qualifying level from 200% FPL to 185% FPL for Medicaid expansion (free) program effective July 1, 2003; reduced minimum income-qualifying level from 200% FPL to 185% FPL for separate child health (premium) program effective June 30, 2004. **Children**: Retroactive eligibility may be determined (6500). **Other**: Aliens: • Maryland residency linked to visa status for women's Breast and Cervical Cancer Health Program effective August 2003. • Ineligible if enrolled in Medicare A or B. • 1902r2: income and resource methodologies liberalized for family and ABD populations.
Massachusetts	**Parents/Adults:** Expansion: Moved Mass Health Limited members to MassHealth Essential effective June 2004. **Parents/Adults**: Cut: Reduced income eligibility for individuals with HIV from under 200% FPL to under 133% FPL. **Disabled:** Expansion: Moved MassHealth Limited members to MassHealth Essential

State	Eligibility Change
	effective June 2004. **Aged**: Expansion: Moved MassHealth Limited members to MassHealth Essential (300 total) effective June 2004. **Other**: Pilot program: Online application with one hospital.
Michigan	**Disabled**: Added Ticket to Work program effective January 1, 2004 (90).
Minnesota	
Mississippi	
Missouri	**Aged and Disabled**: Expanded Medicaid eligibility to 90% from 80% effective October 1, 2003 (17,992 total).
Montana	
Nebraska	**Children**: Eliminated coverage for 19-20 year old Ribicoff kids effective August 2003 (3100)
Nevada	**Children**: Discontinued budgeting income/resources for Child Welfare cases effective March 2004 (600) and automatic Medicaid to unborn effective month of due date effective April 2004 (1300).
New Hampshire	
New Jersey	
New Mexico	
New York	**Disabled**: Added Buy-in program for working disabled effective July 2003 (2000).
North Carolina	**Aged and Disabled:** If a person applying for Medicaid gives away a countable resource, state evaluates it under the transfer of assets policy and applies sanctions as appropriate effective October 2003.
North Dakota	
Ohio	**Disabled**: Home care waiver was modified to exclude persons more appropriately served by the Department of MR/DD who are no longer eligible for this waiver effective July 2003.
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	
Tennessee	
Texas	**Parents/Adults**: Discontinued coverage for adult clients with income above the TANF level (medically needy) effective September 1, 2003 (7866). **Parents/Adults**: Discontinued coverage for pregnant women age 19 and older with income above 158% FPL level effective September 1, 2003 (4973).
Utah	**Parents/Adults**: Lowered cap for PCN waiver program enrollment from 25,000 to 19,900 in Nov 2003- reopened enrollment in May 2004 for adults with children. **Aged and Disabled**: Increased spend down threshold (900 total) effective July 1, 2003. **Other**: Increased blind categorically needy income eligibility from SSI to 100% FPL effective July 1, 2003.
Vermont	
Virginia	**Parents/Adults**: Eliminated 12 months of transitional Medicaid coverage under welfare reform (3400) effective July 1, 2003.
Washington	**Children**: Eliminated continuous eligibility during a 12 month certification period (350,000) effective October 2003.
West Virginia	
Wisconsin	
Wyoming	

Appendix G: Eligibility Related Actions Taken in the 50 States and District of Columbia in FY 2005

State	Eligibility Change
Alabama	**All adults:** Changed nursing home eligibility from average nursing home rate calculation by using actual numbers instead of rounding down. Saved $4 million/year and will delay Medicaid eligibility by up to one month effective July 1, 2004.
Alaska	**Children**: Froze income eligibility standard. **Parents/Adults**: Froze income limit eligibility for poverty pregnant women.
Arizona	**Aged and Disabled**: Federal benefit (SSI-max) increased for aged and disabled only (150,000 total) effective January 1, 2005.
Arkansas	**Parents/Adults**: Will add prenatal care for undocumented aliens using SCHIP dollars with baby getting the benefit.
California	
Colorado	**Other**: Legal immigrants law passed in 2003 to remove from full Medicaid; expected to be implemented in FY 2005 (3514).
Connecticut	
Delaware	
District of Columbia	**Other**: Expand childless adult (ages 50-64) from 50% to 100% FPL and 19-27 up to 50% (new population) pending CMS approval (600). **Disabled**: Elderly and physically disabled waiver added. **Other**: HIV Waiver added.
Florida	**Other**: Clarifies that certain reasonable costs of medically necessary services and supplies as well as the cost of premiums, copayments, coinsurance, and deductibles for supplemental health insurance must be deducted from an individual's income when determining the person's share of the cost of care for NH, ICF/DD or state mental health hospital services.
Georgia	**Parents/Adults**: Reduced the Medicaid eligibility income limit for pregnant women and their infants from 235% FPL to 200% FPL, effective July 1, 2004 (7,500). **Aged**: Eliminated medically needy in nursing home effective September 30, 2004 (1700).
Hawaii	
Idaho	**Disabled**: Medicaid buy-in for disabled workers only for those currently on Medicaid, targeting implementation in January 2005.
Illinois	**Parents/Adults**: Expanded Family care from 90% to 133% (56,000).
Indiana	
Iowa	**Other**: Added family planning coverage 1115 waiver effective July 1, 2004 (39,479).
Kansas	
Kentucky	
Louisiana	**Aged and Disabled**: Abolished in-kind support and maintenance as an income type.
Maine	**Parents/Adults**: Expand income eligibility for parents from 150% to 200% (25,000). **Other**: Increase non-categorical adults from 100% to 125% of FPL (10,000).
Maryland	**Children**: SCHIP: Increase maximum income qualifying level from 185% FPL to 200% FPL for Medicaid expansion (free) program; increase minimum income-qualifying level from 185% FPL to 200% FPL for separate child health (premium) program effective July 1, 2004 (6500).
Massachusetts	**Other**: Automatic MassHealth application process for people in uncompensated care pool effective October 1, 2004 (25,000 to 40,000). **Other**: HIV coverage from under 133% FPL to under 200% FPL effective October 1, 2004 (125).
Michigan	
Minnesota	
Mississippi	**Aged and Disabled**: Eliminate coverage for aged and disabled between 100% and 133% of the FPL that are covered by both Medicaid and Medicare (47,000).
Missouri	**Children**: Lower asset test for SCHIP children to $25,000 from $250,000 net worth effective July 1, 2004 (881). **Parents/Adults**: Reduce income eligibility for low income parents from 77% to 75% of FPL effective July 1, 2004 (324). **Aged and Disabled**: Expanded Medicaid eligibility from 90% to 95% FPL effective October 1, 2004 (11,758 total).

State	Eligibility Change
Montana	
Nebraska	
Nevada	**Children**: Eliminated asset test for CHAP effective July 1, 2004 (897). **Parents/Adults**: Eliminated asset test for CHAP effective July 1, 2004 (897). **Disabled**: Medicaid buy-in program for working disabled effective July 1, 2004 (300). **Other**: Spousal needs: income included in budget for Medicare beneficiaries effective July 1, 2004 (164).
New Hampshire	
New Jersey	
New Mexico	
New York	**Children**: Children between 100%-133% were moved from Medicaid to SCHIP effective October 1, 2004 (70,000). **Parents/Adults**: Added resource test for Family Health Plus (three times higher than medically needy, subject to waiver approval) effective November 1, 2004.
North Carolina	
North Dakota	
Ohio	
Oklahoma	**Other**: Added Breast and Cervical Cancer Program effective January 2005 (10,000) **Other**: Added family planning waiver pending CMS approval (40-45,000 people when fully implemented).
Oregon	**Parents/Adults:** Closed enrollment for OHP Standard effective July 1, 2004. Currently 54,000 enrolled. Expect to reduce the number to between 25,000 and 30,000 people.
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	**Other**: Family planning waiver added in 2005
Tennessee	
Texas	**Parents/Adults**: Reinstated coverage for pregnant women back to 185% FPL effective September 1, 2004.
Utah	
Vermont	
Virginia	
Washington	
West Virginia	
Wisconsin	
Wyoming	

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

State	Benefit Change
Alabama	
Alaska	
Arizona	
Arkansas	
California	**All Adults**: Dental restrictions, no lab, process crowns, cap on caps, required x-rays for 4+ restorations, cut rates for deep root planning/ new utilization controls and limits every year.
Colorado	**Other**: (+) Nursing home visitor services financed through Medicaid **Other**: (-) Non-emergency transportation funding was reduced
Connecticut	**All Adults**: Eliminated physical therapy, naturopathy, chiropractor, podiatry, psychologists; no restorations.
Delaware	
District of Columbia	**Other**: Added new services to EPD waiver (374). **Other**: Added new services to MRDD waiver (450).
Florida	**All Adults**: Eliminated vision and hearing services for adults. Emergency dental care was restored (80,000 total).
Georgia	**Adults:** Dental services reduced for certain procedures **Children**: Prior Authorization for home health therapies (9000).
Hawaii	
Idaho	
Illinois	
Indiana	
Iowa	
Kansas	
Kentucky	
Louisiana	**Children**: EPSDT early intervention services (state plan amendment waiting approval of CMS) **Parents/Adults**: Initiated a new Medicaid program to extend services to pregnant women—state will cover limited dental service to prevent pre-term low birth weight babies (5000 women). **Aged and Disabled**: Long term care-personal care services (PCS) for the elderly or disabled **Other**: Home and Community Based Waiver service expansions
Maine	**Other**: New prior authorization limits for all population groups
Maryland	**All Adults**: Hospital services for adults in FFS are subject to hospital day limits
Massachusetts	**All Adults**: Hospital services for adults in FFS are subject to hospital day limits (6200 total).
Michigan	**All Adults**: Suspended chiropractic, non-emergency dental, hearing aids, and podiatric services were suspended for beneficiaries age 21 and older (170,000 total).
Minnesota	**All Adults**: $500 cap on adult dental services.
Mississippi	
Missouri	**All Adults**: Expand psychologist services to adults.
Montana	**Parents/Adults**: Restored cuts for optional services i.e. dental eyeglasses, hearing aids (34,000 adults). **Other**: Renewed 1115 waiver for able bodied individuals. **Other**: PASSPORT to health waiver extended 4/1/04. **Other**: Implemented new care management services.
Nebraska	**Children**: Orthodontia limited to severe conditions (1800). **All Adults**: Chiropractic limited to 20 visits per year, eyeglass replacement limited to once per year (500 total). **Other**: Added hospice service as a benefit for all populations.
Nevada	**Disabled**: Limit personal care aide IADL hours (36,406). **Aged**: Limit personal care aide IADL hours (9800).
New Hampshire	
New Jersey	

State	Benefit Change
New Mexico	**All Adults**: Tighter ranking for orthodontia, dental sealants, eliminated premolars.
New York	
North Carolina	**Children**: • Implemented coverage for certain over the counter (OTC) drugs (54404). • Limited PCS coverage to 60 hours per month; • Implemented medical necessity criteria for recipients to qualify for up to 20 additional hours over the 60 PCS hour limitation; new service called PCS plus (49). • Implemented coverage of ocular photodynamic therapy with verteporfin for the treatment of age related macular degeneration; and • Implemented coverage of ultrasonic osteogenesis stimulators to promote healing of non-union fractures. **Parents/Adults**: • Implemented coverage for certain OTC drugs (63196); • Limited PCS coverage to 60 hours per month; • Implemented medical necessity criteria for recipients to qualify for up to 20 additional hours over the 60 PCS hour limitation; new service called PCS plus (324). • Implemented coverage of ocular photodynamic therapy with verteporfin for the treatment of age related macular degeneration (2); and • Implemented coverage of ultrasonic osteogenesis stimulators to promote healing of non-union fractures. (5) **Disabled**: • Implemented coverage for certain OTC drugs (139638); • Limited PCS coverage to 60 hours per month; • Implemented medical necessity criteria for recipients to qualify for up to 20 additional hours over the 60 PCS hour limitation; new service called PCS plus (967); • Implemented coverage of ocular photodynamic therapy with verteporfin for the treatment of age related macular degeneration (2); and • Implemented coverage of ultrasonic osteogenesis stimulators to promote healing of non-union fractures. (17) **Aged**: • Implemented coverage for certain OTC drugs (109816); • Limited PCS coverage to 60 hours per month; • Implemented medical necessity criteria for recipients to qualify for up to 20 additional hours over the 60 PCS hour limitation; new service called PCS plus (14677); • Implemented coverage of ocular photodynamic therapy with verteporfin for the treatment of age related macular degeneration (9); and • Implemented coverage of ultrasonic osteogenesis stimulators to promote healing of non-union fractures. (16)
North Dakota	Utilization limits for everyone. Restoration of adult dental, restore partial and root canals in the front of mouth (54,000)
Ohio	**All Adults**: Eliminated of chiropractor and psychologist services (will continue to cover psych through mental health) (390,000).
Oklahoma	**All Adults**: Restored-adult extraction. Annual limit for IPH days increased 15 to 24 days. Drug benefit expanded.
Oregon	
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	**All Adults**: Expanded hospice benefit.
Tennessee	
Texas	**All Adults**: Discontinued coverage for certain optional Medicaid services for adults age 21 and over: eyeglasses/contact lenses, hearing aids, services provided by podiatrists, services provided by chiropractors, psychological services (from licensed Psychologists, licensed marriage and family therapists, licensed professional counselors, and licensed masters social worker-advanced clinical practitioners).

State	Benefit Change
Utah	**All Beneficiaries**: Eliminate circumcision (legislated change).
Vermont	**All Adults**: Indefinite suspension of eyewear coverage.
Virginia	
Washington	**Parents/Adults**: Crowns, root canals on back teeth, mouth guards, and some replacement dentures will not be covered. All dentures and partial dentures require prior authorization.
West Virginia	
Wisconsin	**Disabled**: Implementation of waiver to provide autism to disabled children (1000).
Wyoming	

Appendix I: Benefit Related Actions Taken in the 50 States and District of Columbia in FY 2005

State	Benefit Change
Alabama	**All Adults**: Reduce physician office visits from 14 to 12 per year. Limit Rx brand to 4/month (previously no limits).
Alaska	
Arizona	
Arkansas	
California	
Colorado	**Parents/Adults**: HB 04-1075 extends Medicaid substance abuse treatment services for high-risk pregnant women from 60 days to 12 months post partum (39.5). **Disabled**: Private duty nursing is now limited to 16 hours a day (120). Community transition services were added to the HCBS waiver. **Aged**: Community transition services were added to the HCBS waiver (90 aged and disabled). **Other**: Medical transportation was changed from a Medicaid benefit to an administrative service.
Connecticut	
Delaware	
District of Columbia	**Other**: New coverage for persons needing substance abuse rehabilitation services (2800).
Florida	**Other**: Coverage for dentures and related procedures for adults. (28,000).
Georgia	**Children**: Require prior authorization for child intervention services (occupational therapy, physical therapy, and speech therapy).
Hawaii	
Idaho	
Illinois	
Indiana	
Iowa	
Kansas	**Other**: Expansion of durable medical equipment (DME) for people aging out of EPSDT. Covering battery replacement.
Kentucky	
Louisiana	**Other**: Phase out PCA waiver due to state plan PCS. Elderly and disabled waiver will increase by 175 slots. Adult day waiver will increase by 25 slots. NOW will increase by 66 slots for emergency placements. Also expanding services under School based services and PACE will begin in New Orleans effective February 2005 and is expected to enroll up to 200 Medicaid enrollees in this capitated model of care.
Maine	**Parents/Adults**: MaineCare basic-limit on psychological services, physical therapy, occupational therapy and chiropractic services (5000) **Disabled**: Tighter caps on PCA hours, caps on brain injury rehabilitative hours (700) **Aged**: Tighter caps on day health hours
Maryland	**Parents/Adults**: Adults in FFS subject to further hospital day limits (last year 105%, this year 100% of average length of stay by DRG). Still awaiting federal approval (6200 total). **Disabled**: Adults in FFS subject to further hospital day limits (last year 105%, this year 100% of average length of stay by DRG). Still awaiting federal approval (6200 total).
Massachusetts	
Michigan	**All Adults:** Restored coverage for chiropractic services, podiatry and hearing aids.
Minnesota	**Children**: Changed requirements for children's mental health to provide services to kids before they are diagnosed. **All**: Changed to a vendor for non-emergency medical transport.
Mississippi	
Missouri	**Children**: Expand dental services to include dental hygienists in public health setting (302,032). **Aged and Disabled**: Provide two annual authorized nurse visits (home health/HCBS type of services) (21,590 total).
Montana	

State	Benefit Change
Nebraska	**All Adults**: Will add substance abuse treatment for adult populations through managed care
Nevada	**Aged**: Group care waiver expanded to 3 levels of service.
New Hampshire	
New Jersey	
New Mexico	**Children**: Tightened orthdontia scale. **Parents/Adults, Disabled and Aged**: Decreased: dental for crowns and root canals, capped h.a. decreased podiatry, physical therapy, occupational therapy, speech, DME, eyeglasses, transport, meals and lodging, MRI/CT scan, GBS.
New York	
North Carolina	**All**: NC is implementing a broad mental health reform initiative. The emphasis will be on making community based services more readily available, increasing provider types who are able to bill outpatient behavioral health service, and making an "enhanced benefit" package available to those recipients who exhibit medical necessity.
North Dakota	
Ohio	
Oklahoma	**Other**: High risk OB coverage.
Oregon	**Other**: Modified standard benefit package with limited hospital benefit and prior authorization requirements; adds mental health, chemical dependency, limited DME and supplies, and emergency dental; eliminates physical therapy, occupational therapy and speech therapy (approximately 30,000).
Pennsylvania	
Rhode Island	
South Carolina	**All**: Allowing exceptions to 12 visit per year for physician
South Dakota	
Tennessee	**Other**: Expansion population will be subject to benefit limits-pending CMS approval-children, pregnant women, disabled excluded from limitations.
Texas	
Utah	**All adults**: Restored physical therapy, audiology and emergency dental. Expect to run out of funding and discontinue benefit in January or February of 2005 (60,000).
Vermont	
Virginia	
Washington	
West Virginia	
Wisconsin	
Wyoming	

Appendix J: Disease Management and Case Management Actions Taken in the 50 States and District of Columbia in FY 2004

State	FY 2004 Disease Management/Care Management Initiatives
Arizona	Implemented disease management programs targeting Diabetes and Asthma.
Colorado	Continued disease management pilots and began contracting with administrative service organizations (ASOs). Disease states include asthma, diabetes, neonatal intensive care unit (NICU), schizophrenia with co-morbid medical condition, and intensive care management for long-term care and Chronic Obstructive Pulmonary Disorder (COPD).
District of Columbia	Required managed care organizations to do asthma and diabetes disease management.
Georgia	Implemented enhanced case management and emergency room utilization management programs.
Idaho	Added disease specific education for diabetes and asthma and an emergency room strategy to target emergency room visits related to asthma or diabetes.
Indiana	Implemented a chronic care management program for diabetes, congestive heart failure (CHF), and asthma statewide using a phased in approach.
Iowa	Added an adult diabetes pilot program.
Louisiana	Within PCCM, added chronic asthma patient care coordination with primary care physician.
Maryland	Made changes to the rare and expensive case management program by reducing the number of visits and by reducing rates
Massachusetts	MassHealth Essential includes a plan-based care management component
Missouri	Added case management to disease management. Disease states targeted include diabetes, asthma, depression, and CHF.
Montana	Added a care management program and disease management program targeting asthma, diabetes, CHF, cancer and chronic pain.
New Jersey	Added disease management for mental health, diabetes, asthma and CHF within the fee-for-service (FFS) program.
New Mexico	Disease management performance incentives for behavioral health built into managed care contracts.
North Carolina	Disease management initiatives for asthma and diabetes added within the PCCM program.
Oklahoma	Implemented behavioral health disease management.
Oregon	COPD program added to ongoing disease management programs for diabetes, CHF and asthma. Also, increased the number of enrollees receiving case management including all transplant cases.
Rhode Island	Implemented drug utilization review and drug prior authorization interface with disease management program.

Appendix K: Disease Management and Case Management Related Actions Taken in the 50 States and District of Columbia in FY 2005

STATE	FY 2005 Disease Management/Case Management Initiatives
Arizona	Added obesity program for children.
California	Issuing an RFP for a multi-disease pilot.
Idaho	Broadening scope of programs to include diabetes, asthma and other diseases.
Indiana	Broadening chronic care management program to address hypertension, stroke, and HIV/AIDs.
Kansas	Implementing care management pilot within PCCM program.
Louisiana	Partnering with public hospitals to improve diabetes care and reduce inpatient emergency room utilization and to develop cost-effective care strategies for obesity. Also piloting remote critical care consulting for intensive care unit (ICU) population to shorten length of ICU stay.
Maine	Adding management for high cost cases.
Maryland	Changing utilization control for REM Case management.
Michigan	[No detail provided]
MIssissippi	[No detail provided]
Missouri	Expanding disease management program to include three more disease states and chronic care management. Also expanding drug pager pilot project, telemonitoring pilot project, and telemedicine pilot project.
New Hampshire	Looking at care management for behavioral health system, asthma, diabetes, CHF and chronic obstructive pulmonary disease (COPD).
New Jersey	Implementing disease management
New Mexico	Changed some of the FY 2004 performance measures.
New York	New state budget calls for up to six disease management contracts. Case management enhancement for certain high cost/high service mental health and other "specialty populations."
North Carolina	Adding a pharmacy initiative for diabetes and/or asthma.
Ohio	Implementing a non-capitated community based managed care initiative for certain non-waiver aged and disabled with specific medical conditions including CHF, diabetes, asthma, or COPD and children (under age 21) with asthma.
Oklahoma	Implementing a diabetes program with the University of Oklahoma.
Pennsylvania	Disease management programs for diabetes, CHF, and high risk pregnant women added within the PCCM program.
South Carolina	Will implement a disease management program for fee-for service (FFS) beneficiaries targeting asthma, diabetes and hypertension.
South Dakota	Will implement a care management program for disabled population.
Tennessee	To be implemented in FY 2005
Texas	Disease management programs will begin in FY 2005 and will target common chronic diseases such as diabetes, CHF, coronary artery disease, asthma and COPD.
Virginia	Will implement a pilot disease management program
Washington	Adding a disease management program for COPD.
West Virginia	Implementing an enhanced disease management program for diabetes.
Wisconsin	Implementing mental health drug profiling.
Wyoming	Implementing a "total health management" program that will provide care management for mental health and all chronic illnesses. Every case management intervention will address mental health, substance abuse and weight management.

Appendix L: Survey Instrument

Medicaid Budget Survey for Fiscal Years 2003, 2004 and 2005

State of: _____ Name: _____ Date:_____

Phone: _____ Email: _____

Section I. Medicaid Expenditure Growth: State Fiscal Years 2003, 2004 and 2005

A. For each year shown below, please indicate the annual percentage change in total Medicaid expenditures (excluding administration), and the annual percentage change for each source of funds. **In calculating growth rates, please reflect the enhanced FMAP available for the five quarters from April 2003 through June 2004.**

	% Changes, for Each Source of Funds			
	State Funds	Local or Other Funds	Federal Funds	Total: All Fund Sources
FY 2003 1. Percentage change: FY 2003 Medicaid Expenditures over FY 2002 Expenditures	%	%	%	%
FY 2004 2. Percentage Change: FY 2004 Medicaid Expenditures over FY 2003 Expenditures	%	%	%	%
FY 2005 3. Percentage Change: FY 2005 Medicaid Appropriated Expenditures over FY 2004 Projected Expenditures	%	%	%	%

This space is provided for any comments or explanations:

_____

_____

_____

B. Was FY 2004 spending greater than the original appropriation? Yes ____ No _____ .
If "Yes," how was the shortfall covered?

_____

_____

C. What are your broad impressions of the spending and enrollment trends that your state is experiencing? Are pressures on your Medicaid program (*check one*):

a. ____ Growing,
b. ____ Remaining constant, or
c. ____ Subsiding?

Comments:_____
_____
_____

Section II. State Fiscal Year 2004

1. **Factors Driving Expenditure Changes:** What would you consider to have been *the most significant factors* contributing to the increase/decrease in your state's Medicaid spending in FY 2004?
   a. Most significant factor? _____
   b. Second most significant factor? _____
   c. Other significant factors? _____

2. **Medicaid Enrollment Changes in FY 2004**:
   a. Overall % enrollment growth/decline (+/–), FY 2004 over FY 2003: %
   b. What *eligibility groups* contributed to the increase/decrease in Medicaid enrollment in FY 2004?
      i. Most significant group? _____
      ii. Second most significant group?_____
   c. What were the *key factors* contributing to increases/decreases in enrollment? (E.g., eligibility increases or decreases, changes in the application or redetermination process, economy, etc.)
      i. Most significant factor? _____
      ii. Second most significant factor? _____
      iii. Other significant factors? _____

3. **Provider Payment Rates**: For each provider type, please describe any rate increases (including inflationary increases) or decreases *implemented* in FY 2004 (e.g. indicate % increase, or % decrease). If no change, indicate an X under Freeze.

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

4. **Provider Taxes/Assessments**:
   Please describe any provider taxes that were in place in FY 2004. Also, indicate if any were first *implemented* or *discontinued* during FY 2004 or were *increased* or *decreased* in FY 2004.

Provider Group Subject to Tax	Description	New in FY '04? (Yes or No)	Discont'd in FY '04? (Yes or No)	Increased or Decreased in FY'04? (briefly describe)
a.				
b.				
c.				
d.				

5. Changes in Eligibility Standards or Application/ Renewal Process in FY 2004:
In the table below please describe any expansion, reduction, restriction, restoration or other change in ***eligibility standards*** (e.g., income standards, asset tests) *implemented* during FY 2004.

Eligibility Category	Nature of Eligibility Change: Expansion, Reduction, Restriction, Restoration or Other Change	Effective Date	Estimated No. of People Affected
a. Children			
b. Parents/ Adults			
c. Disabled			
d. Aged			
e. Other			

6. Premiums: In the table below, please describe any premium increases or decreases or any new premiums *implemented* during FY 2004.

Eligibility Category	Nature of Premium Change: Increase, Decrease or New Premium	Effective Date	Estimated No. of People Affected
a. Children			
b. Parents/ Adults			
c. Disabled			
d. Aged			
e. Other			

7. Process: Did your state make any changes to the ***application or renewal process*** in FY 2004 (e.g., changes in verification requirements, face to face interview requirements, application forms, re-determination process, etc.)? Yes ____ No ____

If "Yes," please describe those changes, and the estimated number of people affected:

_____

_____

7. Changes in Benefits or Services in FY 2004: Please describe below any expansion, reduction, restriction, restoration or other change in benefits or services *implemented* during FY 2004.

Populations Affected	Nature of Benefit or Service Change, Expansion, Reduction, Restriction, Restoration or Other Change	Effective Date	Estimated No. of People Affected
a. Children			
b. Parents/ Adults			
c. Disabled			
d. Aged			
e. Other			

9. **Changes in Co-payments**: Please describe any beneficiary co-payment that was *newly implemented, increased* or *decreased* in FY 2004:

Populations Affected	New, Higher or Lower Beneficiary Copays (or other cost sharing requirements) by Service, e.g., for prescription drugs, dental, etc.
a. Parents/ Adults	
b. Disabled	
c. Aged	
d. Other	

10. **Prescription Drug Program Changes:** What *new a*ctions were *implemented* during FY 2004 to slow the growth in Medicaid expenditures for prescription drugs *or* to restore previous cuts? Please briefly describe those that apply.

Program or Policy Actions	Actions Implemented During FY 2004
a. Change in dispensing fees	
b. Change in ingredient cost (i.e., AWP – X% *or* WAC + X%)	
c. New/lower state MAC rates	
d. More/fewer drugs subject to prior authorization	
e. Preferred drug list	
f. Supplemental rebates	
g. Limits on the number of Rx per month imposed or lifted	
h. Requirements to use generics	
i. Mail order pharmacy contract	
j. Contract with a specialized pharmacy claims processor	
k. Long term care pharmacy initiative	
l. Multi-state purchasing	

coalition	
m. Managed care pharmacy carve-out	
n. State sponsored 340B enrollment of eligible entities or State partnerships with 340B eligible entities	
o. Other pharmacy policy change	

11. Other Cost Containment Measures or Policy Changes: What other program or policy actions were *implemented* during FY 2004 to slow the growth in Medicaid expenditures *or* to restore previous cuts? Please briefly describe those that apply.

Program or Policy Actions	Description of Actions Implemented in FY 2004
iv. Managed Care: i. Expansion/contraction of PCCM or MCO service areas ii. Enrollment of new eligibility groups (please specify) iii. Change from voluntary to mandatory enrollment (please specify by eligibility category)	
b. Disease Management or Case Management (specify disease states or approaches)	
c. Long-Term Care Changes: Nursing Home (excluding rate changes listed in Question 4 above.)	
d. Home and Community Based Services	
e. Medicare Crossover Claims Policies	
f. Accounting Change (e.g., shift from accrual to cash accounting.)	
g. Enhanced Fraud and Abuse Controls	
h. Program Administration (e.g. staffing reductions, changes or freezes)	
i. Other:	

Notes on above actions: _____
_____
_____
_____

Section III: State Fiscal Year 2005

12. **Legislative Action**: Has your legislature enacted the Medicaid budget for FY 2005? Yes__ No __

13. **Factors Driving Expenditure Changes:** What factors do you expect to be the principal drivers of Medicaid expenditure changes in FY 2005?

a. Most significant factor? _____
b. Second most significant factor? _____
c. Other significant factors? _____

14. **Enrollment Changes in FY 2005:**

a. Overall % enrollment growth/decline (+/–), projected for FY 2005 over FY 2004: _____%

b. What *eligibility groups are* expected to contribute most to the increase/decrease in Medicaid enrollment in FY 2005?

i. Most significant group? _____
ii. Second most significant group?_____

c. What are the *key factors* contributing to increases/decreases in enrollment? (E.g., eligibility increases or decreases, changes in the application or redetermination process, economy, etc.)

i. Most significant factor? _____
ii. Second most significant factor? _____
iii. Other significant factors? _____

15. **Provider Payment Rates**: For each provider type, please describe any rate increases (including inflationary increases) or decreases to be implemented in FY 2005 (e.g. indicate % increase, or % decrease). Indicate an X for no change).
Please write "**R**" after an indicated % increase if it is a restoration of a previous rate cut.

Provider Type	+% Increase (R?)	-% Decrease	X=No Change
a. Pharmacy			
b. Inpatient hospital			
c. Outpatient hospital			
d. Doctors			
e. Dentists			
f. Managed care organizations			
g. Nursing homes			
h. Home health providers			
i. Home and community-based waiver providers			
j. Others:			

16. **Provider Taxes or Assessments**: Please briefly describe any new provider taxes or changes to be made to existing provider taxes in FY 2005:

Provider Group Subject to Tax	Description	New in FY '05? (Yes or No)	Discont'd in FY '05? (Yes or No)	Increased or Decreased in FY'05? (briefly describe)
a.				
b.				
c.				
d.				

17. Changes in Eligibility Standards or Application Processes in FY 2005: Please describe below any expansion, reduction, restriction, restoration or other change in ***eligibility standards*** (i.e., income or asset tests) to be implemented during FY 2005.

Eligibility Category	Nature of Eligibility Change: Expansion, Reduction, Restriction, Restoration or Other Change	Effective Date	Estimated No. of People Affected
a. Children			
b. Parents/ Adults			
c. Disabled			
d. Aged			
e. Other			

18. Premiums: In the table below please describe any premium increase or decrease or any new premium *implemented* during FY 2005.

Eligibility Category	Nature of Premium Change: Increase, Decrease or New Premium	Effective Date	Estimated No. of People Affected
a. Children			
b. Parents/ Adults			
c. Disabled			
d. Aged			
e. Other			

19. Process: Is your state making any changes to the ***application or renewal process*** in FY 2005 (e.g., changes in verification or face to face interview requirements, applications, renewal process, etc.)? Yes ___ No ___

If "Yes," please briefly describe those changes, and the estimated number of people affected:
_____
_____

20. Changes in Covered Benefits in FY 2005: Please describe below any expansion, elimination, restriction, restoration or other change in *benefits or services* that are to be implemented during FY 2005.

Populations	Nature of Benefit or Service Change: Expansion, Reduction, Restriction, Restoration or Other Change	Effective Date	Estimated No. of People Affected
a. Children			
b. Parents/ Adults			
c. Disabled			
d. Aged			
e. Other			

21. **Prescription Drug Program Changes:** What program or policy actions are to be adopted for FY 2005 to slow the growth in Medicaid expenditures for prescription drugs *or* to restore previous cuts? Please briefly describe those that apply.

Program or Policy Actions	Actions Implemented During FY 2005
a. Change in dispensing fees	
b. Change in ingredient cost (i.e., AWP – X% *or* WAC + X%)	
c. New/lower state MAC rates	
d. More/fewer drugs subject to prior authorization	
e. Preferred drug list	
f. Supplemental rebates	
g. Limits on the number of Rx per month imposed or lifted	
h. Requirements to use generics	
i. Mail order pharmacy contract	
j. Contract with a specialized pharmacy claims processor	
k. Long term care pharmacy initiative	
l. Multi-state purchasing coalition	
m. Managed care pharmacy carve-out	
n. State sponsored 340B enrollment of eligible entities or State partnerships with 340B eligible entities	
o. Other pharmacy changes	

22. **Changes in Copayments**: Please describe any beneficiary copayment to be *newly implemented, increased* or *decreased* for FY 2005:

Populations Affected	New, Higher or Lower Beneficiary Copays (or other cost sharing requirements) by Service, e.g., for prescription drugs, dental, etc.
a. Parents/ Adults	
b. Disabled	
c. Aged	
d. Other	

23. Other Cost Containment Measures or Policy Changes: What other actions are to be used for FY 2005 to control the growth in Medicaid expenditures or to restore previous cuts? Please describe those that apply.

Program or Policy Actions	Description of Actions Implemented in FY 2005
a. Managed Care: i. Expansion/contraction of PCCM or MCO service areas ii. Enrollment of new eligibility groups (please specify) iii. Change from voluntary to mandatory enrollment (please specify by eligibility category)	
b. Disease Management or Case Management (specify disease states or approaches)	
c. Long-Term Care Changes: Nursing Home (excluding rate changes listed in Question 15 above.)	
d. Home and Community Based Services	
e. Medicare Crossover Claims Policies	
f. Accounting Change (e.g., shift from accrual to cash accounting.)	
g. Enhanced Fraud and Abuse Controls	
h. Program Administration (e.g. staffing reductions, changes or freezes)	
i. Other:	

Notes on above actions: _____
_____

24. **Potential Shortfall:** When you look now at the amount appropriated (or that you expect to be appropriated) for FY 2005 for Medicaid, how likely do you believe it is that your state will experience a Medicaid budget shortfall in FY 2005? (Indicate with an **X**.)

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

25. **Use of Enhanced FMAP:** How did your state use the fiscal relief provided through the 2.95% FMAP increase for the five quarters ending June 30, 2004? (*Check as many as apply*.)

a. _____To avoid, minimize or postpone proposed cuts or freezes.
b. _____To provide program increases that would not otherwise have been made.
c. _____To help resolve an overall budget shortfall in the Medicaid budget.
d. _____To help resolve an overall shortfall in the state general fund budget.
e. _____The funds are being held in a reserve or trust.
f. _____Other: _____

26. **Expiration of Enhanced FMAP:** How would you describe the impact on the Medicaid program of the expiration of the enhanced FMAP on July 1, 2004?

_____
_____
_____
_____

27. **Special Financing**: How has the recent enhanced federal scrutiny of special financing programs in Medicaid impacted the Medicaid program in your state? (E.g., the use of provider taxes and IGTs to fund DSH and upper payment limit reimbursement systems.)

_____
_____
_____
_____

28. **Medicare Prescription Drug Benefit:**

a. Are you expecting impacts on your Medicaid program from the implementation of the Medicare discount drug card?

_____
_____
_____
_____

b. Does your FY 2005 budget include funds for administering the low-income prescription drug subsidy? Yes_____ No_____ If "yes", how much has been budgeted?

_____
_____

c. What are the most significant issues that you expect to deal with relating to the Medicare Part D benefit that goes into effect on January 1, 2006?

_____

_____
_____
_____

29. State Pharmacy Assistance Programs:

a. Does your state have an SPAP program? Yes___ No _____

b. Does your FY 2005 budget assume savings to the SPAP program as a result of the drug discount card? Yes___ No _____

If "Yes," please indicate the amount of savings assumed: $_____

30. Outlook: What do you see as the most significant issues Medicaid will face over the next year?

_____
_____
_____

Thank you.

Please send the survey by email, fax or mail to:

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

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

Appendix M: 2004 Legislative Regular Session Calendar

State	Convenes	Adjourns
Alabama	Feb 3	May 17
Alaska	Jan 12	May 11
Arizona	Jan 12	May 26
Arkansas	-------	-------
California	Jan 5	Aug 31
Colorado	Jan 7	May 5
Connecticut	Feb 4	May 5
Delaware	Jan 13	June 30
Florida	March 2	April 30
Georgia	Jan 12	April 7
Hawaii	Jan 21	May 6
Idaho	Jan 12	March 20
Illinois	Jan 14	*
Indiana	Jan 12	March 4
Iowa	Jan 12	April 20
Kansas	Jan 12	May 27
Kentucky	Jan 6	April 13
Louisiana	March 29	June 21
Maine	Jan 7	Jan 30
Maryland	Jan 14	Apr 12
Massachusetts	Jan 7	*
Michigan	Jan 14	*
Minnesota	Feb 2	May 17
Mississippi	Jan 6	May 9
Missouri	Jan 7	May 28
Montana	------	-------
Nebraska	Jan 7	April 15
Nevada	------	------
New Hampshire	Jan 7	July 1
New Jersey	Jan 13	*
New Mexico	Jan 20	Feb 19
New York	Jan 7	*
North Carolina	May 10	Early July
North Dakota	-------	-------
Ohio	Jan 6	*
Oklahoma	Feb 3	May 28
Oregon	-----	-------
Pennsylvania	Jan 6	*
Rhode Island	Jan	June 25

State	Convenes	Adjourns
South Carolina	Jan 13	June 3
South Dakota	Jan 13	March 15
Tennessee	Jan 13	May 21
Texas	-------	-------
Utah	Jan 19	March 3
Vermont	Jan 6	May 20
Virginia	Jan 14	March 16
Washington	Jan 12	March 11
West Virginia	Jan 14	March 21
Wisconsin	Jan 20	*
Wyoming	Feb 9	March 5
American Samoa	Jan 12	
District of Columbia	Jan 2	*
Guam	Jan 12	*
Puerto Rico	Jan 12	June 30
Virgin Islands	Jan 12	*

* =Legislature meets throughout the year

----- =No regular session in 2004

SOURCE: National Conference of State Legislatures, 2004 Legislative Session. Accessed September 21, 2004 at:

http://www.ncsl.org/programs/legman/about /sess2004.htm

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