American Hospital Association

TRENDWATCH

Implications of Federal Medicaid Reform on States, Beneficiaries, and Providers — *April 2005, Vol. 7, No. 1*

Medicaid plays a pivotal role in the health care safety net, but pressures to reduce the deficit put funding for this program at risk.

In fiscal year (FY) 2005, the federal government's share of Medicaid will reach $186 billion, making it the third largest non-defense program in the federal budget behind Social Security and Medicare.[1] The Congressional Budget Office (CBO) projects a cumulative federal deficit of $1.3 trillion between 2006-2010.[2] Medicaid expenditures alone increased by one-third from $205.7 to $275.5 billion between FY 2000-2003.[3] A portion of these costs was attributable to enrollment growth related to the national recession, associated unemployment, and declining employer-sponsored health insurance coverage. While recession-induced enrollment slowed from FY 2003-2004, total Medicaid expenditures rose by $20 billion, with over two-thirds of the increase caused by greater beneficiary use of services.[4] Despite a stronger economy, Medicaid continues to grow in both enrollment and spending, prompting numerous reform proposals.

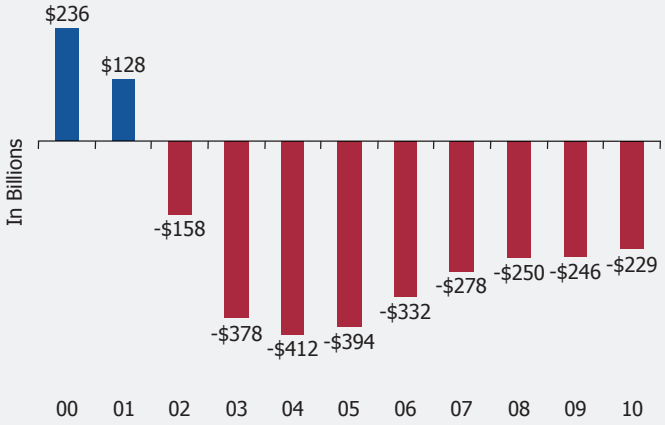
Several ways to curtail spending in the current Medicaid system are being debated. Some are designed to reduce federal expenditures and others promote state flexibility and enrollee choice. The Bush administration's proposed FY 2006 budget would reduce federal Medicaid expenditures by $60 billion over the next decade. Major aspects of the proposal include restructuring pharmacy reimbursement and drug rebates, restricting personal asset transfers for long-term care and further restricting federal matching payments for certain state funding programs. The budget also proposes $15 billion for other initiatives aimed at expanding access to health insurance.[5]

Proposed cuts come at a time when states, faced with their own budget crises, have already been working to rein in Medicaid costs through pharmacy cost containment initiatives, provider rate freezes and reductions and disease management programs.[6]

This issue of TrendWatch provides a brief overview of the Medicaid program, a discussion of the current proposals for Medicaid reform and spending cuts, and an appraisal of their potential implications for states, providers and the health care safety net. Recent efforts by states to reduce state spending can also be found in the State Medicaid Facts Appendix.

Pressure to reduce the federal deficit...

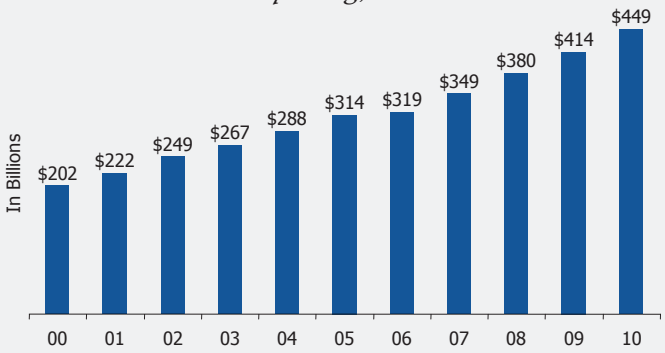
*Chart 1: Growth of Federal Deficit, 2000 – 2010**



*2005 - 2010 CBO's estimate of the president's budget, projected March 2005

...and rising Medicaid expenditures...

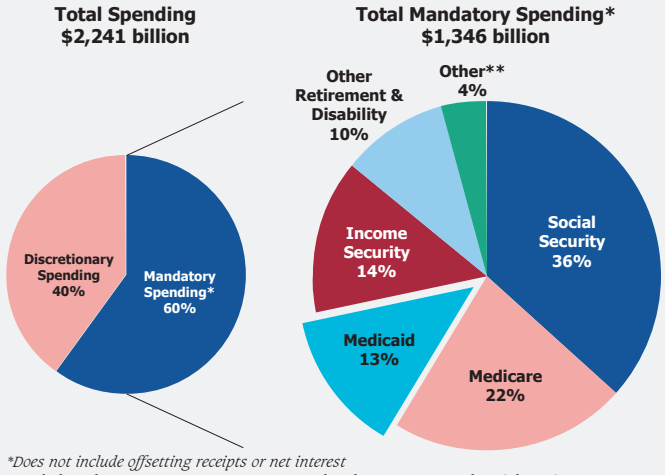
*Chart 2: Total Medicaid Spending, 2000 – 2010**



* State and federal expenditures include medical services, DSH payments and administration, calculated using calendar year data; 2005 - 2010 projected

...have made Medicaid a target for federal spending cuts.

Chart 3: Medicaid as a Percentage of Total Mandatory Federal Spending, 2004



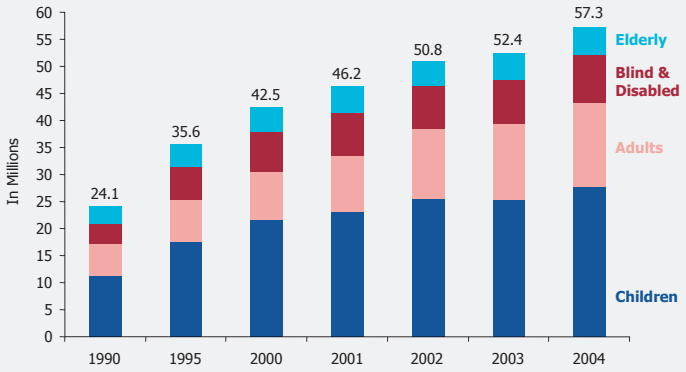
*Does not include offsetting receipts or net interest
**Includes other programs (e.g., TRICARE, Student loans, SCHIP, and Social Services)

The Lewin Group

Medicaid plays a pivotal role in securing the nation's health care safety net…

Enrollment in Medicaid continues to rise…

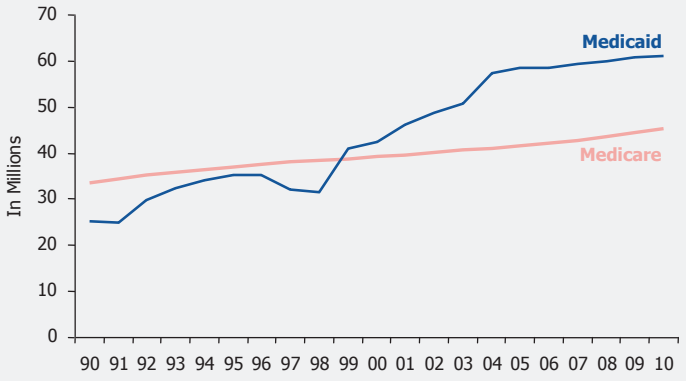
*Chart 4: Medicaid Enrollees, 1990 – 2004**



*Does not include SCHIP population

…surpassing Medicare in 1999…

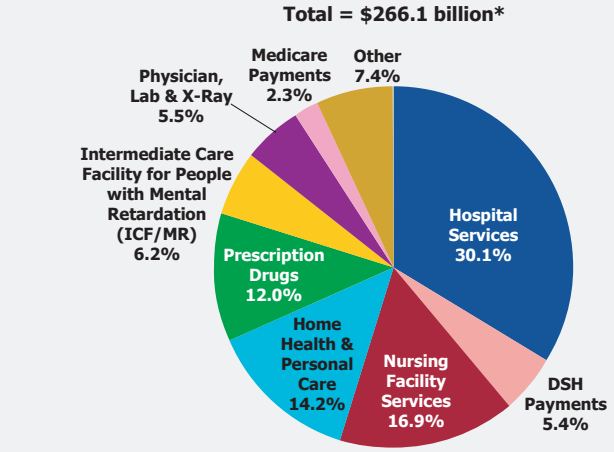
*Chart 5: Medicaid and Medicare Enrollment, 1990 – 2010**



*1990 – 2003 historical CMS data; 2004 – 2010 projected CBO data

…with the bulk of the dollars going to nursing home and hospital care…

Chart 6: Medicaid Spending by Service, 2003



* Includes medical services and DSH payments, not administration, calculated using fiscal year data

In 2004, Medicaid covered 57.3 million individuals, overtaking Medicare as the nation's largest public insurance program.[1] Medicaid accounts for 17 percent of total personal health care spending in the U.S.[2] and 14 percent of all hospital care,[3] making it an important revenue source for hospitals, clinics and other providers.

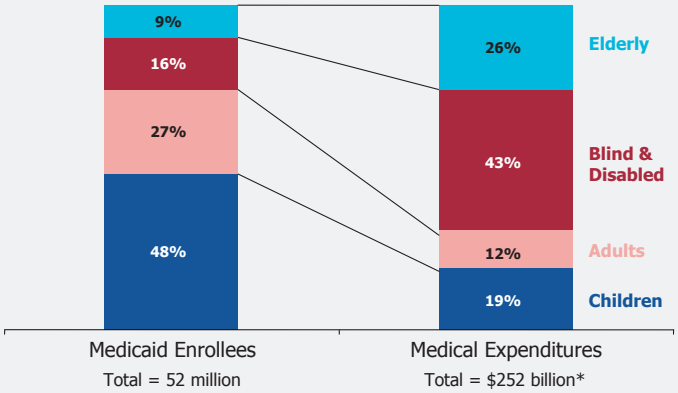
As a core component of the nation's health care safety net, Medicaid insures more than one-fourth of all children[4] (the State Children's Health Insurance Program [SCHIP] enrolled more than 5.8 million additional children in 2003),[5] and finances over half of all public mental health care. Medicaid is also the largest single purchaser of prescription drugs and long-term care.[6,7]

Medicaid covers three main low-income populations: parents and children, elderly people, and individuals with disabilities. The elderly and disabled populations comprise a quarter of beneficiaries but account for approximately 70 percent of spending.[8] The more than seven million "dual eligibles" — low-income seniors and disabled individuals who are also covered by Medicare — account for over a third of Medicaid spending.[9] For this population, Medicaid pays Medicare Part B premiums and, for the poorest dual eligibles, covers other services not covered by Medicare, such as long-term care.

In December 2003, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act (MMA), which added a new Part D to Medicare to provide coverage for prescription drugs, beginning in 2006. Under the law, dual eligibles will be moved from Medicaid prescription drug coverage to Medicare Part D coverage with states, under a "clawback" rule, required to make monthly payments to the federal government to finance a share of the new Medicare drug benefit.[10]

…and to the elderly and disabled populations.

Chart 7: Percentage of Medicaid Enrollees vs. Medical Expenditures by Enrollment Group, 2003



* Includes medical services, not DSH payments and administration, calculated using fiscal year data

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...by providing needed services to vulnerable populations.

While the federal government solely funds and administers Medicare, Medicaid is jointly financed by the federal government and states and administered by the states.

The Centers for Medicare & Medicaid Services (CMS) oversees the Medicaid program and administers the Medicaid matching payments to states. The federal medical assistance percentage (FMAP) is based on each state's average per capita income and is updated yearly. To receive matching dollars, states must meet federal mandates for coverage of certain population groups and health care services. In FY 2005, the FMAP ranged from 50 to 77.08 percent.

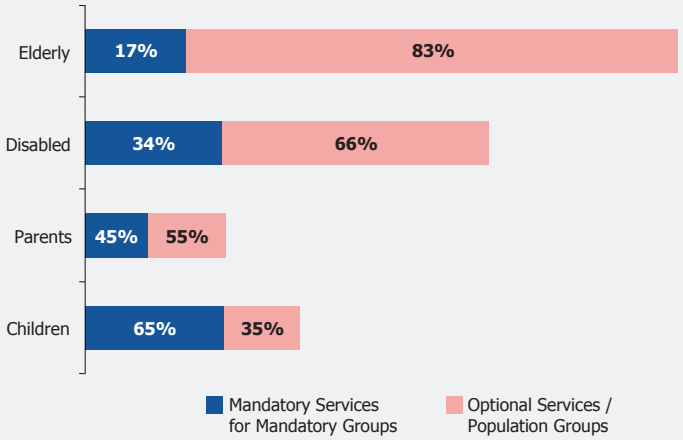
State Medicaid agencies manage enrollment, design benefits, and set and make provider payments. Certain types of services and population groups must be covered; others are at the states' discretion. Most states offer optional services (e.g., pharmacy and dental benefits) and cover optional populations. Optional services, primarily for the elderly and disabled, account for the majority of all Medicaid spending. In addition, federal waivers give states added flexibility to provide services to other groups. For example, Section 1115 waivers, such as Health Insurance Flexibility and Accountability (HIFA) waivers, encourage states to use innovative approaches to expand coverage.[1]

Medicaid provider payments vary greatly across states. Since the repeal of the Boren amendment, state requirements for hospital payments are limited to implementing a public rate-setting process, assuring beneficiary access comparable to the private sector, and ensuring payments do not exceed Medicare payment rates.

Federal law requires that states consider the special circumstances of hospitals serving a disproportionate share (DSH) of low-income patients when setting hospital payment rates. State DSH programs vary with some linking payments to provider taxes or intergovernmental transfer payments.

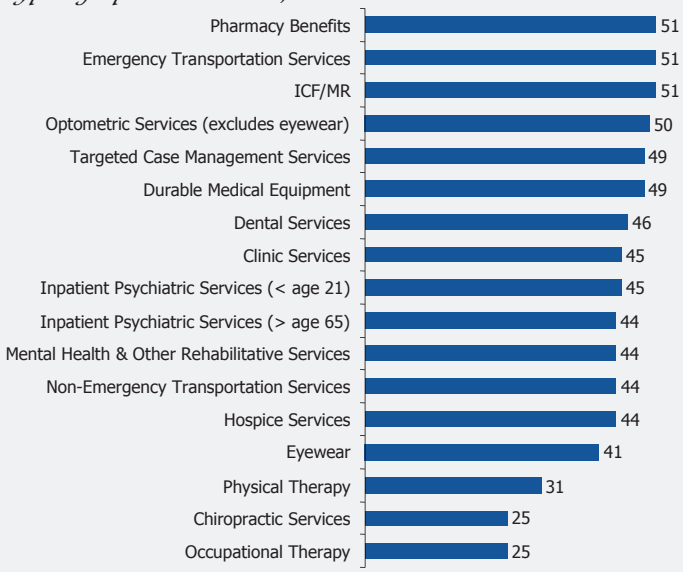
Close to two-thirds of Medicaid spending is for "optional" services and/or populations.

Chart 8: Distribution of Medicaid Mandatory and Optional Spending, 1998 (Length of bar is proportional to amount of Medicaid spending)



Many "optional" services are viewed by states as medically necessary.

Chart 9: Number of States & District of Columbia with Selected Types of Optional Services, 2003



Medicaid Eligibility Groups

Mandatory Groups

- Low-income families with children under Transitional Assistance for Needy Families (TANF)
- Supplemental Security Income (SSI) recipients
- Infants born to Medicaid-eligible pregnant women
- Children < age 6 + pregnant women with income ≤ 133% FPL
- Children < age 19 in families with incomes ≤ 100% FPL
- Recipients of adoption assistance + foster care under Title IV-E
- Certain low-income Medicare beneficiaries
- Special protected groups on Medicaid for a period of time

Optional Groups

- Infants ≤ age 1 & pregnant women w/income between 133% - 185% FPL
- Optional targeted low-income children
- Certain aged, blind, or disabled adults with income < 100% FPL
- Institutionalized individuals with low income and few resources
- Persons enrolled in home and community-based service waivers
- State supplementary payment (SSP) recipients
- Certain TB-infected persons
- Certain women diagnosed with breast or cervical cancer
- Medically needy persons
- Certain working, disabled persons

FPL = Federal Poverty Level
Source: CMS

The President's Medicaid proposal aims to reduce spending…

By FY 2010, federal spending on the Medicaid program is estimated to reach $257.8 billion, a 63.7 percent increase over current federal expenditures.[1] In order to control costs, the Bush administration has proposed a $60 billion cut in spending over the next 10 years. However, the congressional budget process will ultimately determine the funding for Medicaid and other mandatory and discretionary spending programs. Specific provisions of the administration's budget include:

Administrative Cost Reductions

The Bush administration is currently considering several approaches to curb Medicaid-related administrative costs. The basic federal matching rate for most administrative services is 50 percent but rises to as much as 90 percent for some tasks, such as developing systems to manage claims and information. The president is proposing to establish individual state allotments for all Medicaid administrative costs. Other options include fixing the administrative match at 50 percent and capping the per-enrollee amount paid by the federal government.

Limits on Provider Payments and Taxes

Under current federal regulations, Medicaid provider payments cannot exceed a reasonable estimate of Medicare payments for the same service — called the Medicaid upper payment limit (UPL). The administration is proposing to change the UPL for services delivered by local government providers to a cost-based system. The president is also proposing to restrict the use of intergovernmental transfers (transfers of public funds between government entities) by limiting federal matching funds for benefit payments.

The president's budget would also phase down the current safe harbor (the threshold that permits repayment) for provider taxes from 6 percent to 3 percent. The proposal would extend provider tax restructuring to taxes applied to managed care premiums.

Prescription Drug Payment

Total Medicaid outlays for prescription drugs grew at an average annual rate of 18.5 percent between 1998 and 2003, reaching $33.7 billion in 2003.[2] The president is proposing to align prescription drug payments with acquisition costs (the prices pharmacies pay for these drugs). Payments would be based on the drug's average sales price, plus a 6 percent fee for storage, dispensing and counseling.[3]

The administration is also examining ways to change the prescription drug rebate program. Under current law, the federal government and states receive rebates of at least 15.1 percent of the average wholesale price of brand-name drugs. Rebates can be higher based on the "best-price" provision, giving Medicaid the lowest price paid by any U.S. purchaser. By boosting the minimum rebate to 20 percent, the federal government could save approximately $6.1 billion over the next five years.[4]

Long-term Care

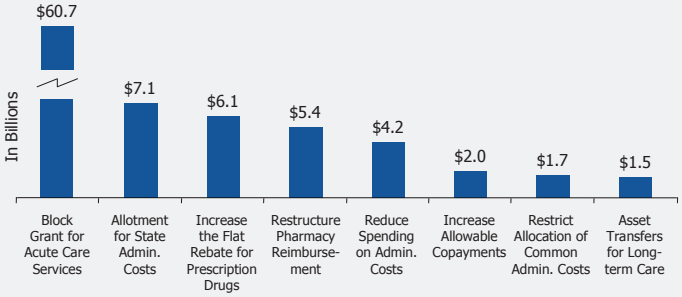
The administration is also supporting two Medicaid reforms related to long-term care. The first program limits circumstances under which persons may transfer or shelter personal assets in order to gain Medicaid eligibility. The second proposal promotes the purchase of long-term care (LTC) insurance. Under the plan, persons who exhaust their LTC benefits will be able to access Medicaid without having to meet the same means-tested requirements as other Medicaid recipients.[5]

"The budget savings and reforms in the budget are important components of achieving the president's goal of cutting the budget deficit in half by 2009, and I urge the Congress to support these reforms…. I intend to enter into a serious discussion with governors and Congress to decide the best way to provide states the flexibility they need to better meet the health care needs of their citizens."

Michael O. Leavitt, U.S. Secretary of Health and Human Services

Federal savings from Medicaid proposals vary.

Chart 10: Estimated Federal Savings from Selected Medicaid Reform Options and Cost Containment Measures, FY 2006 - 2010



...while other proposals focus on broader issues of restructuring and reform.

Options for broader restructuring of the Medicaid program are also being discussed:

Block Grants and Per Capita Caps

A federal block grant to states would convert the federal Medicaid contribution from a percentage of overall Medicaid spending into a fixed allocation that would not increase or decrease with changes in eligibility. Although most experts believe a block grant of mandatory populations and services is unlikely, there has been speculation that the administration would consider a block grant for optional populations and services. Depending on how they are implemented, block grants can provide increased flexibility for states. However, block grants can also increase fiscal pressure on states, as federal resources would remain relatively constant regardless of caseload changes. This may prompt states to scale back their current level of Medicaid spending and coverage for the populations they serve.

Per capita caps, which place an upper limit on spending per enrollee, are another option for limiting Medicaid program growth. Originally proposed in 1997 by the Clinton administration, this option does not penalize states for enrollment growth; however, states may need to limit or eliminate medically necessary services to fit under the cap when budgets are tight.[1]

Tiered Programs

Alternatively, federal reform may follow recent state efforts to adopt tiered Medicaid programs. Tiered programs provide different benefit packages and cost sharing arrangements for higher-income, expansion Medicaid populations.[2] Although these programs often cover more people, they generally increase cost sharing and enrollment fees beyond levels typically seen in traditional Medicaid programs. Higher costs to beneficiaries could pose financial barriers to accessing care, and the primary care-focused services available to expansion groups may not fully meet the medical needs of all participants.

Vouchers and Health Spending Accounts

Several state proposals are under consideration as potential national Medicaid reform models. Florida's governor recently introduced a Medicaid Modernization plan, which proposes giving vouchers to Medicaid beneficiaries to purchase health care services either in managed care organizations or preferred provider organizations. The plan also calls for maximum benefit limits on spending per enrollee.[3] Similarly, New Hampshire's governor has proposed giving enrollees health spending accounts to purchase preventive and emergency services.[4] Both plans rely on Medicaid enrollees taking a more active role in managing their care, including shifting at least a portion of the financial risk to the beneficiary. These proposals also assume support from private sector plans and that enrollees will have sufficient knowledge to make informed decisions regarding enrollment and purchasing benefits.

Chart 11: Medicaid Reform Proposals Focusing on State Flexibility and Enrollee Choice

Reform Efforts	Pros	Cons
Global Caps (Block Grants)	• Provides incentives to states to spend cost-effectively • Encourages state innovation and flexibility in program design	• Shifts financial risk for eligibility & cost growth solely to states • States may limit or eliminate medically necessary services to fit under the cap
Per Capita Caps	• States not at risk for fluctuations in enrollment growth • Re-investment of state savings can be used for expanded coverage of the uninsured	• States may limit or eliminate medically necessary services to fit under the cap
Tiered Programs (e.g., UT)	• Covers more people • Provides states more flexibility in benefit design for various populations	• Enrollees may lack means to pay higher cost sharing • Narrow benefits for expansion group may not adequately meet health care needs of enrollees (e.g., no inpatient care)
Vouchers (e.g., FL)	• Provides choice to enrollees • Enrollees would go into mainstream health plans	• Enrollees may lack the knowledge to make informed decisions • Weakens safety net if private plans deny coverage
Health Spending Accounts (e.g., NH)	• Enrollees manage a portion of own health care dollars • Creates incentives for patients to help control costs	• Shifts some financial risk to Medicaid consumer increasing the likelihood that care may be delayed due to increased cost sharing • Enrollees may lack the knowledge to make informed decisions

State Medicaid Facts

State	STATE CHARACTERISTICS													
	State Medicaid Expenditures as % of Total State Funds[1]	% FMAP 2005[2]	Federal $ Received per State $1 Spent in 2005[3]	Average % Uninsured 2001-2003[4]	Total Number Enrolled in Medicaid, 2002[5]	% of Population Enrolled in Medicaid, 2002[6]	Adults as a % of Medicaid Enrollees, FFY 2002[7]	Children as a % of Medicaid Enrollees, FFY 2002[7]	Blind and Disabled as a % of Medicaid Enrollees, FFY 2002[7]	Elderly as a % of Medicaid Enrollees, FFY 2002[7]	% of Medicare Dually Eligible for Medicaid, 2002[8]	Distribution of Medicaid Managed Care, 2003[9]		Provider Taxes as of 2004[10]
												MCO	PCCM	
Alabama	10.20%	70.83%	$2.43	13.3%	845,125	18.86%	16.27%	49.41%	22.65%	11.68%	22.96%	0%	100%	B, E
Alaska	5.98%	57.58%	$1.36	17.8%	121,400	18.94%	21.96%	62.52%	10.11%	5.41%	19.66%	NA	NA	NPT
Arizona	9.01%	67.45%	$2.07	17.3%	1,053,602	19.37%	36.65%	48.76%	10.44%	4.14%	9.18%	100%	0%	NR
Arkansas	7.33%	74.75%	$2.96	16.6%	608,017	22.46%	22.72%	51.08%	17.89%	8.31%	27.12%	0%	100%	B
California	12.88%	50%	$1.00	18.7%	9,336,447	26.68%	43.51%	38.78%	10.60%	7.11%	23.25%	99%	1%	NR
Colorado	11.66%	50%	$1.00	16.3%	438,670	9.75%	20%	54.03%	15.10%	10.84%	14.68%	46%	54%	NPT
Connecticut	22.43%	50%	$1.00	10.4%	487,989	14.11%	21.07%	53.85%	12.42%	12.66%	16.01%	100%	0%	NPT
Delaware	7.40%	50.38%	$1.02	10.1%	147,197	18.26%	35.83%	44.87%	11.99%	7.32%	12.89%	100%	0%	NR
District of Columbia	N/A	70%	$2.33	13.3%	204,591	36.23%	25.33%	46.54%	21.41%	6.72%	25.62%	100%	0%	NR
Florida	13.51%	58.90%	$1.43	17.6%	2,691,502	16.13%	20.01%	51.09%	19.41%	9.50%	14.12%	50%	50%	A
Georgia	10.45%	60.44%	$1.53	16.4%	1,459,631	17.09%	17.38%	59.23%	15.94%	7.45%	18.92%	0%	100%	B, H
Hawaii	5.16%	58.47%	$1.41	9.9%	195,684	15.85%	32.03%	47%	12.07%	8.89%	15.77%	100%	0%	NR
Idaho	10.12%	70.62%	$2.40	17.5%	196,406	14.62%	15.18%	64.65%	13.57%	6.60%	6.94%	0%	100%	NR
Illinois	18.33%	50%	$1.00	14%	2,076,146	16.50%	19.08%	53.01%	14.47%	13.44%	13.43%	100%	0%	A, B
Indiana	11.33%	62.78%	$1.69	12.9%	881,942	14.32%	17.36%	60.54%	13.21%	8.89%	14.44%	49%	51%	C
Iowa	9.77%	63.55%	$1.74	9.5%	358,708	12.22%	19.67%	51.81%	16.93%	11.59%	13.97%	47%	53%	C
Kansas	8.73%	61.01%	$1.56	10.9%	305,110	11.25%	15.62%	56.99%	17.33%	10.06%	11.74%	43%	57%	A‡
Kentucky	9.06%	69.60%	$2.29	13.3%	769,826	18.82%	14.32%	49.30%	27.01%	9.37%	32.80%	26%	74%	A, B, C, G
Louisiana	10.55%	71.04%	$2.45	19.4%	990,286	22.12%	11.13%	60.34%	17.90%	10.63%	23.21%	0%	100%	B, C, E, H
Maine	13.49%	64.89%	$1.85	10.7%	346,449	26.70%	15.90%	28.88%	34.44%	20.77%	21.98%	0%	100%	NR
Maryland	11.62%	50%	$1.00	13.2%	752,065	13.82%	18.94%	57.53%	16.16%	7.36%	13.86%	100%	0%	H
Massachusetts	13.51%	50%	$1.00	9.6%	1,204,312	18.78%	30.05%	40.10%	20.20%	9.65%	22.42%	47%	53%	H
Michigan	11.64%	56.71%	$1.31	11%	1,527,627	15.21%	18.71%	55.30%	19.45%	6.53%	15.15%	100%	0%	A, B, C, E, F, H
Minnesota	13.32%	50%	$1.00	8.2%	680,627	13.54%	25.60%	50.36%	13.79%	10.25%	15.43%	100%	0%	A, B, C, D
Mississippi	9.51%	77.08%	$3.36	17%	707,986	24.69%	12%	54.74%	22.80%	10.46%	31.70%	NA	NA	A, B
Missouri	18.74%	61.15%	$1.57	10.9%	870,828*	15.33%*	22.15%*	55.38%*	13.43%*	9.04%*	18.42%	100%	0%	A, B, E
Montana	6.12%	71.90%	$2.56	16.1%	106,229	11.66%	20.65%	53.18%	16.65%	9.51%	11.42%	0%	100%	B
Nebraska	9.80%	59.64%	$1.48	10.3%	266,245	15.42%	19.40%	60.29%	11.22%	8.84%	14.46%	47%	53%	NR
Nevada	14.39%	55.90%	$1.27	18.3%	203,251	9.37%	22.95%	51.09%	16.34%	9.62%	11.10%	100%	0%	B, H
New Hampshire	19.51%	50%	$1.00	9.9%	115,517	9.06%	14.40%	62%	12.65%	10.95%	11.37%	100%	0%	NR
New Jersey	13.49%	50%	$1.00	13.7%	982,676	11.46%	21.10%	49.34%	18.20%	11.37%	14.10%	100%	0%	A, B, D
New Mexico	6.88%	74.30%	$2.89	21.3%	462,878	24.95%	19.47%	63.59%	11.89%	5.05%	15.99%	100%	0%	B
New York	15.63%	50%	$1.00	15.5%	4,139,898	21.62%	29.99%	43.78%	16.62%	9.62%	22.03%	99%	1%	A, B, F, G
North Carolina	11.96%	63.63%	$1.75	16.1%	1,389,455	16.72%	18.66%	51.51%	17%	12.83%	23.09%	1%	99%	B
North Dakota	9.15%	67.49%	$2.08	10.5%	71,619	11.30%	25.27%	46.98%	13.74%	14.01%	14.53%	2%	98%	NPT
Ohio	23.79%	59.68%	$1.48	11.7%	1,754,379	15.38%	21.17%	54.63%	15.93%	8.24%	12.79%	100%	0%	H
Oklahoma	8.14%	70.18%	$2.35	18.7%	677,788	19.43%	13.86%	64.73%	11.99%	9.42%	18.27%	53%	47%	H
Oregon	9.60%	61.12%	$1.57	14.8%	637,140	18.08%	41.04%	41.24%	10.73%	6.96%	13.50%	96%	4%	A, C, H
Pennsylvania	19.83%	53.84%	$1.17	10.7%	1,710,999	13.88%	16.57%	48.42%	22.58%	12.42%	15.95%	88%	11%	B, D ‡‡
Rhode Island	16.56%	55.38%	$1.24	9.3%	204,789	19.16%	25.58%	46.06%	18.76%	9.60%	19.17%	100%	0%	A, B, C, H
South Carolina	10.11%	69.89%	$2.32	13.1%	895,863	21.82%	24.85%	52.72%	13.71%	8.71%	20.27%	100%	0%	A
South Dakota	9.14%	66.03%	$1.94	11%	113,925	14.98%	15.95%	60.74%	14.41%	8.90%	14.91%	0%	100%	NPT
Tennessee	19.88%	64.81%	$1.84	11.8%	1,700,384	29.36%	31.26%	43.42%	20%	5.32%	29%	100%	0%	B, C, D, H
Texas	13.16%	60.87%	$1.56	24.6%	3,202,171	14.74%	16.70%	59.48%	11.85%	11.97%	20.91%	69%	32%	NPT
Utah	6.31%	72.14%	$2.59	13.6%	233,156	10.05%	23.90%	58.87%	12.04%	5.19%	8.84%	0%	100%	NR
Vermont	14.21%	60.11%	$1.51	9.9%	156,958	25.46%	31.37%	43.92%	12.17%	12.53%	30.64%	0%	100%	A, B, G
Virginia	8.49%	50%	$1.00	12.5%	727,784	10.01%	13.35%	54%	19.15%	13.50%	16.08%	77%	24%	NR
Washington	14.45%	50%	$1.00	14.3%	1,104,813	18.21%	25.64%	53.96%	13.21%	7.19%	14.10%	100%	1%	A, B, C, F, H
West Virginia	3.39%	74.65%	$2.94	14.8%	362,264	20.07%	16.53%	50.50%	24.78%	8.19%	14.86%	32%	68%	A, B, C, F, G, H
Wisconsin	5.98%	58.32%	$1.40	9.5%	776,638	14.28%	24.28%	45.48%	17.94%	12.30%	15.49%	100%	0%	NR
Wyoming	3.66%	57.90%	$1.38	16.5%	69,802	13.98%	20.20%	59.61%	12.60%	7.59%	13.36%	NA	NA	B, C, E, F, H
National				**15.1%**	**51,552,491**	**17.90%**	**25.71%**	**49.43%**	**15.63%**	**9.23%**	**18.18%**	**73%**	**26%**	

*Indicates data from Missouri Hospital Association analysis of Missouri Department of Social Services Annual Table 5 for FY 2002 data, provided to The Lewin Group by request

[1] National Association of State Budget Officers, *2003 State Expenditure Report*

[2] Federal Register

[3] Families USA, *Medicaid: Good Medicine for State Economies, 2004 Update*, May 2004

[4] U.S. Census Bureau, *Current Population Survey, 2002 to 2004 Annual Social and Economic Supplements*

[5] The Lewin Group analysis of CMS Medicaid Statistical Information System (MSIS) data, 2002

[6] The Lewin Group analysis of CMS MSIS data, 2002; U.S. Census Bureau, 2002

[7] The Lewin Group analysis of CMS MSIS data, 2002; Percentages may not sum to 100% due to enrollees with unknown basis of eligibility; Percentages equal proportion of Medicaid enrollees in each eligibility group; FFY = Federal Fiscal Year

[8] Kaiser Commission on Medicaid and the Uninsured, *State Health Facts*, 2002; CMS, 2002

[9] Kaiser Commission on Medicaid and the Uninsured, *State Health Facts*, 2003; MCO = Managed Care Organization; PCCM = Primary Care Case Management; NA = Not Applicable (indicates states which have no enrollees in comprehensive plans); MCO includes both commercial MCO and Medicaid-only MCO

[10] Form CMS-64 data, as of quarter ending September 30, 2004, provided to The Lewin Group by request; feedback from state hospital associations;
A - Hospital; B - Nursing; C - Mental Health & ICF/MR; D - MCOs; E - Pharmacy; F - Physician, Lab, X-Ray; G - Home/Personal; H - Other; NPT - No provider taxes, fees or assessments reported; NR - data not reported to CMS; ‡ Indicates that provider tax is pending approval and would be retroactive to July 1, 2004; ‡‡ Indicates that provider tax was passed as of 2005

State Medicaid Facts (Continued)

State	STRATEGIES IMPLEMENTED IN FY 2004[11]							STRATEGIES IMPLEMENTED IN FY 2005[11]						
	Eligibility Cuts	Reduced or Cut Optional Benefits (other than RX)	Pharmacy Cost/ Utilization Control Initiatives	Long-term Care Reductions	Beneficiary Copayments	Provider Rate Freezes/ Reductions	Disease Management	Eligibility Cuts	Reduced or Cut Optional Benefits (other than RX)	Pharmacy Cost/ Utilization Control Initiatives	Long-term Care Reductions	Beneficiary Copayments	Provider Rate Freezes/ Reductions	Disease Management
Alabama			✓			✓		✓		✓			✓	
Alaska	✓		✓			✓		✓		✓	✓		✓	
Arizona	✓		✓		✓	✓	✓	✓		✓		✓	✓	✓
Arkansas			✓			✓				✓			✓	
California	✓	✓	✓			✓				✓			✓	✓
Colorado		✓	✓		✓	✓	✓	✓	✓		✓		✓	
Connecticut	✓	✓	✓	✓	✓	✓				✓			✓	
Delaware			✓	✓		✓				✓			✓	
District of Columbia			✓			✓	✓						✓	
Florida		✓	✓	✓	✓	✓				✓	✓	✓	✓	
Georgia		✓	✓			✓	✓	✓	✓	✓			✓	
Hawaii			✓			✓				✓			✓	
Idaho			✓			✓	✓			✓	✓		✓	✓
Illinois			✓			✓				✓			✓	
Indiana			✓	✓	✓	✓	✓			✓	✓		✓	✓
Iowa	✓		✓	✓	✓	✓	✓	✓		✓	✓		✓	
Kansas			✓			✓				✓			✓	✓
Kentucky	✓				✓	✓							✓	
Louisiana	✓		✓			✓	✓	✓		✓			✓	✓
Maine		✓	✓		✓	✓		✓	✓	✓			✓	✓
Maryland	✓		✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
Massachusetts	✓		✓	✓	✓	✓	✓			✓				
Michigan		✓	✓	✓		✓				✓	✓		✓	✓
Minnesota	✓	✓	✓	✓	✓	✓		✓		✓			✓	
Mississippi					✓			✓		✓		✓		✓
Missouri			✓			✓	✓	✓		✓			✓	✓
Montana			✓			✓	✓			✓			✓	
Nebraska		✓	✓			✓					✓		✓	
Nevada	✓	✓	✓			✓		✓		✓			✓	
New Hampshire			✓			✓				✓			✓	✓
New Jersey			✓			✓	✓				✓		✓	✓
New Mexico		✓	✓			✓	✓	✓	✓	✓	✓		✓	✓
New York			✓			✓		✓		✓	✓	✓	✓	✓
North Carolina	✓	✓	✓	✓	✓	✓	✓			✓	✓			✓
North Dakota		✓	✓		✓	✓				✓		✓	✓	
Ohio	✓	✓	✓		✓	✓				✓	✓		✓	✓
Oklahoma			✓			✓	✓			✓			✓	✓
Oregon			✓			✓	✓	✓	✓	✓			✓	
Pennsylvania			✓			✓							✓	✓
Rhode Island			✓			✓	✓						✓	
South Carolina			✓	✓	✓	✓				✓	✓		✓	✓
South Dakota	✓		✓			✓				✓		✓	✓	✓
Tennessee	✓		✓			✓				✓		✓	✓	✓
Texas	✓	✓	✓	✓		✓				✓		✓	✓	✓
Utah	✓	✓	✓		✓	✓							✓	
Vermont	✓	✓	✓			✓				✓	✓		✓	
Virginia	✓		✓		✓	✓				✓				✓
Washington	✓	✓	✓			✓				✓		✓	✓	✓
West Virginia				✓	✓	✓				✓			✓	✓
Wisconsin	✓		✓	✓	✓	✓				✓	✓		✓	✓
Wyoming			✓			✓				✓			✓	✓
Total for options	**21**	**18**	**48**	**14**	**20**	**50**	**18**	**15**	**5**	**43**	**17**	**10**	**47**	**28**

[11] Kaiser Commission on Medicaid and the Uninsured, *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005, Results from a 50 State Survey*, October 2004

Reducing the growth of federal Medicaid expenditures may negatively impact states…

Medicaid was designed as a federal-state partnership with shared responsibility and financial risk. The flexibility of the current financing structure affords Medicaid the capacity to respond to changing needs, including expansions in enrollment, particularly during times of economic downturn. Reductions and/or caps in federal contributions would shift a greater financial burden to states, which in turn would face difficult decisions, including raising taxes, cutting other state spending, or reducing state Medicaid spending and losing additional federal matching payments.

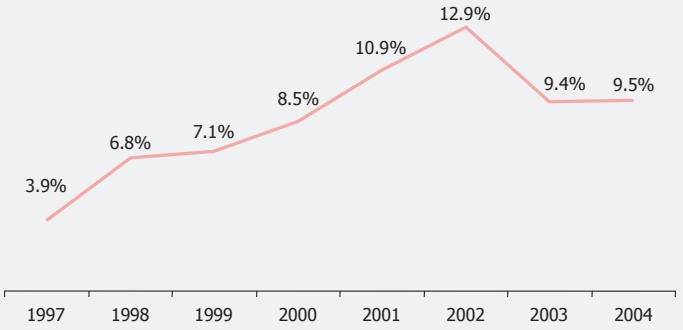
The loss of this funding could impact states at a time when they are already making difficult choices regarding eligibility and benefit design. States are just beginning to rebound from sharp declines in tax revenues, as well as the fiscal strain of rising Medicaid enrollment. Since Medicaid spending growth still far exceeds the growth of state tax revenues, states may struggle to replace the loss of federal funds in order to maintain coverage levels.

In fact, cost containment measures already implemented by states may suggest that there are few areas left where states can reasonably make reductions without extensively altering the nature of Medicaid. Between FY 2002 – 2005 most states cut eligibility and benefits. In addition, numerous states are considering further limits to their Medicaid programs in FY 2006. For example, Montana is considering restrictions on asset transfers for long-term care,[1] while Missouri is proposing to eliminate certain types of specialty services for adults.[2]

Decreases in Medicaid funding are often felt throughout a state's entire economy. The direct economic impact of Medicaid is represented in provider expenditures, such as hospitals and nursing homes, while the indirect effects of Medicaid financing are also felt when health care employees make purchases that help support their local and state economies. The decline in health care spending that results from Medicaid cuts may have adverse ripple effects on jobs, economic growth, and state tax revenues.

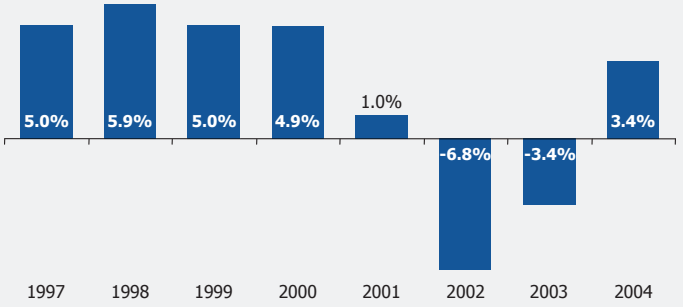
Medicaid spending growth remains high…

Chart 12: Percentage Growth in Medicaid Spending, 1997 – 2004



…which state tax revenues seem unlikely to cover…

Chart 13: Percentage Growth in State Tax Revenue , 1997 – 2004



…potentially forcing states to make cuts, leading to weakened state economies.

Chart 14: Potential Impact of Cuts to State Medicaid Programs

Cuts Made	Jobs Lost	Economic Impact
South Carolina: If State Medicaid funding ↓ 10%	6,181	$150 million in lost wages
Missouri: If State Medicaid and SCHIP funding ↓ by $43 million	2,049	$73 million in lost wages $150 million in lost economic activity $5.4 million in lost tax revenue

"We could well be on a collision course where state revenues are not expanding enough to meet the needs of the program at the same time the federal contributions are being cut back. The end result will be fewer people or services covered. There's no safety net below Medicaid." — Diane Rowland, Executive Director of the Kaiser Commission on Medicaid and the Uninsured

...beneficiaries, and the health care safety net.

Medicaid is a crucial part of the nation's health care safety net, financing health care for some of the neediest populations.[1] Reductions in federal Medicaid expenditures, combined with rising health costs and state fiscal constraints, place Medicaid recipients at risk. States are already making significant cuts in eligibility.[2] The temporary increase in federal matching payments in 2003 and 2004 prevented the loss of further Medicaid coverage.[3] Any federal reduction would likely mean additional cuts in eligibility. Once individuals lose Medicaid coverage, approximately 65 percent become uninsured.[4] Since 2000, the number of people without health insurance has risen by 5 million. Without Medicaid, many more would likely have become uninsured.[5]

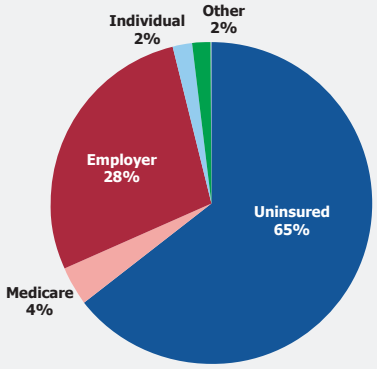
Cuts in federal Medicaid allotments may also compromise beneficiary access to care. States have used optional coverage to expand the role of Medicaid in caring for the safety net population. Although labeled "optional" by statute, some of the sickest and poorest Medicaid beneficiaries often fall into this category.[6] Recently, the Bush administration indicated a willingness to grant states more flexibility to alter optional benefits and/or populations. Such flexibility may include reforms that resemble those that U.S. Department of Health and Human Services Secretary Michael Leavitt implemented while governor of Utah. Under Utah's waiver program, benefits are provided to a greater number of beneficiaries, but there are varying levels of coverage and cost sharing based on income level. Adults have limited primary care benefits, there is no coverage for hospital, specialty and mental health care, and all beneficiaries pay an enrollment fee and copayments.[7]

Some evidence suggests that increased physician copayments can decrease access to care. One study of Utah's experience found that increased copayments resulted in fewer physician visits. Similarly, a study of Oregon's Medicaid program found that imposing premiums, ranging from $6-$20 per month, led to an estimated 50 percent decrease in enrollment in the Medicaid program with the greatest effect on the poorest recipients (e.g., beneficiaries between 0-50% FPL).[8] As a result, clinics reported difficulty in meeting patient needs and emergency room visits increased for some conditions no longer covered under the waiver (e.g., drug and alcohol use).[9]

Further Medicaid cuts could also threaten the viability of safety net providers. Reducing benefits or eligibility will not eliminate the substantial health care needs of vulnerable populations. Providers will struggle to absorb the cost of caring for the uninsured without federal support.

Loss of Medicaid coverage has led to more uninsured...

Chart 15: Distribution of Transitions from Medicaid to Other Sources of Coverage (Under Age 65), During 1996 – 1999



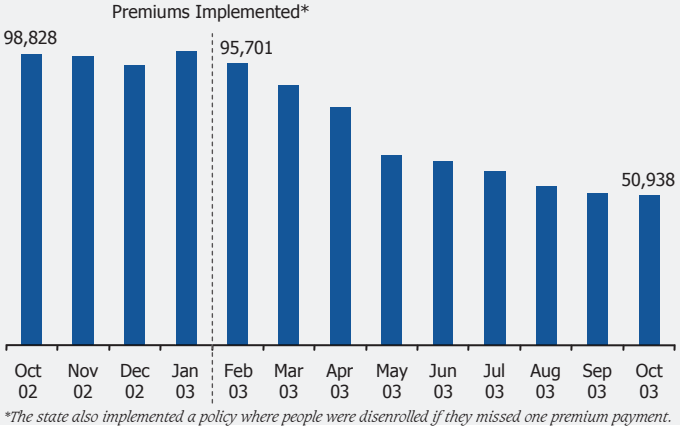
...while program cuts have decreased benefits, increased beneficiary costs,...

Chart 16: Examples of Benefits Covered and Not Covered Under Utah's Three Medicaid Programs

Covered Services	Traditional Medicaid	Waiver Coverage	
		Utah's Non-traditional Medicaid	Utah's Primary Care Network (PCN)
Inpatient Hospital	X ($220 coinsurance per admission)	X ($220 coinsurance per admission)	Not Covered
Outpatient Hospital	X	X	Not Covered
Emergency Room	X ($6 copayment)	X ($6 copayment)	X ($30 copayment)
Physician Services	X ($2 copayment)	X ($3 copayment)	X ($5 copayment)
Specialty Care	X	X	Not Covered
Long-term Care	X	Not Covered	Not Covered
Prescription Drugs	X ($1 copayment/ prescription)	X (limited to 7 drugs/ month, with exceptions $2 copayment/prescription)	X (limited to 4 drugs/ month, no exceptions $5 copayment/ prescription, generics)
Mental Health and Chemical Dependency	X	X (30 outpatient & 30 inpatient days/year)	Not Covered

...and reduced access to care for the neediest populations.

Chart 17: Oregon Health Plan, Number of Medicaid Enrollees, Before & After Premiums Implemented, October 2002 – 2003



**The state also implemented a policy where people were disenrolled if they missed one premium payment.*

Policy Questions

The current discourse on Medicaid reform has highlighted many strategies for reducing costs and restructuring the health care safety net. This debate has engaged many stakeholders around the country, including governors, state legislatures, provider groups, beneficiary advocates and more. Although their approaches for Medicaid reform differ, there seems to be consensus that reform is necessary.

Unlike many other programs, Medicaid, as written in federal statute, has remained largely intact since its inception in 1966. Many of the original eligibility and benefit mandates, as well as limits on cost sharing can today only be modified through federal waivers.[1] Although cost containment is the primary objective of recent Medicaid reform proposals, several of these initiatives fundamentally restructure Medicaid. If some of these ideas take hold, Medicaid's character as an entitlement program could change to one that is bound by annual budget appropriations.

Moving forward in this debate, policymakers will confront a number of important questions:

- What is the appropriate balance between the role of the states and the role of the federal government in the Medicaid program? In particular, what is the appropriate balance in financing long-term care?
- How will giving states less federal money but more flexibility to alter benefit and eligibility requirements impact beneficiaries, such as the elderly and disabled, and their access to and quality of care?
- What are the long-term implications of a capped federal funding requirement on coverage and access to care?
- What are the long-term cost implications of potential cuts in optional Medicaid populations and services? How will the nation's safety net ultimately be affected?
- If more people become uninsured, will the health care system be able to pay for the cost of their care? If the increased costs are passed onto the private sector, will employers reduce or cut benefits?

Quotes from the Field

"Recently, Bush administration officials declared their intention to seek changes that will cut the cost of Medicaid by $60 billion over the next 10 years….Judging from the lack of public outcry, most Americans view these developments with indifference...[but], they are in for a shock. Wholesale cuts to Medicaid may provide the shock that triggers a catastrophic failure of the health care system in one or more American cities. If this happens... it will no longer matter whether you are insured. Because either way, you'll have nowhere to go." — Dr. Arthur Kellerman, Chairman of the Department of Emergency Medicine at Emory University School of Medicine.

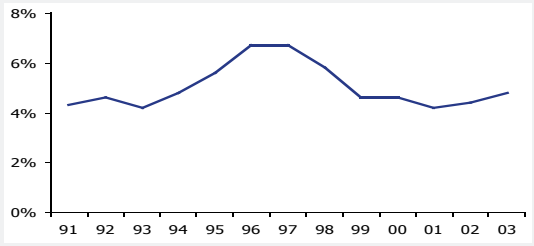
"Policy should drive the budget, but the budget shouldn't drive [Medicaid] policy." — Haley Barbour, Governor of Mississippi

"Governors are very anxious about signing on to a $60 billion number if we don't know how you will get there. We like ideas that save money for the federal government and the states through program efficiencies, but we do not support recommendations that would save the federal government money at the expense of the states." — Bob Taft, Governor of Ohio

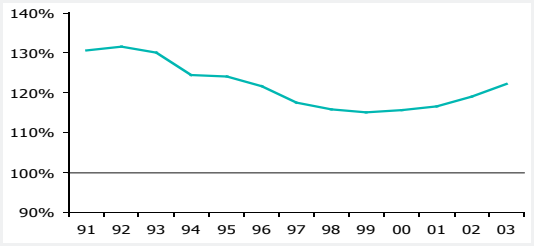
Stats to Know

Hospital Sector

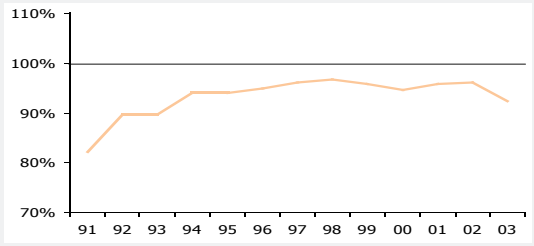
Total Hospital Margin: 91 to 03	2001	2002	2003
	4.2%	4.4%	4.8%



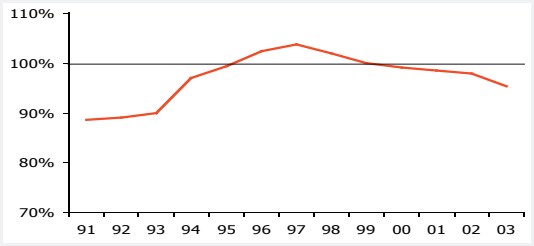
Private Pay Payment-to-Cost Ratio: 91 to 03	2001	2002	2003
	116.5%	119.0%	122.3%



Medicaid Payment-to-Cost Ratio: 91 to 03	2001	2002	2003
	95.8%	96.1%	92.3%

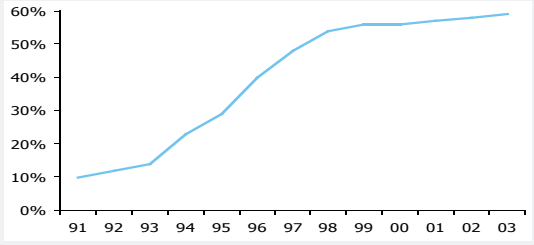


Medicare Payment-to-Cost Ratio: 91 to 03	2001	2002	2003
	98.4%	97.9%	95.3%

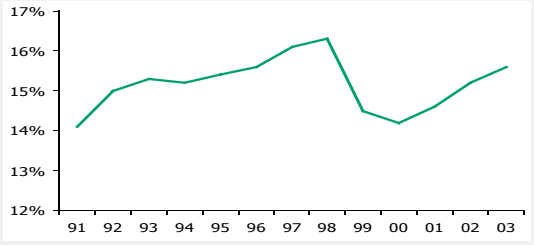


Health Sector & Safety Net

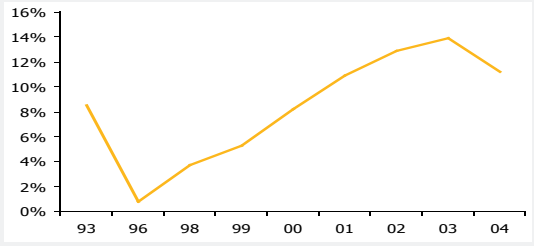
Percentage of Medicaid Beneficiaries in Managed Care: 91 to 03	2001	2002	2003
	57%	58%	59%



Percentage Uninsured: 91 to 03	2001	2002	2003
	14.6%	15.2%	15.6%



Percentage Change in Health Insurance Premiums: 93 to 04	2002	2003	2004
	12.9%	13.9%	11.2%



Percentage Unemployed: 91 to 04	2002	2003	2004
	5.8%	6.0%	5.5%

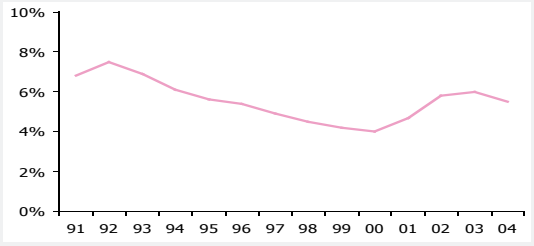


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Chart 2: CMS, Form CMS-64
Chart 3: CBO, *The Budget and Economic Outlook: Fiscal Years 2006 to 2015*, January 2005
Chart 4: CMS. For 2002 – 2004 data, CBO's March Baseline, 2003 – 2005; Other Title XIX data – 1990 = 1.1 million and 1995 = 0.6 million
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Chart 6: CMS, Form CMS-64; Payments to Managed Care entities have been allocated among providers receiving MCO payments per CMS methodology; Hospital services include inpatient hospital services, outpatient hospital and clinic services, payments made to rural health clinics and federally qualified health centers
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