

With a total enrollment in 2003 of about 53 million people (12 million more than Medicare) and annual federal and state expenditures now topping \$315 billion,¹ the Medicaid program attracts a lot of attention from policymakers these days.

State budget officials have watched while a weak U.S. economy pushed unemployment rates up and reduced the rates of employer-sponsored health insurance. This contributed to greater enrollment in Medicaid among lower-income families — just when health care costs were again spiking and state revenues were plummeting.²

This caused a dilemma for state lawmakers and governors who by law have to balance budgets. Yet from the perspective of policymakers concerned with trying to reduce the number of uninsured, Medicaid's increasing enrollment is good news. It underscores Medicaid's importance as the nation's number one health safety net program, providing services to families who would otherwise have no access to a stable source of health coverage.

Policymakers are increasingly recognizing the significant role that Medicaid plays in state economies. For every dollar invested in Medicaid, the program generates about three dollars of business activity in the form of local jobs and wages, in revenues for hospitals and other providers, and in support of community clinics and safety net facilities, those that provide services to the indigent population. Medicaid's contribution to local economies is tied to the state's federal match rate. For example, in FY 2004, for every dollar invested by Kentucky, which has a high federal match rate of 73 percent, the state received \$2.71 in federal Medicaid funding. Once the federal match rate dropped down to 71 percent on June 30 (See box, "Temporary Increase in Medicaid Match Rates."), Kentucky receives \$2.33 for every dollar spent on health care services.³

KEYFACTS

- The federal Centers for Medicare and Medicaid Services estimates that Medicaid provided services in FY 2003 to 53 million people.^a
- In FY 2002, Medicaid provided services to 25 million children (more than one in four), 13 million adults (primarily low-income working parents), 5 million seniors, and 8 million persons with disabilities.^b Medicaid pays for more than one-third of all births in the U.S.^c
- Medicaid pays for about half of all nursing home care and is the largest single funding source for such care.^d
- State revenue shortfalls have led to slower Medicaid enrollment growth since 2002. Even so, the federal Centers for Medicare and Medicaid Services estimates that Medicaid enrollment in FY 2003 was 53 million.^e
- Medicaid spending for long-term care services, provided principally to frail elders and individuals with disabilities, constitutes about 40 percent of total Medicaid spending.
- Medicaid spending per beneficiary varies greatly by population group. In 2003, estimated average spending per child was \$1,746, while average per-person spending on the elderly, the highest-cost group, was \$12,828.^f Seven million elders and individuals with disabilities on Medicaid are also eligible for Medicare. They are known as "dual eligibles."^g
- Since 2001, in an effort to keep Medicaid expenditures in check, 35 states have reduced or eliminated some Medicaid services, and 32 states have increased copayments on some services for some populations.^h
- Analysis of enrollment increases in Medicaid and other state-run public programs since 2000 suggest that the programs offset the loss of employer-sponsored health insurance among children, and partly offset the growth in the number of uninsured adults.ⁱ
- Every state tax dollar invested in Medicaid leverages \$1 to \$3.33 in federal matching funds.^j

For key fact sources, see endnotes.

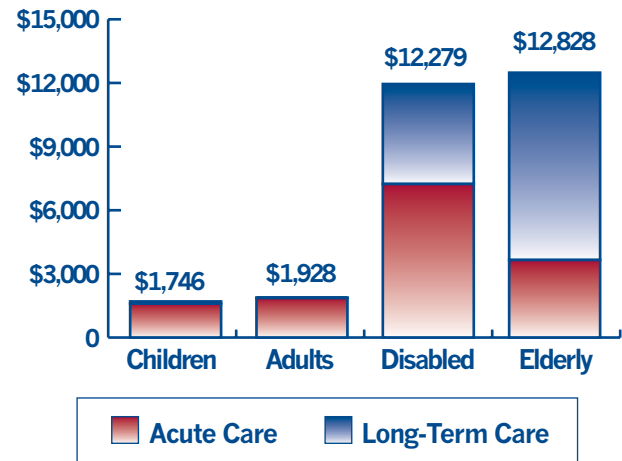
COVERAGE BASICS

Medicaid covers a wide range of services, predominantly acute care services for mothers and children, and a mix of acute and long-term care services for the elderly and persons with disabilities. Under federal law, states are *required* to provide services to the following groups:

- **Pregnant women** whose family income is at or below 133 percent of the federal poverty level (amounting to \$20,840 for a three-person family in 2004).
- **Infants** born to mothers who became eligible while pregnant are entitled to receive services for up to one year.
- **Children under age 6** whose family income is at or below 133 percent of the poverty level, and children ages 6 to 18 whose family income is at or below the poverty level (amounting to \$15,670 for a family of three in 2004).
- **Individuals who meet eligibility standards** under the old Aid to Families with Dependent Children (AFDC) program that governed receipt of cash assistance prior to enactment of the welfare reform law in 1996.
- **Individuals receiving Supplemental Security Income (SSI) payments**, who are generally poor elders and persons with disabilities.
- **Certain low-income Medicare beneficiaries and other specially protected groups**, including individuals who are returning to the workforce, and recipients of adoption or foster care assistance.⁴

In addition to the mandatory groups listed above, states can choose under federal law to provide services to a wide range of additional, or optional, categories of Medicaid eligibility. As a result, eligibility rules for optional groups vary substantially from state to state, with most linked to income, family status, and disability. Immigration status is a separate factor for eligibility. States that choose to expand eligibility to optional groups are required to provide services to everyone in the group, if they meet the criteria.

MEDICAID EXPENDITURES PER ENROLLEE, FY 2003



Source: Kaiser Commission on Medicaid and the Uninsured (2004) (www.kff.org/medicaid/upload/30463_1.pdf)

Under federal law, all states participating in Medicaid must offer the following services:

- Physicians' services
- Laboratory and X-ray services
- Inpatient hospital services
- Outpatient hospital services that are preventive, diagnostic, therapeutic, rehabilitative, or palliative in nature
- Family planning services and supplies
- Nurse-midwife services
- Pediatric nurse practitioner or family nurse practitioner services
- Nursing facility services for individuals 21 and older
- Home health services for individuals determined to be eligible for nursing facility services
- Services furnished in certain federally qualified health centers
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21.

Among the mandatory services enumerated above, the EPSDT benefit for children is arguably the most comprehensive. EPSDT services encompass a wide

range of health screening services, physical exams, immunizations, lab tests that include lead blood level assessments, health education, vision, dental and hearing services, and other "necessary health care, diagnostic services, and treatment necessary to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services."⁵

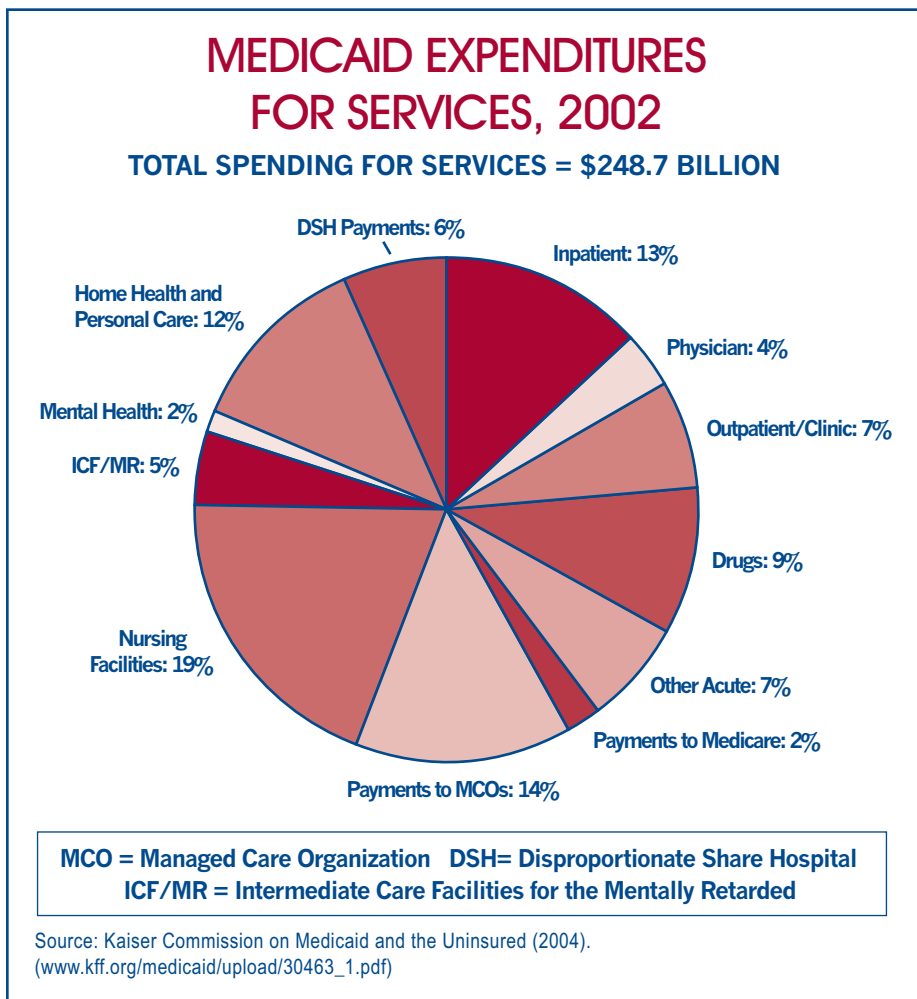
States must provide all mandatory services both to those groups they are required to cover, and to all optional groups a state chooses to cover.

States can choose to offer optional services to mandatory populations, to optional populations, or to both. Optional services vary significantly from state to state. Among the most popular are: prescription drugs, services for individuals in Intermediate Care Facilities for the Mentally Retarded (ICF/MR),

caregiver respite, personal care services, dental services, glasses, and hearing aids. (See charts, "Medicaid Expenditures per Enrollee, FY 2003," and "Medicaid Expenditures For Services, 2002.")

Individuals needing long-term care may be able to qualify for Medicaid through the optional medically needy program. The 36 states that have such programs allow individuals with high medical expenses to subtract them from their household income when determining eligibility. As a result, individuals who have catastrophic long-term expenses due to acute illness or chronic disease may meet the state's eligibility threshold and qualify for Medicaid.⁶

For example, if a state's threshold is \$1,000 a month, and an individual's income is \$1,200 a month, he or she could qualify for Medicaid coverage if the state were to factor in the person's monthly medication expenditures of \$200. However, services provided to medically



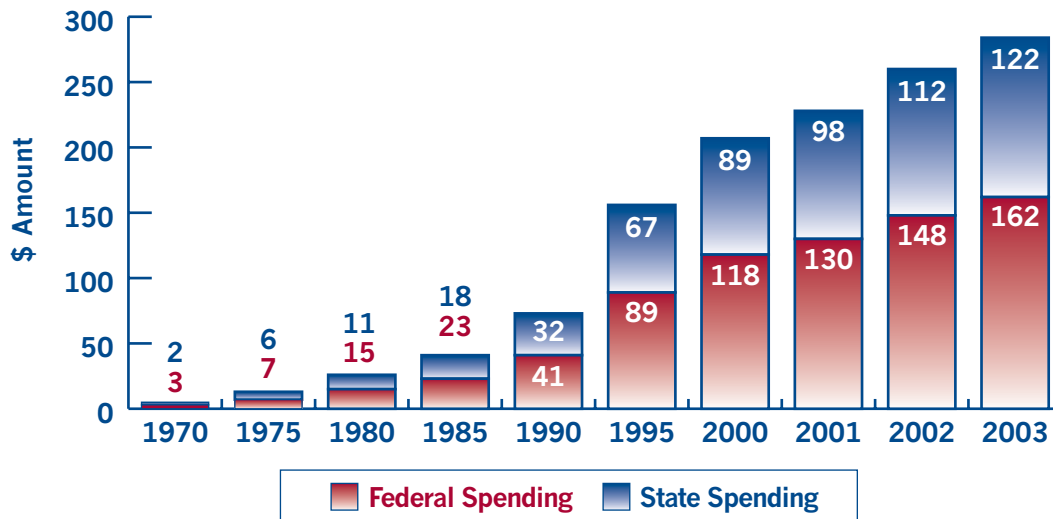
needy individuals may be different than those offered to other populations. In 2000, more than 3.5 million individuals qualified for Medicaid through state medically needy programs.⁷

Before 1996, individuals automatically qualified for Medicaid if they received benefits through the SSI program for the elderly and disabled, or the old family cash assistance program, AFDC. Enactment of welfare reform legislation broke the automatic link between AFDC and Medicaid and shifted control over the program to the states. The law changed the terms of coverage to a block grant with time limits on cash assistance. It also required Medicaid coverage for families who, when they applied, qualified under AFDC's 1996 federal eligibility rules.

In the aftermath of welfare reform in 1997 and 1998, Medicaid enrollment initially declined, but has since rebounded. Moreover, Congress has extended and

ACTUAL AND PROJECTED TOTAL MEDICAID SPENDING, SELECTED YEARS, 1970 to 2003

(IN BILLIONS OF DOLLARS)



Source: National Association of State Budget Officers (2002). "State Expenditure Report." (www.nasbo.org/publications/2002expendreport.pdf).

funded the Transitional Medical Assistance (TMA) program since 1996, which allows people who would otherwise lose eligibility after returning to work to continue receiving Medicaid services for up to a year.

Coverage options for low-income children not eligible for Medicaid were expanded with enactment of the State Children's Health Insurance Program (SCHIP) in 1997. Today, this program is closely linked with Medicaid in many states. (For more information on SCHIP, see Chapter 4, Children's Coverage.)

SPENDING TRENDS

Currently, Medicaid pays for about half of all nursing home care, 17 percent of prescription drug spending, and 12 percent of physician and other standard medical services.⁸ Combined federal-state Medicaid funding increased from \$156 billion in FY 1995 to an estimated \$284 billion in FY 2003.⁹ (See chart, "Actual and Projected Total Medicaid Spending.") Projected total spending for FY 2004 is \$305 billion, and for FY 2005, \$316 billion.¹⁰

Federal Medicaid spending rose by 10 percent in 2001

and 14 percent in 2002, after which spending growth is estimated to have slowed to about 8 percent per year between FY 2002-2004.¹¹ The strong economic climate that prevailed during the late 1990's allowed many states to expand Medicaid services to higher-income individuals, often through optional waiver programs. When a weakened economy caused tax revenues to plummet in 2001-2002, states began to trim provider payments, and later cut back eligibility for optional populations and optional services, resulting in lower overall spending growth rates.

In a January 2004 analysis, the Congressional Budget Office (CBO) projected that the federal share of Medicaid spending would decline from earlier projections by a total of \$142 billion over the ten years from 2004 to 2013.¹² This lower level of spending is attributable to the Medicare Modernization Act (MMA). MMA shifts prescription drug coverage from Medicaid to Medicare, for individuals, known as dual eligibles, who are enrolled in both programs.

But state Medicaid savings from this shift will be much lower than the \$107 billion one might expect, based on an average 57 percent federal Medicaid share. That's

WAIVING THE RULES: MEDICAID 1115 AND 1915(C) WAIVERS

Unlike many federal programs — which can operate demonstration programs only within stringent rules — Medicaid Section 1115 waiver authority is both flexible and broad. Section 1115 of the Social Security Act gives the HHS Secretary the ability to approve state requests to modify ("waive") Medicaid's core requirements, generally for five years. This means that the range of services for waiver participants can and often does differ from services provided to those in the regular Medicaid program. Moreover, unlike the regular Medicaid program, under which enrollment is open to anyone in the state who meets the applicable eligibility criteria, enrollment caps that limit their size, scope and cost may be included in 1115 waiver programs. Copayments may be higher for waiver participants, while they are nominal under federal regulations governing the regular Medicaid program. As of January 2004, 19 states had comprehensive Section 1115 waivers approved by HHS.

As with Section 1115 waivers, states with approved section 1915(c) waivers may provide a different mix of services to participants, and they are not required to offer these services to all similarly situated individuals across the state. Waivers under Section 1915(c) are generally used for smaller populations of individuals who are eligible for long-term services and wish to receive them at home or in community-based settings.

During the last several years, the Bush Administration has created two simplified ways for states to seek Section 1115 and 1915(c) waivers. One is the Health Insurance Flexibility and Accountability (HIFA) waiver initiative, under which states may offer Medicaid beneficiaries coverage in private insurance plans. In effect, HIFA waivers are being used as an alternative vehicle for coverage of beneficiaries needing standard medical services. As of December 2003, nine states had received approval for a HIFA waiver.

A second waiver initiative, Independence Plus, is designed for individuals needing long-term care services. The program provides cash to disabled waiver participants in lieu of regular Medicaid services. As of April 2004, five states had received Independence Plus waivers, which can be structured either as Section 1115 waivers, or as HCBS waivers under Section 1915(c).

Sources: Center for Medicare and Medicaid Services, 1115 Waiver Research and Demonstration Projects, <http://www.cms.hhs.gov/medicaid/1115/default.asp> and Home and Community-Based Services Waiver Program, <http://www.cms.hhs.gov/medicaid/1915c/design.asp>.

Congressional Research Service, "Medicaid and SCHIP Section 1115 Research and Demonstration Waivers," updated March 5, 2004.

Mann, Cindy (2003). "Assessing the role of recent waivers in Providing New Coverage." Kaiser Commission on Medicaid and the Uninsured, December, p. 3, Table 2. (<http://www.kff.org/medicaid/4158.cfm>). Retrieved May 24, 2004.

Center for Medicare and Medicaid Services (2004). "Testimony of Dennis Smith, Director of the Centers for Medicare & Medicaid Services, on the New Freedom Initiative Before the Senate Finance Committee." April 7. (<http://www.cms.hhs.gov/media/press/testimony.asp?Counter=1011>). Retrieved May 25, 2004.

because under the law, states are required to make a substantial contribution to the cost of Medicare drug coverage for dual eligibles. Specifically, beginning in 2006 the law's so-called "clawback" provision holds states responsible for financing 90 percent of what they were spending per dual eligible in 2003. Over a 10-year period, the 90 percent state share will decrease to 75 percent, for a total cost to states of \$88 billion. States will be left with 10-year savings of about \$19 billion.¹³ (For more information on the MMA, see Chapter 5, Medicare.)

In FY 2003, all 50 states and the District of Columbia froze or cut payment rates for at least one group of providers, and all states implemented a wide range of policies to moderate prescription drug costs. Thirty-five states have reduced or eliminated some services, and 32

states have increased copayments on some services for certain beneficiary populations.¹⁴

Thirty-eight states planned to freeze or reduce physician rates in FY 2004, while 22 states said they would freeze hospital rates and 10 planned to cut hospital rates. Nineteen states planned to cut or freeze nursing home payments, and an equal number said they would freeze or cut managed care payments. However, 29 states planned to boost nursing home payments in FY 2004, and 20 states planned to increase HMO rates.¹⁵

Beneficiaries have been affected as well. Many states have curtailed their fully state-funded optional coverage of legal immigrants, raised Medicaid prescription copayments, and created waiting lists for thousands of individuals needing home and community-based

services.¹⁶

Each state sets its own reimbursement levels for doctors, hospitals and other providers serving Medicaid beneficiaries. These rates have historically been lower than those paid by other insurers. Hospitals, for example, received Medicaid payments averaging 98 percent of their costs in 2001, although that percentage varied widely from state to state. By comparison, Medicare paid 99 percent of hospital costs, and private payers paid an average of 113 percent of costs.¹⁷

Medicaid payments to physicians grew slowly during the 1990s compared to Medicare, with the result that by 1998, Medicaid fees paid to doctors were only 62 percent of Medicare fees, on average. Concerns about the willingness of physicians to see Medicaid beneficiaries helped spur faster growth from 1998 to 2003, when fees rose by 27 percent.¹⁸

In 2002, almost 60 percent of Medicaid beneficiaries were enrolled in some type of managed care program, ranging from traditional managed care models (HMOs) to more open networks with select providers.¹⁹ While managed care plans have the potential to improve beneficiary access to a range of basic services, providers in many states argue that state payments are too low, and in recent years HMOs in some states have ended their participation in Medicaid.

The average cost of coverage provided to beneficiaries varies dramatically among different population groups. Medicaid's relatively healthy population of low-income families and children, who comprise three-quarters of all beneficiaries, account for about 30 percent of spending on services. The elderly and persons with disabilities, who comprise the remaining one-quarter of beneficiaries, account for about 70 percent of total spending. In 2003, estimated Medicaid spending per

TEMPORARY INCREASE IN MEDICAID MATCH RATES EXPIRED JUNE 30

State Medicaid budget problems during the last few years have not gone unnoticed by the federal government. In May 2003, in response to widespread state revenue shortfalls, Congress enacted legislation to provide states with \$10 billion in extra funding over several quarters of FYs 2003 and 2004. The net effect was an increase in each state's federal match rate of 2.95 percentage points. This resulted in 42 states reporting that the increased funding helped them to resolve a Medicaid budget shortfall, while 27 reported that the extra money allowed them to avoid, minimize, or postpone additional planned Medicaid cuts or freezes.

The \$10 billion in federal fiscal relief expired on June 30, 2004. Unless Congress moves to enact additional Medicaid fiscal relief, many states will be faced with the need to significantly increase their own Medicaid spending on program services to keep pace with average recent Medicaid cost growth rates, or to find ways to moderate program spending. It is already evident that some states — which cut back on spending in FY 2003 and FY 2004 — will be challenged by enrollment increases and slow recovery from recent revenue shortfalls.

In the case of the state with the highest match rate, Mississippi — which saw its federal match rate drop back to 77 percent from 80 percent — state policymakers would need to increase state Medicaid dollars by almost 24 percent in FY 2005 if total Medicaid spending were to keep pace with an average national annual growth rate of 8 percent. Mississippi legislators voted in May 2004 not to raise tobacco taxes to finance a projected Medicaid deficit of nearly \$400 million for FY 2005. They enacted legislation to reduce the deficit by dropping 65,000 frail elders and disabled persons from Medicaid by halving income eligibility levels.

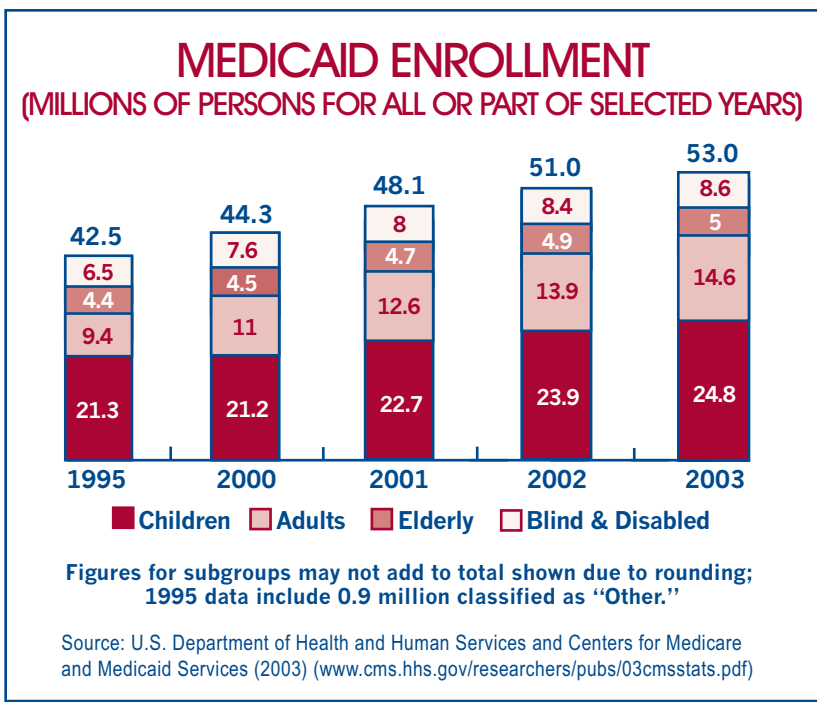
Sources: Smith, V., Ramesh, R., Gifford, K., Ellis, E., Wachino, V., & O'Malley, M. (2004, January). "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Action." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. (<http://kff.org/medicaid/7001.cfm>) and Title II Community AIDS National Network. "State Medicaid Eligibility Cutbacks and Exclusions - Proposed and Recently Enacted, 2001-2004." (<http://www.tiicann.org/>).

Calculation for Mississippi spending was made by Alliance for Health Reform staff, based on Mississippi match rates for FY 2004-2005, assuming an 8 percent annual growth rate for Medicaid spending.

child was \$1,746, while per-person spending on the highest-cost group — frail elders — was \$12,828.²⁰ (See chart, "Medicaid Expenditures Per Enrollee, FY 2003.")

ENROLLMENT TRENDS

Rising Medicaid expenditures are in part a result of enrollment increases. Between FY 2000-2002, the number of beneficiaries enrolled for all or part of the year increased from 44 million to 51 million. Federal projections are that enrollment reached 53 million in FY 2003.²¹



Medicaid's partner program, SCHIP, also added several million enrollees from FY 2000 to FY 2003, when the total number of enrolled children (and, in a few states, other family members) was projected to reach 5.8 million.²² (For more information on SCHIP and other sources of coverage for children, see Chapter 4, Children's Coverage.) Overall, Medicaid in 2002 provided services to 25 million children, more than one in four; 13 million adults, primarily low-income working parents; 5 million seniors; and 8 million persons with disabilities.²³ (See chart, "Medicaid Enrollment 1995-2003.")

One major trend that has become evident is expanded enrollment in Medicaid home and community-based services (HCBS) waiver programs. States are increasingly turning to HCBS waiver programs for coverage of aged and disabled persons, and for individuals with developmental disabilities. Total enrollment in HCBS waiver programs in 2001 reached 833,000. Nonetheless, demand for HCBS services considerably outstrips supply. As of 2002, states that maintain waiver waiting lists reported a total of 157,640 individuals on those lists. Today, HCBS waiver expenditures account for about one-third of all Medicaid spending on long-term care services. In addition, HCBS waiver spending is eclipsing other state spending on community-based services, namely the

optional personal care benefit, which dropped from 22 percent of total community-based services spending in 1992 to 11 percent in 2002.²⁴

Among children, combined Medicaid and SCHIP coverage appears to have played a key role in reducing the percentage of uninsured children from 13 percent to 11 percent between 1999 and 2003. However, about half of the total number of children who are currently uninsured may be eligible for Medicaid or SCHIP enrollment.²⁵ While efforts to simplify enrollment and improve outreach in Medicaid and SCHIP have yielded positive results, analysts caution that state budget constraints have triggered cutbacks in both Medicaid and SCHIP budgets. Many states have changed eligibility criteria, imposed enrollment caps, and discontinued support for outreach activities.²⁶ This may make it

difficult to maintain the recent coverage gains among children.

Analysis of Medicaid enrollment increases since 2000 suggest that the program has moderated — by about 1.5 million — recent growth in the number of uninsured adults.²⁷ One federal survey estimates that between 2000 and 2003, the number of uninsured individuals of all ages increased from 41.3 million to 43.1 million.²⁸ Some analysts suggest that if states had not cutback eligibility to reduce Medicaid costs during this period, the number of uninsured would have grown more slowly.²⁹

STATE BUDGETS AND MEDICAID

Medicaid constitutes the second-largest share of spending by state governments after elementary and secondary education, accounting for an estimated 21 percent of total state spending from all sources,³⁰ and 16 percent of spending from state-only sources in FY 2002.³¹ Rising Medicaid costs became a problem for state budgets after revenues in many states dropped precipitously in FY 2002. Revenues began to improve significantly in FY 2003, and by mid-2004, states were projecting an overall shortfall of only \$720 million for FY 2004, down from a February 2003 projected gap of \$25.7 billion.³² But with Medicaid spending continuing

to rise, albeit more slowly, all states and the District of Columbia report that they are continuing to develop and implement cost containment strategies.³³

Until states fully recover the substantial revenue losses that occurred during 2002, it is likely that most will continue to tightly regulate Medicaid spending — even as revenues improve. In part, this is because, unlike the federal government, states cannot incur deficits from one year to the next. With the exception of Vermont, all states and the District of Columbia are required by their constitutions to balance their budgets on an annual basis.

Since 1965, Medicaid costs have been split between the federal government and the states. On average, the federal government finances 57 percent of total Medicaid costs. The 43 percent share paid by states varies according to a formula that awards more federal funding to states with low per-capita incomes. The highest federal match rate is 77 percent, and the lowest is 50 percent. In effect, Medicaid services in less affluent states with high match rates are financed mainly with federal dollars. So if a less affluent state decides to cut its Medicaid budget, its high match rate dictates that the state will incur a substantial loss in federal matching funds. Congress has temporarily adjusted the federal match rate for certain states on several occasions, but has never undertaken a wholesale revision of the formula program.

CURRENT POLICY DEBATES AND PROPOSALS

Several of the current Medicaid policy debates concern complex state-federal financing mechanisms that have enabled some states to receive more federal dollars than would normally be permitted under the applicable federal match rate. One front in these ongoing policy wars centers on "upper payment levels" (UPL), and a second concerns how states use their funds to make intergovernmental transfers for purposes of drawing down federal Medicaid funds.

While federal officials protest that states are improperly drawing down federal dollars, governors and Medicaid officials in states using these devices respond that their ability to deliver health care to vulnerable populations would be compromised if they are forced to end these practices fully and immediately.

Prior to 2001, regulatory UPL ceilings applied to some service providers were higher than the amounts actually paid by states for services. These states were able to get federal Medicaid matching funds for amounts up to the UPL, effectively increasing the amount of federal Medicaid funding they would have otherwise received. Congress has moved to tighten UPL rules, but is allowing states a phase-out period of up to eight years to change their practices.

Intergovernmental transfers — transfers of public funds from one government entity to another — are one way to finance the state share of Medicaid spending. New York, for example, requires its counties to provide half of the state's 50 percent match for federal Medicaid funds. Some states were able to combine intergovernmental transfers with UPL payments to some public hospitals or nursing homes, and draw down billions of additional federal Medicaid dollars without putting up any new state matching funds. Such policies prompted the Centers for Medicare and Medicaid Services (CMS) to announce in 2004 that it will require states to provide detailed descriptions of "each source of revenue" used to claim federal Medicaid funds — meaning that states will not be able to receive federal dollars without the agency's approval.³⁴

Debate also continues about the strengths and weaknesses of the HIFA and Independence Plus waiver initiatives of the Bush Administration. (See box, "Waiving the Rules: Medicaid 1115 and 1915(c) Waivers.") While proponents praise the flexibility built into these initiatives, opponents express concern about the potential of 1115 waivers to erode the entitlement nature of the Medicaid program.

The 1999 U.S. Supreme Court decision in *Olmstead v. L.C.* — which interpreted the non-discrimination provisions of the 1990 Americans with Disabilities Act to apply to Medicaid and other publicly funded health care programs — has pushed states to consider making more non-institutional placements available to individuals with disabilities who wish to live at home or in community settings. In 2000, an estimated 140,000 individuals with mental retardation or developmental disabilities lived in nursing facilities. In the view of most disability organizations, the vast majority of institutionalized persons with disabilities could live in small homes in the community with appropriate support.

To date, the results of states' efforts following the *Olmstead* decision appear mixed. While many states have drafted *Olmstead* plans that are broadly designed to increase community placements, fewer are actively engaged in identifying community settings for institutionalized persons who do not oppose community placement. In addition, state budgets frequently do not reflect *Olmstead* planning goals.³⁵

Looking ahead, the prospect of continuing tight state Medicaid budgets — in combination with large federal deficits, rising health care costs, and expanding program enrollment — is certain to fuel further policy debates about the program's future. Those discussions may include consideration of whether the program's financing system could include ways to allow states to weather short-term economic difficulties, without major changes in eligibility and services. Other options may include allowing states more flexibility, including allowing them to lessen beneficiaries' entitlement to services.

STORY IDEAS

- What changes has your state made to Medicaid benefits in the last year? How has this affected access to services for beneficiaries? If services were trimmed, which ones were cut, and by how much? What factors went into this decision? How much money did the state save, and how much less in federal Medicaid funding was received as a result of the cuts? If Medicaid payments to providers were reduced, which providers (e.g., hospitals, nursing homes) were affected?
- How is the Medicaid program in your state financed — through general revenues, or in combination by dedicated funding? Has the financing changed in recent years? What percent of the state's general revenue is now dedicated to Medicaid? Has this changed, and what are the projections? What are the main cost drivers in your state's Medicaid budget, and what steps are being taken to moderate the growth of these costs?
- How are Medicaid drug formularies designed in your state? How have rising prescription drug costs affected formularies? What is the impact on beneficiaries?
- How is the "best price" calculated by your state for covered prescription drugs? How have these best prices changed in recent years, and how do they differ from prices paid by the Department of Veterans Affairs and other large payers, e.g., managed care plans? Is your state engaged in any litigation against drug manufacturers using the False Claims Act, sometimes referred to as "whistleblower" cases?
- How is implementation of the Medicare drug benefit in 2006 likely to affect Medicaid costs in your state? What steps are state officials taking to prepare for enrolling low-income Medicaid beneficiaries who are also eligible for Medicare (known as "dual eligibles") in the new drug benefit program? Since the Medicare Modernization Act requires states to continue financing a significant portion of the drug coverage for dual eligibles, what steps is your state planning to try to control these costs?
- Has your state asked the HHS Secretary for authority to waive standard Medicaid services for low-income workers under Health Insurance Flexibility and Accountability (HIFA) waivers? Has your state obtained an Independence Plus waiver? If so, how do Medicaid services for enrolled individuals differ from long-term care services that would otherwise be provided?
- Does your state deliver long-term care services through a home and community-based services (HCBS) waiver program? How many such waivers does your state have, what kinds of individuals are enrolled, and what services are provided? What impact, if any, has the 1999 Supreme Court's *Olmstead* decision had on state policy to increase the availability of community placements for individuals with disabilities? For example, has the number of HCBS waiver slots increased?
- During economic downturns, Medicaid enrollment tends to rise. Has it increased in your state during the last three years? What do policymakers see happening to enrollment in the future? Are state revenues healthy enough to finance increased program enrollment? If policymakers are taking steps to curb enrollment growth, what is the impact of this on low-income working families?

- Is your state engaged in other types of anti-fraud Medicaid activities, e.g., initiatives to shut down so-called "Medicaid mills," under which providers bill the program for services that are not actually provided?
- How widespread is the practice of people transferring assets to establish eligibility for Medicaid long-term care services? Does the state attempt to recover Medicaid costs from the estates of deceased beneficiaries in such cases?

SOURCES AND WEBSITES

Analysts/Advocates

John Alker, *Research Professor*, Georgetown University Health Policy Institute, 202/687-0880

Deborah Chollet, *Senior Fellow*, Mathematica Policy Research, Inc., 202/554-7528

Richard Curtis, *President*, Institute for Health Policy Solutions, 202/789-1491

Karen Davenport, *Senior Program Officer*, Robert Wood Johnson Foundation, 607/627-7659

Karen Davis, *President*, Commonwealth Fund, 212/606-3800

Jon Gabel, *Vice President Health System Studies*, Health Research and Educational Trust, AHA, 202/626-2688

Sherry Glied, *Professor and Department Chairman of Health Policy & Management*, Columbia Univ. Joseph L. Mailman School of Public Health, 212/305-0299

John Goodman, *President*, National Center for Policy Analysis, 972/386-6272

Robert Helms, *Resident Scholar*, American Enterprise Institute, 202/862-5877

Leighton Ku, *Senior Fellow of Health Policy*, Center on Budget and Policy Priorities, 202/408-1080

Jeanne Lambrew, *Associate Professor of Health Policy*, The George Washington University, 202/416-0479

Barbara Lyons, *Vice President and Deputy Director of Kaiser Commission on Medicaid and the Uninsured*, Kaiser Family Foundation, 202/347-5270

Cindy Mann, *Research Professor*, Georgetown Univ. Health Policy Institute, 202/687-0880

Jack Meyer, *President*, Economic and Social Research Institute, 202/833-8877, x *812

CANDIDATES' VIEWS

The different policy approaches to changing Medicaid being taken by President Bush and Senator Kerry illustrate differing philosophies when it comes to changing the program.

President Bush is actively promoting additional flexibility, or authority, for states to reconfigure Medicaid, in part through encouraging statewide 1115 waiver programs. These administrative waivers can effectively permit substantial changes in program benefits, eligibility, cost-sharing and in how health care services are delivered.³⁶ The Bush administration also supports expansion of Medicaid 1915c waiver programs for home and community-based services only, which can benefit individuals with disabilities.

By comparison, Senator Kerry would use Medicaid as a platform for significant expansion of health care coverage by allowing states to enroll children and adults up to 300 percent of the federal poverty level. States that opted to extend eligibility to this threshold would see the costs of all children enrolled in Medicaid assumed by the federal government.³⁷

Ron Pollack, *Executive Director*, Families USA, 202/628-3030

Sara Rosenbaum, *Chair of the Department of Health Policy, Professor of Health Policy*, George Washington University, 202/530-2343

Diane Rowland, *Executive Vice President and Executive Director of Kaiser Commission on Medicaid and the Uninsured*, Kaiser Family Foundation, 202/347-5270

Andy Schneider, *Principal*, Medicaid Policy LLC, 202/393-6898

Steve Somers, *President*, Center for Health Care Strategies, 609/895-8101

James Tallon, *President*, United Hospital Fund of New York, 212/494-0700

Ken Thorpe, *Robert Woodruff Professor and Chair Department of Health Policy and Management*, Rollins School of Public Health at Emory University, 404/727-3373

Government and Related Groups

Joan Henneberry, *Director of the Health Policy Studies Division*, National Governors Association, 202/624-5300

Kathryn Kotula, *Director of Health Policy Unit*, National Association of State Medicaid Directors, 202/682/0100

Richard Price, *Section Head for Healthcare and Medicine*, Congressional Research Service, 202/707-7370

Joy Wilson, *Director of the Health Committee*, National Conference of State Legislatures, 202/624-5400

Stakeholders

Chris Burch, *Executive Director*, National Association of Public Hospitals, 202/585-0100

Tom Nickels, *Senior Vice President of Federal Relations*, American Hospital Association, 202/626-2314

Websites

Alliance for Health Reform
www.allhealth.org

Center for Health Care Strategies
www.chcs.org

Centers for Medicare and Medicaid Services
www.cms.gov

The Commonwealth Fund
www.cmwf.org

Families USA
www.familiesusa.org

Kaiser Family Foundation
www.kff.org

National Academy for State Health Policy
www.nashp.org

National Association of State Medicaid Directors
http://www.nasmd.org/members.htm

National Coalition on Health Care
www.nhc.org

The Robert Wood Johnson Foundation
www.rwjf.com

State Coverage Initiatives
www.statecoverage.net

Urban Institute
www.urban.org

ENDNOTES

- a U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services (2003). "2003 CMS Statistics." p. 11, Table 11. (<http://www.cms.hhs.gov/researchers/pubs/03cmsstats.pdf>). Retrieved May 21, 2004.
- b Kaiser Commission on Medicaid and the Uninsured (2004). "The Medicaid Program at a Glance." January. (http://www.kff.org/medicaid/upload/30463_1.pdf). Retrieved May 24, 2004.
- c Urban Institute, "Federalism and Health Policy: An Overview." (2003). (<http://www.urban.org/pubs/federalism/chapter1.html>). Retrieved July 15, 2004.
- d Kaiser Commission on Medicaid and the Uninsured (2004). "The Medicaid Program at a Glance." January. (http://www.kff.org/medicaid/upload/30463_1.pdf). Retrieved May 24, 2004.
- e Kaiser Commission on Medicaid and the Uninsured (2004). "The Medicaid Program at a Glance." January. (http://www.kff.org/medicaid/upload/30463_1.pdf). Retrieved May 24, 2004.
- f Kaiser Commission on Medicaid and the Uninsured (2004). "The Medicaid Program at a Glance." January. (http://www.kff.org/medicaid/upload/30463_1.pdf). Updated 2003 numbers obtained through personal communication with Risa Elias, May 4, 2004.
- g Kaiser Commission on Medicaid and the Uninsured (2004). "Dual Eligibles, Medicaid's Role for Low-Income Medicare Beneficiaries." January, p. 1. (<http://www.kff.org/medicaid/4091-02.cfm>). Retrieved May 25, 2004.
- h Kaiser Commission on Medicaid and the Uninsured (2004). "The Medicaid Program at a Glance." January. (http://www.kff.org/medicaid/upload/30463_1.pdf). Retrieved May 24, 2004.
- i Strunk, Bradley C. & James D. Reschovsky (2004). "Trends in U.S. Health Insurance Coverage, 2001-2003." Center for Studying Health System Change, Tracking Report No. 9, August, p. 1-2. (<http://www.hschange.org/CONTENT/694/#ib1>) Retrieved on August 3, 2004.
- j Wachino, Victoria, et al. (2004.). "Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds." Kaiser Commission on Medicaid and the Uninsured (January). (<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30545>). Retrieved July 20, 2004.

- 1 Congressional Budget Office (2004). March budget baseline projection for 2004 (assuming federal Medicaid spending is 57% on average of total Medicaid spending). (<http://www.cbo.gov/showdoc.cfm?index=1944&sequence=0#table1>). Retrieved July 16, 2004.
- 2 Holohan, John & Brian K. Bruen (2003). "Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?" Urban Institute, September 1, p. 4. (www.urban.org/url.cfm?ID=410875). Retrieved on May 11, 2004.
- 3 Wachino, Victoria, et al. (2004.). "Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds." Kaiser Commission on Medicaid and the Uninsured (January). (<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30545>). Retrieved on July 20, 2004.
- 4 Centers for Medicare and Medicare Services (2004). "Medicaid: A Brief Summary." January 28. (<http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp>). Retrieved on May 26, 2004.
- 5 Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book." (2002).
- 6 Centers for Medicare and Medicare Services (2004). "Medicaid: A Brief Summary." January 28. (<http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp>). Retrieved on May 26, 2004.
- 7 Kaiser Family Foundation. "State Health Facts Online: Medicaid Medically Needy Enrollees by Eligibility Category, 2000." (www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Missouri&category=Health+Coverage+%26+Uninsured&link_category=Medicaid+%26+SCHIP&link_subcategory=Medicaid+Medically+Needy&link_topic=Enrollment+by+Eligibility+Category). Retrieved Aug. 9, 2004.
- 8 Kaiser Commission on Medicaid and the Uninsured (2004). "Medicaid Program at a Glance." January. (<http://www.kff.org/medicaid/2004-04.cfm>). Retrieved on May 11, 2004.
- 9 National Association of State Budget Officers. (2003). "State Expenditure Report: 2002." p. 47 (www.nasbo.org/publications/2002expendreport.pdf); Congressional Budget Office (2004).
- 10 Congressional Budget Office (2004). March baseline projection (and assuming federal Medicaid spending is 57% on average of total Medicaid spending). (<http://www.cbo.gov/showdoc.cfm?index=1944&sequence=0#table1>). Retrieved on July 16, 2004.
- 11 Holahan, John & Brian Bruen (2003). "Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?" The Kaiser Family Foundation, September. (<http://www.kff.org/medicaid/kcmu4139report.cfm>). Retrieved on May 24, 2004.; Congressional Budget Office (2004). "The Budget and Economic Outlook: Fiscal Years 2005 to 2014." January, p.50, Table 3-1. (<http://www.cbo.gov/showdoc.cfm?index=4985&sequence=0>). Retrieved on May 18, 2004.
- 12 Holtz-Eakin, Douglas (2004). "Estimating the Cost of the Medicare Modernization Act." Congressional Budget Office, testimony of CBO Director before the House Ways & Means Committee, March 24. (<http://www.cbo.gov/showdoc.cfm?index=5252&sequence=0>). Retrieved on May 10, 2004.
- 13 Wilson, Joy Johnson (2003). "Medicare Prescription Drug Reform." National Conference of State Legislatures, December 10, p. 10. (<http://www.ncsl.org/statedfed/health/mcsum1210.pdf>). Retrieved on May 25, 2004; Holtz-Eakin, Douglas (2004). "Estimating the Cost of the Medicare Modernization Act." Congressional Budget Office, testimony of CBO Director before the House Ways & Means Committee, March 24. (<http://www.cbo.gov/showdoc.cfm?index=5252&sequence=0>). Retrieved on May 10, 2004. Calculation of net state savings by Alliance for Health Reform, based on a 57 percent federal Medicaid share.
- 14 Kaiser Commission on Medicaid and the Uninsured (2004). "Medicaid Program at a Glance." January. (<http://www.kff.org/medicaid/2004-04.cfm>). Retrieved on May 11, 2004.
- 15 Smith, Vernon et al. (2003). "States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004." Kaiser Commission on Medicaid and the Uninsured, September, p. 19, Figure 11. (<http://www.kff.org/medicaid/kcmu4137report.cfm>). Retrieved on May 25, 2004.

- 16 McCormack, Thomas P. (2004) "State Medicaid Eligibility Cutbacks and Exclusions - Proposed and Recently-Enacted, 2001-2004." Title II Community AIDS National Network, May 16. (<http://www.tiicann.org>). Retrieved on May 19, 2004.
- 17 Medicare Payment Advisory Commission. (2003). "Medicare Payment Policy." (Report to Congress). March, p. 278, Table D-13. (http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf) . Retrieved on May 25, 2004.
- 18 Zuckerman, Stephen, et al., "Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation." Health Affairs (June 2004). (<http://www.healthaffairs.org>). Retrieved on July 16, 2004.
- 19 Hurley, Robert E. & Stephen A. Somers (2003). "Medicaid and Managed Care: A Lasting Relationship?" Health Affairs, 22(1), p. 77. (<http://www.healthaffairs.org>). Retrieved on May 25, 2004.
- 20 Kaiser Commission on Medicaid and the Uninsured (2004). "Medicaid Program at a Glance." January. (<http://www.kff.org/medicaid/2004-04.cfm>). Updated 2003 numbers obtained through personal communication with Risa Elias, May 4, 2004.
- 21 U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services (2003). "2003 CMS Statistics." p. 11, Table 11. (<http://www.cms.hhs.gov/researchers/pubs/03cmsstats.pdf>). Retrieved May 21, 2004.
- 22 Centers for Medicare and Medicaid Services (2004). "FY 2003 Number of Children Ever Enrolled in SCHIP by Program Type." January 22. (<http://www.cms.hhs.gov/schip/enrollment/schip03.pdf>). Retrieved on May 21, 2004.
- 23 Kaiser Commission on Medicaid and the Uninsured (2004). "Medicaid Program at a Glance." January. (<http://www.kff.org/medicaid/2004-04.cfm>). Retrieved May 11, 2004.
- 24 Kaiser Commission on Medicaid and the Uninsured (2004). "Recent Growth in Medicaid Home and Community-Based Service Waivers." April. (<http://www.kff.org/medicaid/7077-index.cfm>). Retrieved July 19, 2004.
- 25 Kenney, Genevieve, et al (2003). "Children's Insurance Coverage and Service Use Improve." Urban Institute, July. (http://www.urban.org/UploadedPDF/310816_snapshots3_no1.pdf). Retrieved on July 16, 2004.
- 26 Hill, Ian, et al (2004). "Squeezing SCHIP: States Use Flexibility to Respond to the Ongoing Budget Crisis." Urban Institute, June.
- 27 Holohan, John & Brian K. Bruen (2003). "Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?" Urban Institute, September 1, p. 1. (www.urban.org/url.cfm?ID=410875). Retrieved on May 11, 2004.
- 28 U.S. Centers for Disease Control and Prevention (2004). "January-September 2003 National Health Interview Survey." March 24, table 1.1. (<http://www.cdc.gov/nchs/about/major/nhis/released200403.htm>). Retrieved on May 24, 2004.
- 29 Center on Budget and Policy Priorities (2003). "Number of Americans Without Health Insurance Rose in 2002: Increase Would Have Been Much Larger If Medicaid and SCHIP Enrollment Gains Had Not Offset the Loss of Private Health Insurance." October 8. (<http://www.cbpp.org/9-30-03health.htm>). Retrieved on May 25, 2004.
- 30 National Governors Association and National Association of State Budget Officers (2004). "The Fiscal Survey of States." April, p. 3. (<http://www.nga.org/cda/files/FSS0404.pdf>). Retrieved May 25, 2004.
- 31 Wachino, Victoria, et al. (2004.). "Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds." Kaiser Commission on Medicaid and the Uninsured (January). (<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30545>). Retrieved on July 20, 2004.
- 32 National Conference of State Legislatures (2004). "State Budget Gaps Shrink, NCSL Survey Finds: States Report Modest Budget Improvements." April 28. (<http://www.ncsl.org/programs/press/2004/040428.htm>). Retrieved May 25, 2004.
- 33 Smith, Vernon et al. (2003). "States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004." Kaiser Commission on Medicaid and the Uninsured, September, p. 2, Figure 2. (<http://www.kff.org/medicaid/kcmu4137report.cfm>). Retrieved May 25, 2004.

- ³⁴ Rousseau, David & Andy Schneider (2004). "Current Issues in Medicaid Financing - An Overview of IGTs, UPLs and DSH." Kaiser Commission on Medicaid and the Uninsured, April. (<http://www.kff.org/medicaid/7071.cfm>). Retrieved on May 25, 2004.
- ³⁵ National Council on Disability (2003). "Olmstead: Reclaiming Institutionalized Lives." (September). (http://www.allhealth.org/recent/audio_06-21-04/reclaimabridged.pdf). Retrieved on June 15, 2004.
- ³⁶ George W. Bush 2004. "Making Health Care More Accessible and Affordable" (www.georgewbush.com/healthCare/Brief.aspx) Retrieved August 23, 2004.
- ³⁷ The Commonwealth Fund (2003). "Health Care Reform Returns to the National Agenda: the 2004 Presidential Candidates' Proposals." September. Retrieved March 2004.