

State Budget Cuts and Medicaid Managed Care: *Case Studies of Four States*

Prepared for the NASHP by:

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June 2004

*Prepared with support from the
Association for Health Center Affiliated
Health Plans, AMERIGROUP Corporation,
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TABLE OF CONTENTS

Executive Summary	1
Interview Findings.....	1
Introduction.....	3
Background on State Medicaid Budget Reduction Strategies	3
Methodology for Conducting the Four Case Studies	7
Table One: Summary of Four States’ Budget Cutting Strategies in 2003 and 2004	8
Key Findings from Interviews and Discussion.....	11
The Four States’ Medicaid Agencies Have Some Discretion In Proposing Budget Cut Strategies	11
The Extent to Which Medicaid Agencies Include the MCOs in Budget Reduction Strategy Development Varies	12
State Agencies Have Not Devoted Significant Resources to Identifying the Indirect Effects of Budget Reduction Strategies on the MCOs or How to Mitigate Them. Such Effects Can Be Significant.	12
State Agency Staff Expressed Satisfaction with an Arduous Yet Effective Budget Reduction Process.....	14
State Agency Staff and MCOs Are Realistic About the State of the Economy.....	14
Most State Agency Staff and MCOs Perceive Medicaid Managed Care as Weaker.....	15
Conclusion	16
Appendix A: List of State Agency Personnel Interviewed and Advisory Group Members	
Appendix B: Background on States’ Strategies for Reducing Medicaid Expenditures	
Appendix C: Questionnaire Used to Interview State Agency Staff and MCO Representatives	

EXECUTIVE SUMMARY

In the past few years states have experienced profound pressure to control costs and reduce state budget deficits. Accordingly, states have had to implement changes in their Medicaid budgets that include across-the-board provider rate cuts and direct cuts in benefits and eligibility. All of these actions have had an impact on states' Medicaid managed care programs. Using survey data and interviews with state Medicaid and oversight agency staff in four states—Florida, Massachusetts, Michigan, and Oregon—staff of Bailit Health Purchasing have examined the strategies states have employed to manage their Medicaid budgets and the policy, programmatic and operational implications these strategies have had for the states' Medicaid managed care plans. The information in this paper is timely as most states are still facing deficits and will be forced to implement additional cost-cutting strategies in the near future.

To provide a sense of the types of Medicaid budget cutting strategies states are employing across the country, we reviewed the results of surveys conducted of all 50 states and the District of Columbia by the Kaiser Family Foundation (KFF). Telephone interviews were then conducted using a NASHP-approved questionnaire. State agency staff and at least one managed care organization (MCO) in each state were interviewed. In developing this paper, we consulted with a project advisory group and the project funders. Advisory group members provided input on state selection, reviewed the draft protocol, and reviewed a draft of the paper. State interviewees all had an opportunity to review the draft of the paper before it was finalized.

Interview Findings

1. Medicaid agencies in the four states have some discretion in proposing budget cut strategies.

In each of the four states, the Medicaid budget cutting strategies that had been implemented or were being implemented by state staff were usually not dictated by the legislature.

2. The extent to which Medicaid agencies include managed care organizations in budget reduction strategy development varies.

Typically, the Medicaid agency staff in the four states use extensive internal processes to develop their proposals. However, the manner and degree of health plan involvement in the agency's budget and implementation strategy development processes vary by state. In two of the four states, the MCOs were invited to participate before the state agency budget was proposed to the legislature. In the other two cases, they were excluded until the Medicaid agency's and the Governor's proposals had been presented to the legislature.

3. State agencies have not devoted significant resources to identifying the indirect effects of budget reduction strategies on the MCOs or how to mitigate them, and such effects can be significant.

The state agencies did not devote significant resources to considering the indirect impact of changes—such as changes to fee-for-service provider payment rates, eligibility rules, new or increased beneficiary cost-sharing and state agency staffing—on managed care organizations. These changes have had a significant adverse administrative and financial

impact on the MCOs. State agency staff, even those who involve the MCOs in budget cutting strategy development, indicated that they did not spend time projecting the impact of changes other than MCO rate changes. The area of greatest contention between the MCOs and state agency staff was whether, how, and when the agencies decreased MCO rates to reflect anticipated saving from the budget cuts.

4. State agency staff expressed satisfaction with an arduous yet effective budget reduction process

State agencies judged their budget cutting processes successful since they were able to achieve budget passage without fundamentally undermining their programs and negatively impacting access to care.

5. The staff of both the state agencies and the managed care plans are realistic about the state of the economy

State agency staff and MCOs both recognize that the economy and the health of state budgets fluctuate over time. However, some state agency staff worry that little, if anything, remains to be cut that will not seriously harm the viability of the Medicaid and the Medicaid managed care programs.

6. State agency staff and plans generally perceive Medicaid managed care as weakened

Most state agency and MCO staff view the Medicaid managed care programs as weaker than they were and, in some cases, quite vulnerable. State agency staff expressed the hope that they will be able to protect participating MCOs from further cuts in the coming fiscal year, as they believe that Medicaid managed care improves both access and quality. MCOs reported that they continue to be committed to the Medicaid business.

Findings are discussed in greater detail in the Key Findings section of this paper.

INTRODUCTION

In the past few years, states have experienced profound pressure to control costs and reduce state budget deficits. Accordingly, states have had to implement cuts in their Medicaid budgets that include both across-the-board provider rate cuts and direct cuts in benefits and eligibility. The purpose of this report is to provide information about the policy, programmatic, and operational implications these budget-cutting strategies have for states' Medicaid managed care plans.

The paper presents findings from interviews, conducted by Bailit Health Purchasing staff on behalf of NASHP, with state Medicaid and Medicaid oversight agency staff and Medicaid MCO representatives in Florida, Massachusetts, Michigan, and Oregon. The interview findings are followed by a discussion of lessons learned and best practices in the four selected states, lessons that may be helpful for any state embarking on new rounds of budget cuts. The paper also explores the impact of a variety of budget cutting strategies on Medicaid managed care programs. Appendix B contains detailed information on state Medicaid budget reductions and strategies, information gleaned from a review of reports by the Kaiser Commission and the National Academy for State Health Policy (NASHP).

Background on State Medicaid Budget Reduction Strategies

Over the last several years, states have faced a deteriorating budget situation. For many states, tax revenue grew strongly in the late 1990s and then crashed in FY 2002.¹ Since then, revenues have remained relatively stagnant while expenditures continue to increase, particularly within state Medicaid programs.² The result is multi-year deficits, deficits that total between \$70 billion and \$85 billion for FY 2004.³ Double digit increases in the cost of some services, like pharmacy, have also caused Medicaid to swallow increasingly larger portions of all state expenditures. Medicaid is typically the second-largest item on a state's general fund budget, accounting for roughly 16 percent of expenditures.⁴ Because total Medicaid spending rose by approximately 25 percent between FY 2000 and FY 2002 (almost 12.5 percent per year), states have focused heavily on containing Medicaid expenditures.⁵

¹ N. Jenny, "Underlying State Revenue Picture Remains Bleak: Preliminary State Tax Revenues." *The Rockefeller Institute State Fiscal News* Vol. 3, No. 6, August 2003.

² N. Johnson and B. Zahradnik, "State Budget Deficits Projected for Fiscal Year 2005," Center on Budget and Policy Priorities (Washington, DC: The Center, January 30, 2004). After adjusting for inflation and legislative changes, state revenues grew only slightly (0.4%) in the July to September 2003 quarter.

³ I. Lav and N. Johnson, "State Budget Deficits For Fiscal Year 2004 Are Huge And Growing," Center on Budget and Policy Priorities (Washington, DC: The Center, January 23, 2003).

⁴ National Association of State Budget Officers, "The Fiscal Survey of States" (Washington, DC: The Association, December 2003). Education is the largest component, accounting for 35.4 %.

⁵ J. Holahan and B. Bruen, "Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?," Kaiser Commission on Medicaid and The Uninsured, September 2003.

To address budget deficits, states cut \$25.5 billion in spending over FY 2002 and FY 2003. At the same time, they raised taxes by nearly \$20 billion.⁶ States' Medicaid cost-control initiatives helped to reduce Medicaid's growth rate from 12.8 percent in FY 2002 to 9.3 percent in FY 2003.⁷ Preliminary FY 2004 expenditure data suggest that states have been able to slow Medicaid's spending growth to approximately 8.2 percent.⁸ Over the decade, Medicaid is now expected to grow by an average annual rate of 8.5 percent.⁹ Although an improvement, this reduction is not enough.¹⁰ First, Medicaid costs are still increasing. Second, state revenues are expected to grow at a rate far less than 8.5 percent. Overall growth in state revenues are projected to be 5.1 percent in FY 2004.¹¹ The Medicaid program competes with other state priorities, such as education, transportation, housing, and public health. This indicates that additional cuts in state Medicaid programs are likely. The following is a description of the Medicaid cost containment approaches that states have typically employed over the past several years. Each of the four case study states has implemented at least some of these types of strategies.

Medicaid cost containment approaches employed over the past several years

Since 2001, the Kaiser Family Foundation (KFF) has commissioned a survey of all 50 states and the District of Columbia to study the relationship between their deteriorating fiscal conditions and how states are responding with changes to their Medicaid programs and budgets. For FY 2003 and FY 2004, the KFF report cited five primary areas where states have been focusing their cost-containment policies: provider payments, pharmacy, benefits, eligibility, and beneficiary cost-sharing.

⁶ "States' Fiscal Crises Seem To Be Easing, But Many Still Face Rising Health Care Costs, Report Says," Kaiser Daily Health Policy Report, December 5, 2003.
http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=21197

⁷ Health Management Associates (HMA) and Victoria Wachino, "States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2003).

⁸ Health Management Associates, V. Wachino, and M. O'Malley, "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2004). See also: National Association of State Budget Officers, "The Fiscal Survey of States," December 2003 (indicating relatively constant growth of 8.5% for the decade).

⁹ National Association of State Budget Officers, "The Fiscal Survey of States," December 2003.

¹⁰ Center On Budget And Policy Priorities, "State Budget Deficits Projected for Fiscal Year 2005," January 30, 2004. (Thirty states already estimate budget shortfalls for FY 2005, totaling some \$39 billion to \$41 billion.)

¹¹ National Association of State Budget Officers, "The Fiscal Survey of States," December 2003.

Provider payments

For FY 2003, all but one state cut or froze Medicaid payment rates for at least one provider group—hospitals, physicians, nursing homes, or managed care organizations—and 39 states had plans to either freeze or reduce provider payment rates in FY 2004.¹²

Interviewees report that because new federal requirements specify that managed care capitation rates must be actuarially sound, states are limited in whether managed care rates can be reduced or frozen. For some states, the new federal requirements even require substantial increases in capitation rates. As some of the interviewed MCO staff pointed out, an MCO's ability to achieve cost reductions depends largely on its provider and vendor contracts. For example, managed care organizations may not be able to quickly or automatically reduce provider rates; they must wait until their provider contracts are up for renewal and then negotiate with providers to accept lower reimbursement. Depending on how much notice is provided to managed care organizations prior to any cuts taking effect, managed care organizations may need to continue paying higher rates or providing benefits for which there is no or only partial reimbursement under existing capitation rates.

Pharmacy

In FY 2003, 46 states implemented cost containment initiatives directed at reducing pharmacy expenditures, and 43 states indicated that they would implement new or additional pharmacy related initiatives in FY 2004. The most common initiative the states employ is to establish a preferred drug list (PDL), which requires providers to follow an override process in order to prescribe drugs not included on the state's PDL. PDLs focus on promoting the use of lower-cost drugs.

Some states also negotiate supplemental rebates from drug manufacturers. The state negotiates for payment of a supplemental rebate from drug manufacturers, which is an amount that is above the standard federally required rebate. In exchange, the state includes the drug manufacturer on the state's PDL.

Changes to benefits

In FY 2003, 18 states restricted or reduced the availability of benefits, and in FY 2004, 17 states plan to reduce or restrict benefits. Most of these states focused on restricting one or two optional services, such as adult dental and vision services.¹³ Depending on how much notice is provided, MCOs may need to continue providing benefits for which there is no, or only partial, reimbursement under the capitation rates. These organizations must provide sufficient notice to beneficiaries and providers of any benefit changes before they can reconfigure their operations and services.

¹² The national information about specific Medicaid cuts presented in this section was drawn from the December 2003 update by Health Management Associates and Wachino: "States Respond to Fiscal Pressure," unless otherwise indicated.

¹³ These state numbers are based on the September 2003 report from the Kaiser Commission on Medicaid and the Uninsured: "Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?" An updated survey, released in January 2004, does not break out the specific types of benefit cuts.

Changes to eligibility

In FY 2003, 25 states reduced or cut eligibility for Medicaid enrollees, and in FY 2004, 18 states plan to implement new eligibility restrictions. The temporary increase in federal matching dollars for FYs 2003 and 2004 from the federal government (attributable to the Jobs and Growth Tax Relief Reconciliation Act of 2003) limits states' ability to implement eligibility restrictions. To receive the additional federal funds, states must maintain eligibility at levels in effect as of September 2, 2003. This "maintenance-of-effort" provision has likely prevented states from reducing eligibility for the last 15 months. If the higher federal matching rate for Medicaid expires in 2004, states may consider reductions in eligibility as a way of reducing costs.

Co-payments

In FY 2003, 17 states imposed new or higher co-payments, and in FY 2004, 21 states will implement either new or higher co-payments. These efforts are tempered by federal law, which protects beneficiaries from incurring excessive co-payment requirements that would prevent them from receiving necessary care. For instance, without a waiver from the federal government, states cannot apply co-payments to services delivered to children, pregnant women, and institutionalized individuals, and co-payments generally cannot exceed \$3 per service. In addition, even if beneficiaries are unable to afford and do not pay the co-payments, providers still must provide the service. Some state Medicaid agency staff interviewed reported that—as co-payments have been introduced or increased, providing MCOs and providers with additional revenue—they have reduced managed care capitation rates. However, reducing payment rates to reflect expected increases in co-payment collections could create a challenge for MCOs and providers if they cannot actually collect the co-payment but are still obligated to deliver the service. In this case, the MCOs/providers may experience a net loss.

Managed care

In the past, state Medicaid agencies turned to managed care to assist with cost containment, as well as to improve access and quality. Since 1998, more than half of all Medicaid beneficiaries were enrolled in some form of managed care (an MCO, pre-paid health plan, or primary care case management program).¹⁴ By 2002, 58 percent of Medicaid's beneficiaries were enrolled in managed care arrangements, with the majority of these enrollees—almost 64 percent—in capitated managed care plans.¹⁵ Since 1998, however, commercial MCOs have been withdrawing from capitated managed care programs, citing inadequate capitation rates.¹⁶ This has resulted in fewer participating MCOs per state, and the remaining MCOs are mostly Medicaid-only MCOs. While Medicaid-only MCOs have a different mission from that of commercial MCOs, revenue levels and their ability to cover expenses remain a major concern. A small number of states are implementing managed care expansions to control expenditures. In 2003, six states implemented such expansions, and the number is expected to grow to 13 in FY 2004.

¹⁴ Neva Kaye, *Medicaid Managed Care: A Guide for States*, 5th edition (Portland, ME: National Academy for State Health Policy, May 2001).

¹⁵ Neva Kaye, National Academy of State Health Policy, *Survey of State Medicaid Programs*, 2003.

¹⁶ R. Hurley and S. Somers, "Medicaid and Managed Care: A Lasting Relationship?" *Health Affairs* (January/February 2003): 77-88.

Methodology for Conducting the Four Case Studies

Interviews were conducted in each of the four study states to determine how each one had approached its Medicaid budget problems and to understand the current and future implications of various budget cutting strategies on the Medicaid managed care programs in those states and, potentially, in other states.

Criteria for selecting four case study states

Michigan, Florida, Massachusetts, and Oregon were selected, with the input of the project advisory group, primarily based on the application of the following five criteria.

- *First*, the state had significant deficits in FY 2004 (at least 7.5 percent of their overall state budget). While states facing a budget deficit can choose to react by increasing revenues or by reducing non-Medicaid expenses, states with larger deficits are more likely to face the need for substantive budget cuts.
- *Second*, a large number of the state's beneficiaries (at least 25 percent) were enrolled in a capitated managed care program as of December 31, 2002. Unless the state had made a significant investment in managed care, it might be able to look past its managed care programs when making budget cuts.
- *Third*, the state had implemented a variety of cuts. By focusing on states that used a number of different kinds of budget cutting strategies, we hoped to determine how they selected specific strategies and to explore the challenges posed by each one.
- *Fourth*, we sought to include states that represented different parts of the country. In doing so, we hoped to achieve greater representation of diverse populations and needs than might otherwise have been possible.
- *Fifth*, we excluded states that were confronted with more than budget cut decisions, such as those that were in court over policy change or states that were experiencing a change in leadership.

It should be noted that Michigan and Florida MCOs reported that they were in poor fiscal health prior to the implementation of state budget cutting strategies in 2003 and 2004 because providers and MCOs in these states had not had adequate rate increases in several years. The following table depicts the budget cutting strategies used by the four selected states.

Table One: Summary of Four States' Budget Cutting Strategies in 2003 and 2004¹⁷

Strategy	Florida	Massachusetts	Michigan	Oregon
SFY 04 budget deficit (as % of state budget) ¹⁸	10.1%	7.5%	17.5%	23.8%
# of areas of cost reduction	SFY 04: 7 SFY 03: 7	SFY 04: 6 SFY 03: 6	SFY 04: 6 SFY 03: 2	SFY 04: 5 SFY 03: 7
% of Medicaid enrollees in MCO as of 12/31/02	32%	26%	64%	61%
Provider payments	<p>In 2003 the legislature approved a 1% increase in the discount factor used to set the 2004 MCO rates (i.e., from 92% of the FFS equivalent to 91%).</p> <p>Cuts imposed in nursing facility rates. Scheduled increase in staffing requirements delayed.</p> <p>Applied for upper payment limit for physicians.</p>	<p>In SFY 03 all providers experienced small rate cuts (average 3-5%).</p> <p>In SFY 04, increases for MCOs, but smaller than previous ones because of anticipated savings from eligibility changes and the introduction of pharmacy co-pays in the fee-for-service (FFS) population.</p> <p>Decreased pharmacy reimbursement rate from <i>wholesale acquisition cost (WAC) plus 10%</i> to <i>WAC plus 6%</i>.</p>	<p>In SFY 03 rates frozen at about 83% FFS. Rate increases only as result of MCO provider tax implementation.</p> <p>SFY 04 MCOs received a small increase, now are at about 90% of the FFS equivalent; other providers' rates frozen.</p> <p>Imposed quality assessment fee on hospitals, nursing facilities, and MCOs.</p>	<p>In SFY 03, hospital rates cut by 12%; rates for dentists, home care providers, and most physicians frozen. Physical health MCO rate increased by 8.1% in SFY 03 and in SFY 04 limited by legislature to 9.2%. Also in SFY 04, dental health plan rates increased slightly and behavioral health MCO rates decreased by 17.2% due to elimination of OHP Standard. (See eligibility discussion below.) Rates for physicians, home health providers, nursing facilities, and residential and adult foster care providers frozen. Hospital rates increased to restore the 12% cut taken in 2003 and to provide a small increase.</p> <p>Provider taxes established on hospitals, nursing facilities, and MCOs.</p>
Benefit reductions	<p>SFY 03 – eliminated adult dental but for emergencies.</p> <p>SFY 04 – eliminated vision and hearing.</p> <p>Capped child dental and adjusted MCO rates downward accordingly.</p>	<p>SFY 03 – eliminated prosthetics, vision, orthotics, adult dental.</p> <p>SFY 04 – restored orthotics and prosthetics. Required prior authorization for ancillary therapies. Expanded the state's preferred drug list to promote generics. Limited enrollment in Prescription Advantage program.</p>	<p>SFY 04 eliminated adult dental, hearing aids, adult home help benefit, podiatry, and chiropractic services.</p>	<p>Eliminated adult dental, vision, non-emergency transportation, DME, and also eliminated retrospective coverage (back to date of application) of hospitalization for "1115 expansion adults." Eliminated mental health and chemical dependency services in SFY 03 but restored in SFY 04. Also reduced covered services in SFY 03 and has requested to reduce more in SFY 04.</p>

¹⁷ Source: J. Holahan, R. Bovbjerg, T. Coughlin, I. Hill, B. Ormond, and S. Zuckerman, "State Responses to Budget Crisis in 2004: An Overview of Ten States," Kaiser Commission on Medicaid and the Uninsured, January 2004, and interviews with Vernon Smith, Ph.D., and state agency staff. (See Appendix A.)

¹⁸ Source: I. Lav and N. Johnson, "State Budget Deficits for Fiscal Year 2004 are Huge and Growing," Center on Budget and Policy Priorities, January 23, 2003.

Table One: Summary of Four States' Budget Cutting Strategies in 2003 and 2004 (continued)

Strategy	Florida	Massachusetts	Michigan	Oregon
Eligibility cuts	SCHIP and Healthy Kids programs enrollment capped. Discontinued outreach services.	SFY 03 cut unemployed adult expansion population. SFY 04 cut special status immigrants. Outreach services reduced. Eligibility determination process tightened. Non-entitlement program enrollment cap and reinstatement of asset test for 19 to 65 year olds were approved by legislature but will not be implemented in FY04.		During SFY 03/05 biennium, proposed to replace the Medically Needy program and restructure the Oregon Health Plan (OHP) ¹⁹ into three distinct benefit plans: 1. OHP Plus (provides a full package of Medicaid benefits to all mandatory Medicaid populations); 2. OHP Standard (provides a more limited benefit package to low-income adults up to 100% FPL, who do not qualify for OHP Plus); 3. OHP premium assistance (provides assistance in purchasing private coverage for those with incomes up to 200% FPL who do not qualify for OHP Plus or OHP Standard. Also tightened eligibility rules.
Co-pays, co-insurance, and premiums	Added 2.5% co-insurance for pharmacy and added 15% co-pay for non-emergency use of emergency room by non-pregnant adults. Regarding SCHIP, raised premiums for children's programs (\$15 per family per month for families with income up to 150% FPL and \$20 per family per month for families with income between 150-200% FPL).	In SFY 04: <ul style="list-style-type: none"> Pharmacy co-pay made mandatory and increased from \$.50 to \$2.00 with an annual cap. (When it was voluntary, most MCOs did not enforce.) Added co-pay for inpatient stays. Implementing small premium for all Medicaid populations. 	SFY 04 co-payments implemented for prescription drugs, office visits, non-emergency use of emergency room, and optometry for one group of eligibles and proposed for a second group.	In SFY 03, added pharmacy co-pays for OHP standard and some Plus populations. Mandatory co-payments for premium assistance population.
Disease management	Ongoing relationship with two pharmaceutical companies.	Plan to target high cost Medicaid members.		Implemented pharmaceutical cost management initiatives: preferred drug list, disease management for asthma, diabetes, and congestive heart failure. Case management for high cost eligibles.
Other	The legislature directed that managed care enrollment in MCOs be increased to 55% in 2003 and to 60% in 2004. Fraud and abuse and long-term care cost reduction strategies implemented in SFY 03 and SFY 04.	Plan to target increased managed care enrollment for SFY 05. Implemented Senior Care Options to improve management of "dual eligibles." Expanded estate recovery efforts. Implemented fraud and abuse reduction strategies in SFY 03 and SFY 04, and long-term care cost reduction strategies implemented in SFY 04	Fraud and abuse reduction strategies implemented in SFY 04.	The legislature directed that managed care enrollment in MCOs be increased to 70%. Managed care expansion strategy implemented in SFY 04. Long-term care cost reduction strategies implemented in SFY 03 and SFY 04.

¹⁹ Oregon's Medicaid program operates under an 1115 waiver and is referred to as the Oregon Health Plan.

Questions asked of interviewees

Bailit staff created a questionnaire, reviewed by the advisory group and approved by NASHP, with which to seek state agency staff and MCO representatives' thoughts on the following:

- Whether state agency staff participated in and had discretion over what Medicaid budget cutting strategies would be proposed in state fiscal years 2003 and 2004;
- Whether state agency staff had anticipated the impact of budget cutting strategies— either direct (such as MCO rate cuts) or indirect (such as cuts or increases in other providers' reimbursement)—on its Medicaid-participating MCOs;
- Whether the state's budget cutting strategies had an impact on Medicaid-participating MCOs;
- Whether the MCOs and primary care providers (in the case of state Medicaid agencies with PCCMs) worked with the state in developing the proposed Medicaid budget cutting strategies;
- What budget cutting strategies might be proposed for the coming state fiscal year and whether the state agency staff anticipated that these strategies would have an impact on the Medicaid-participating MCOs;
- Whether the state agency staff believed the Medicaid-participating MCOs were stronger or weaker as a result of the budget cutting strategies implemented; and
- What the state Medicaid and oversight agency staff sentiment was regarding the importance of maintaining the Medicaid managed care program.

The questionnaire is included here as Appendix C.

Bailit staff first contacted Medicaid directors or directors of the Medicaid oversight agencies in each of the four selected states and conducted telephone interviews using the questionnaire. Bailit then scheduled follow-up interviews with the state agency staff charged with MCO oversight in each state to get more detailed information on the nature of the discussion between the state agency staff and the Medicaid-participating MCOs regarding budget cutting strategies.

The state personnel who were interviewed for this project are included in Appendix A, as are the members of the project's advisory group. We have withheld the names of the MCO representatives we interviewed and the MCOs they represent in order to ensure confidentiality.

KEY FINDINGS FROM INTERVIEWS AND DISCUSSION

The following findings are based on interviews with state Medicaid and Medicaid MCO oversight agency staff, and with MCO representatives of at least one health plan in each of the four states. It should be noted that references to the “state” or “state staff” refer to the state agencies that employ those who were interviewed and not to the Governor’s office or the legislature.

The Four States’ Medicaid Agencies Have Some Discretion In Proposing Budget Cut Strategies

In each of the states in which we interviewed state agency staff, the Medicaid budget cutting strategies that had been implemented or were being implemented by agency staff were usually not strategies that had been dictated by the legislature. At the Medicaid program level, the staff have the discretion to propose budget cut strategies to the Governor’s office and the legislature. Furthermore, the four states’ Medicaid agencies and Medicaid oversight agencies reported strong commitment to their managed care programs and sought to protect them during budget development. They all indicated that they value their managed care programs, and particularly their capitated health plans, as a means to manage costs, *and* ensure access and quality. State agency representatives in two states stated that it was only through the managed care plans that they were able to ensure that Medicaid-participating providers were paid adequately and that this had been a key motivator in moving to managed care in the first place. Agency staff in all four states reported that, among other objectives, they had wanted to avoid a negative impact on the financial viability of the MCOs. This was borne out by the types of budget cutting strategies they proposed.

Most of the four states had already experienced several years of budget cutting, and so provider-based cuts, usually the first target of systemic budget reductions, had already been exhausted. In all four cases, the state agencies first targeted cuts on optional benefits and implemented very modest co-payments for some services or premiums. In some cases the proposed benefit cuts did not apply to the Medicaid MCO enrollees, while in most cases, the co-payments or premiums did. In addition, in most cases, the state agencies proposed providing rate increases for the MCOs, albeit modest ones, even, in some cases, when other providers’ rates were frozen.

In a couple of states, the legislature was, or ultimately became, directive about one or two specific cuts, but in general, legislatures granted the Medicaid agencies considerable flexibility in determining the array of budget cutting and implementation strategies they would employ. In the case of the agencies that ultimately received legislative directives that affected the Medicaid budget, in general, the directives focused on the calculation of specific Medicaid providers’ rate increases and whether, and by how much, Medicaid managed care enrollment in MCOs should be increased. In general, the legislative directives resulted after extensive sessions with the state agency staff and external stakeholders, including Medicaid-participating providers and advocates, during which the anticipated impact of a variety of budget cutting strategies, including their impact on managed care, were debated.

The Extent to Which Medicaid Agencies Include the MCOs in Budget Reduction Strategy Development Varies

Typically, in the four states, the Medicaid agency staff use extensive internal processes to develop their proposals. However, the manner and degree of health plan involvement in the state's budget and implementation strategy development processes varies by state. In two cases, the MCOs were invited to participate before the state agency's budget was proposed to the legislature, and in the other two cases, external parties including the MCOs were excluded and did not participate in the budget discussions until the Medicaid agency's and the Governor's proposals had been presented to the legislature. In all four states, the MCO operational staff meet fairly regularly with the state Medicaid managed care operations staff.

Also in all four states, regardless of whether the plans had input into the cost cutting strategies proposed by the state agency, opportunities did exist for the MCOs to comment on how a new budget initiative might be implemented in order to minimize any negative effects on the MCOs. One state, for example, included MCO representatives in the planning for the implementation of a premium. The MCO representative was able to work with the state agency staff to ensure that the proposed implementation procedures would not be too complex and administratively burdensome on the MCOs or the MCOs' participating providers.

The MCOs expressed appreciation for the opportunity to participate in budget discussions whether their involvement begins within the state agency or occurs only in the legislative process.

State Agencies Have Not Devoted Significant Resources to Identifying the Indirect Effects of Budget Reduction Strategies on the MCOs or How to Mitigate Them. Such Effects Can Be Significant.

The state agencies reported that they did not devote significant resources to considering the indirect impact of changes on the MCOs, such as changes to fee-for-service (FFS) provider payment rates, eligibility rules, new or increased cost-sharing and state agency staffing. Interviewed MCOs reported that these changes have had a significant adverse administrative and financial impact on the MCOs. The most significant indirect effects reported by the MCOs were as follows:

State Action	Impact on the Plan
Decrease in MCO rates to reflect budgeted decrease in fee-for-service provider payment rates.	Rate basis, and thus rates, decreased, although MCOs were unable to realize the same amount of savings. In addition, some savings have not materialized.
Eligibility changes including: <ul style="list-style-type: none"> • Tighter rules • Elimination of some covered populations. 	Need to reduce MCO staff. Increase in membership churning. Reduction in membership. Increased administrative burden.
Increased or new premiums and co-pays	Reduction in membership. Increased administrative burden.
State staff reduction	Increased administrative burden.
Benefit reductions	Managing fewer benefits makes it harder for plans to manage members' care cost-effectively.

State agency staff, even those who were involved in budget cutting strategy development, indicated that they, themselves, did not spend time projecting the impact of non-rate changes on the MCOs. In most cases, the state agency staff indicated that even had they contemplated doing so, they did not have sufficient data from the MCOs nor the time required to project the impact. In the two states in which MCOs participated with the state staff in the development of possible budget cutting strategies, MCO staff were able to identify potential impacts fairly early in the process, and the agency staff considered these impacts sooner than in other states.

The area of greatest contention between the MCOs and state agency staff was around whether, and how, the states factored projected savings for cost cutting initiatives that targeted the fee-for-service population into the rate basis for the MCOs' new rates. Arguments most commonly heard from the MCOs were:

- The state assumed the MCOs could achieve the same savings projected for the fee-for-service population. For example, one state Medicaid agency imposed a pharmacy co-payment to help contain costs on the fee-for-service program and reduced the capitation rate paid to the MCOs to reflect the same level of savings as that projected for the FFS population. The MCOs, however, had a contractual provision in place that prohibited them from collecting a co-payment, which prevented them from obtaining any savings from the implementation of a co-payment. Furthermore, although the contractual provision can be changed, it cannot be changed without renegotiating the contract, which is typically not something that can be quickly achieved.

- One MCO reported that sometimes the state Medicaid agency projected an amount of savings from a policy change that the MCOs believed could not, in fact, be achieved. Because capitation payments are calculated prospectively, the full amount of anticipated savings was built into the MCO rate-setting calculations, thus reducing the MCO's capitation rate by an amount of savings that the MCO could not achieve.
- MCOs also argued that the savings produced by some changes might be offset by increases in utilization of other services and that these potential increases in cost were not taken into account in the rate-setting process. Some MCOs reported that they believed that this threatened their financial viability. A couple of MCOs indicated that they were not confident that the state Medicaid agency's actuary would develop an actuarially sound rate and sought a fuller understanding of how the rates were developed.

State Agency Staff Expressed Satisfaction with an Arduous Yet Effective Budget Reduction Process

States agencies judged their budget cutting processing successful since they were able to achieve budget passage without fundamentally undermining their programs and negatively impacting access to care. In at least one case, this was accomplished with no legislative alteration. In all four cases, the state agency staff described the sessions with the legislature to be longer and more involved than usual. Despite the process being so time-consuming, states expressed satisfaction that they had done the best that they could in a bad situation. One state agency representative suggested that the process had resulted in a legislature that is now much better educated about the Medicaid program.

State Agency Staff and MCOs Are Realistic About the State of the Economy

State agency staff and MCOs both recognize that the economy, and hence the health of the state's budget, fluctuates over time. Still, despite all the budget cutting strategies that have been implemented, the states are all concerned that they may not yet be able to manage expenses within the approved budget and that they will be obligated to find more to cut. Some within the states believe there is nothing left to cut without seriously harming the viability of the Medicaid program and the Medicaid managed care program. In states that had some idea of the cuts that would be sought for 2005, the agency staff thought that efforts would be made to protect Medicaid and the Medicaid managed care programs.

Most State Agency Staff and MCOs Perceive Medicaid Managed Care as Weaker

Staff members of both the state agencies and MCOs interviewed for this report view the Medicaid managed care programs as weaker than they were and, in some cases, quite vulnerable. Despite an awareness of the states' financial problems and concern about the impact cost cutting will continue to have on them, the MCOs report that they remain committed to the Medicaid business. They perceive the Medicaid budget as a target for cost cutting and sympathize with the difficult position of the state Medicaid staff. They did not suggest that state agency staff have targeted savings initiatives at the MCOs. Still, some MCOs have left Medicaid entirely, unable to bear the rates of its hospital providers given the capitation rate. Others have dropped coverage of the disabled population, suggesting that the cushion once built into the non-disabled rate, a cushion used to offset inadequate rates for the disabled population, is no longer there.

State agency staff expressed the hope that they will be able to protect MCOs participating in Medicaid managed care from further cuts. In cases in which an MCO has left, has threatened to leave Medicaid, or has dropped a population, the state agency staff have been able or will attempt to find arrangements that will enable the MCO to continue to participate. Such arrangements in the future include, in one state, creating a contract with the MCO as a partially capitated organization that excludes inpatient hospital coverage. This action minimizes the risk that the MCO will have to bear, a necessary arrangement in this state because of pending state eligibility changes that will result in uncertain enrollment volumes.

CONCLUSION

It is apparent that the magnitude of cost cutting in the Medicaid budget in each of the four states has been great and may continue to be so. In each state the legislature has generally afforded the agencies the opportunity to propose their Medicaid budgets prior to mandating any Medicaid cuts. In only two of the states did the legislatures weigh in and direct two specific changes, both of them pertaining to MCO rates. Most of the Medicaid budget reduction strategies in the four states, even if not directed at MCOs, appeared to have implications for the MCOs, typically in terms of decreasing the plans' membership or in decreasing the fee-for-service base used in calculating the MCO rates.

In two states, Oregon and Michigan, the development of the Medicaid and the Medicaid managed care budget is a more inclusive process than in the other two states, and the MCOs in Oregon and Michigan clearly appreciate the sense of collaboration with the state. However, state agency staff in all four states generally indicated that when developing the Medicaid and Medicaid managed care cost projections and budget reduction strategies, they did not comprehensively analyze the potential negative indirect impact on the MCOs. In Oregon, the state did not have the data or the resources to do so. Because they were included in at least part of the cost cutting process, the MCOs in Michigan and Oregon may have had more opportunity to provide input on, and possibly prevent, budget cutting strategies that would have a significantly negative indirect impact on them, but it cannot be concluded from the interviews conducted that this was so.

The state staff interviewed in all four states expressed strong support for Medicaid managed care and an emphasis on MCOs over PCCM programs. In three of the four states, strategies will be implemented to increase MCO enrollment.

In determining future budget cuts, it is recommended that state agencies that seek to sustain the health of MCOs participating in Medicaid managed care and to facilitate their successful participation in the program carefully consider the potential effects on the MCO of proposed cost cutting strategies. In particular, states may wish to assess the impact of strategies of savings projections in fee-for-service that will be factored into the calculation of MCO rates. In addition, states might also consider consulting the MCOs in the early development of their budget reduction strategies so that the plans may raise issues and offer suggestions before strategies are adopted.

Appendix A

STATE AGENCY PERSONNEL INTERVIEWED AND ADVISORY GROUP MEMBERS

During December 2003 and January 2004 the following state staff were interviewed:

Florida

Ken Thurston, Chief Financial Officer, Medicaid
Robert Butler, Bureau Chief for Medicaid Program Analysis

Massachusetts

Doug Brown, ex-Medicaid director
Linda Green, responsible for all Medicaid managed care rate analysis and development
Darrin Shaffer, Chief Financial Officer, Medicaid
Trisha Spellman, ex-Medicaid budget director
Kate Willrich-Nordahl, the state's HMO program director

Michigan

Janet Olszewski, Director of the Michigan Department of Community Health
Sue Moran, Director of the Bureau of Medicaid Programs and Quality Assurance

Oregon

Lynn Read, Administrator of the Oregon Medical Assistance Program
Joan Kapowich, Manager of the Program and Policy Unit

The following were advisory group members to the project:

Barbara Edwards
Deputy Director
Office of Medicaid
Ohio Department of Jobs and Family Services

Catherine Halverson
Senior Vice President
Business Development and Government Relations
Centene Corporation

Kay Holmes
Chief Administrator
Managed Care Claims and Quality Assurance
Division of Social Services
Delaware Department of Health and Social Services

Appendix B

BACKGROUND ON STATES' STRATEGIES FOR REDUCING MEDICAID EXPENDITURES

Medicaid Cost Containment Approaches Employed Over the Past Several Years

For FY 2003 and FY 2004, the Kaiser Family Foundation report cites five primary areas where states are focusing their cost-containment policies: provider payments, pharmacy, benefits, eligibility, and beneficiary cost-sharing.

Provider payments

For FY 2003, all but one state cut or froze Medicaid payment rates for at least one provider group—hospitals, physicians, nursing homes, or managed care organizations—and 39 states had plans to either freeze or reduce provider payment rates in FY 2004.²⁰

Because new federal requirements specify that managed care capitation rates must be actuarially sound, states are limited somewhat in precisely how much managed care rates can be reduced or frozen. (Of course, actuarially sound rates do not guarantee positive operating margins.) For some states, the new federal requirements even require substantial increases in capitation rates. For instance, Michigan Medicaid staff reported that they competitively bid their 2000 managed care contracts based largely on price. Health plan officials noted this resulted in very low rates with no rate adjustments for future years.²¹ Going forward, however, given the new federal requirements, state agency staff report that it is likely Michigan will need to evaluate bids on factors other than price, such as quality of care.

Even with the new federal requirements, 14 states planned to freeze their managed care rates in FY 2004; five other states planned to reduce rates, reflecting either benefit or provider rate reductions or capitation rates that were too high.²² A managed care organization's ability to realign its operations depends largely on its provider and vendor contracts. For example, managed care organizations may not be able to simply reduce provider rates; more than likely they must wait until their provider contracts are open for renewal. Depending on how much notice is provided to managed care organizations prior to any cuts taking effect, managed care organizations may need to continue paying higher rates or providing benefits for which there is no or only partial reimbursement under existing capitation rates. Finally, freezing or reducing

²⁰ Unless otherwise noted: Health Management Associates, V. Wachino, and M. O'Malley. *States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions*. Kaiser Commission on Medicaid and the Uninsured, January 2004.

²¹ K. Morris, "4 Medicaid HMOs mired in insolvency; If they lose deal, patients lose too," *Detroit Free Press*, September 12, 2003.

²² See note 1. The January 2004 updated survey results do not break out the type of provider payment cuts. Please note, though, the total number of states indicating provider payment reductions for fiscal year 2004 fell from 49 to 39 between the September 2003 report and the January 2004 update.

reimbursement rates magnifies the administrative burden and the cost of increased reporting requirements for managed care organizations.

Pharmacy

In FY 2003, 46 states implemented cost-containment initiatives directed at reducing pharmacy expenditures, and 43 states indicated that they would implement new or additional pharmacy related initiatives in FY 2004. The most common initiative is establishing a preferred drug list (PDL), which requires providers to follow an override process in order to prescribe drugs not included on the state's PDL. PDLs focus on promoting the use of lower-cost drugs.

Many states also negotiate supplemental rebates from drug manufacturers. The state negotiates for payment of a supplemental rebate from drug manufacturers, which is an amount that is above the standard federally required rebate. In exchange, the state includes the drug manufacturer on the state's PDL.

The savings achieved from PDLs and supplemental rebates have sparked an ongoing debate regarding whether or not states would be more successful than managed care organizations at controlling pharmacy expenditures. Arizona commissioned The Lewin Group to analyze the effectiveness of carving out pharmacy from its managed care program. Lewin concluded ultimately that a carve-out option would not create additional savings.²³

Changes to benefits

In FY 2003, 18 states restricted or reduced the availability of benefits, and in FY 2004, 17 states plan to reduce or restrict benefits. Most of these states focused on restricting one or two optional services, such as adult dental and vision services.²⁴ A few states made more severe changes. For instance, although they will increase some benefits, Oregon and Utah applied to the federal government for a waiver to reduce benefits for select eligibility groups while increasing other benefits. Oregon, for instance, wants to eliminate non-emergency hospital services and instead provide expanded mental health and substance abuse services.

Depending on how much notice is provided, MCOs may need to continue providing benefits for which there is no or only partial reimbursement under the capitation rates. These organizations must provide sufficient notice to beneficiaries of any benefit changes before they can reconfigure their operations and services. Similarly, MCOs must honor contractual obligations with providers, the provisions of which may not change until the contracts are renegotiated.

²³ The Lewin Group, *Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System* (Center for Health Care Strategies, Inc., November 2003).

²⁴ Health Management Associates (HMA) and Victoria Wachino, "States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2003). The January 2004 updated survey does not break out the specific types of benefit cuts.

Changes to Eligibility

In FY 2003, 25 states reduced or cut eligibility for Medicaid enrollees, and in FY 2004, 18 states plan to implement new eligibility restrictions. The temporary increase in federal matching dollars for FY 2003 and FY 2004 from the federal government (attributable to the Jobs and Growth Tax Relief Reconciliation Act of 2003) limits states' ability to implement eligibility restrictions. To be eligible, states must maintain eligibility at levels in effect as of September 2, 2003. This "maintenance-of-effort" provision—although offset by the higher federal match—has the potential to *compound* the financial strain on states' Medicaid budgets.

Eligibility restrictions can have a ripple effect on MCOs' operations. MCO financial projections are based on serving a certain level and distribution of enrollees. A significant decrease in the number of enrollees (which could result from new eligibility restrictions) may affect an MCO's ability to achieve economies of scale and thereby cover operating costs. In addition, some MCOs use payment for lower-cost enrollees to help sustain the costs of higher cost enrollees. Should enrollment fall disproportionately, leaving a disproportionately higher volume of higher cost Medicaid managed care enrollees enrolled than previously, managed care organizations may find covering Medicaid managed care enrollees to be too great a financial burden.

Co-payments

In FY 2003, 17 states imposed new or higher co-payments, and in FY 2004, 21 states will implement either new or higher co-payments. These efforts are tempered by federal law, which protects beneficiaries from incurring excessive co-payment requirements that would prevent them from receiving necessary care. For instance, co-payments cannot apply to children, pregnant women, and institutionalized individuals, and they generally cannot exceed \$3 per service. In addition, even if beneficiaries are unable to afford the co-payments, providers still must provide the service.

In essence, states are reducing managed care capitation rates to account for the collection of co-payments. But not every beneficiary can afford the co-payments. Because providers are unable to deny services to beneficiaries for this reason, providers must pick up this cost; they are not typically reimbursed by the state or managed care organizations. Accordingly, providers may either not accept Medicaid patients or attempt to negotiate an arrangement with the managed care organization to ensure they receive appropriate compensation. For these reasons, rather than implementing co-payments, managed care organizations often opt instead to operate with lower capitation rates.

The KFF report notes in passing that a small number of states are implementing managed care expansions to control expenditures. Six states did so in FY 2003, and the number is expected to grow to 13 in FY 2004. Some states are also restructuring their existing managed care programs. For example, Delaware is saving money by switching from a managed care program with two

outside contracts to a program with only one contract, operated in combination with a state-operated PCCM program.²⁵

Temporary federal fiscal relief also allowed 27 states to minimize or delay some of their FY 2004 cuts.²⁶ When federal matching rates return to normal levels in FY 2005, however, states most likely will have to implement deeper cuts in order to keep pace with the rise in Medicaid expenditures over the prior two fiscal years.

Finally, as states move toward difficult and politically-sensitive cuts, like provider rates or benefits and eligibility requirements, interested parties are turning to the courts. For instance, when California announced an across-the-board reimbursement cut of five percent for all providers (except for inpatient and outpatient services, nursing homes, and county clinics), twelve provider groups filed a lawsuit claiming that the measure violates the Social Security Act, which requires that Medicaid rates “attract enough doctors to serve the program’s patients.”²⁷ How involved the courts will be in these types of issues has yet to be determined.

The following table summarizes the strategies adopted by each of the 50 states to reduce Medicaid expenditures in FY 2003 and FY 2004.

²⁵State of Delaware. Governor Ruth Ann Minnor. Remarks to the U.S. House Budget Committee, www.state.de.us, Friday, October 17, 2003.

²⁶Health Management Associates, V. Wachino, and M. O’Malley. “States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions.” Kaiser Commission on Medicaid and the Uninsured, January 2004.

²⁷“12 Groups Representing Medicaid Providers In California File Suit Against State To Prevent Payment Reductions,” *Daily Health Policy Report* (Nov. 11, 2003) <<http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=20804>>.

State Strategies for Reducing Medicaid Expenditures
(States listed in order of the size of their Medicaid population, from largest to smallest)

State	% in MCOs	FY 2004 Budget Deficit as % of State Budget	Provider Payments		Pharmacy Controls		Benefit Reductions		Eligibility Cuts		Copays		Managed Care Expansions		DM/CM		Fraud and Abuse		LTC	# of Areas Selected For Cost Reduction - FY 04	# of Areas Selected For Cost Reduction - FY 03	
			FY 04	FY 03	FY 04	FY 03	FY 04	FY 03	FY 04	FY 03	FY 04	FY 03	FY 04	FY 03	FY 04	FY 03	FY 04	FY 03				
CA	48%	28.6% ²⁸	x	x	x	x	x	x	x								x	x		5	4	
NY	13%	26.7%	x	x	x	x						x						x		3	3	
FL	32%	10.1%	x	x	x	x	x	x	x	x	x	x	x				x	x	x	x	7	7
TX	30%	19.3%	x	x	x	x	x		x			x		x			x	x		7	3	
IL	8%	14.8%		x	x	x					x							x		1	4	
OH	26%	9.2%	x	x	x	x	x		x	x		x		x			x	x		7	4	
PA	70%	6%	x	x		x							x				x	x	x	2	5	
TN	100%	6.6%	x	x	x				x								x			3	2	
MI	64%	17.5%	x	x	x	x	x	x	x	x							x		x	6	2	
GA	0%	5.8%	x	x	x	x	x	x						x	x			x	x	6	4	
NC	1%	14.6%	x	x				x	x	x	x		x				x			5	4	
MA	26%	7.5%	x	x	x	x		x	x	x	x						x	x	x	6	6	
WA	49%	10.4%	x	x	x	x	x		x	x				x	x		x	x		7	5	
MO	44%	13.1%	x	x	x	x	x		x					x	x		x			4	5	
NJ	74%	19%	x	x	x		x		x					x				x		5	2	
SC	6%	13.6%	x	x	x	x			x	x	x		x				x			5	5	
LA	0%	N/A	x	x	x	x			x	x			x	x			x		x	6	6	
AZ	100%	15.3%	x	x	x			x	x	x										4	3	
AL	0%	9.3%		x		x										x				0	3	
IN	36%	8.8%	x	x	x	x	x	x		x	x		x	x			x	x	x	x	8	7
WI	48%	17.6%	x	x	x	x	x		x			x		x			x		x	9	2	
MD	75%	11%	x	x	x	x	x			x	x						x			5	3	
KY	19%	5.1%	x	x	x	x			x	x		x							x	x	4	6
MN	68%	18.7%	x	x	x	x			x		x						x		x	6	2	

²⁸ The percent noted for CA, NY, TX, PA, MA, OR, ME, NE, and RI represent the midpoint of the range of the estimated budget deficit as a percent of the state budget.

State Strategies for Reducing Medicaid Expenditures

State	% in MCOs	FY 2004 DEFICIT AS % OF STATE BUDGET	Provider Payments		Pharmacy Controls		Benefit Reductions		Eligibility Cuts		Copays		Managed Care Expansions		DM/CM		Fraud and Abuse		LTC		# of Areas Selected For Cost Reduction -- FY 04	# of Areas Selected For Cost Reduction - FY 03
			FY 04	FY 03	FY 04	FY 03	FY 04	FY 03	FY 04	FY 03	FY 04	FY 03	FY 04	FY 03	FY 04	FY 03	FY 04	FY 03	FY 04	FY 03		
MS	0%	N/A	x	x	x		x		x		x				x	x		x			2	7
AR	0%	7.0%	x	x	x	x				x					x		x			x	4	4
VA	46%	9.3%		x	x	x					x	x									2	3
OK	40%	11.8%		x	x	x			x		x		x		x		x				4	5
OR	61%	23.8%	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	5	7
NM	63%		x	x	x	x	x				x				x		x				6	2
CT	0%	12.9%		x	x	x			x	x	x	x						x			3	6
ME	0%	16.5%	x	x	x	x					x						x				4	2
CO	49%	13.4%	x	x	x	x	x	x	x	x	x				x	x	x	x		x	7	7
WV	17%	8.9%	x	x	x	x					x		x							x	5	2
IA	24%	9.0%	x	x	x	x					x		x							x	4	3
KS	26%	15.7%	x	x	x	x			x		x										2	5
NE	16%	15.1%	x	x		x	x		x	x											3	4
UT	57%		x	x	x	x			x		x	x									3	4
RI	67%	8%	x	x		x										x	x				2	4
HI	78%			x	x																1	1
NV	45%	19.0%	x	x	x	x	x				x			x		x					6	3
ID	0%	10.1%		x	x	x			x					x		x					1	5
VT	0%	3.2%		x		x			x				x								1	4
DC	71%		x	x	x	x												x			2	3
DE	75%	12.2%	x	x	x	x					x	x									3	3
AK	0%	37.8%		x	x	x			x		x						x	x	x		3	5
NH	12%	8.6%	x	x	x	x					x				x	x	x				5	3
SD	0%	6.4%				x	x														1	1
MT	0%	4.9%		x	x	x			x						x						2	4
ND	2%		x	x		x			x	x	x									x	2	6
WY	0%			x	x	x									x	x	x	x	x		4	4
TOTAL	36%		39	50	43	46	17	18	18	25	21	17	13	6	19	13	24	19	14	10		

Sources: Kaiser Commission, NASHP, and Center on Budget and Policy Priorities.

Appendix C

QUESTIONNAIRE USED TO INTERVIEW STATE AGENCY STAFF AND MCO REPRESENTATIVES

Questions for State Agency Personnel

Origins of Budget-Driven Program Changes

1. Did you receive a legislative or administrative mandate to cut a specific amount from your Medicaid managed care budget in FY03? In FY04?
If so, who mandated the cut(s) and what was the budget percentage and/or dollar amount you were mandated to cut each year? (If a dollar amount, what percentage of the budget cut does that equate to?)

Basis for Determining Specific Program Changes (both for deciding to make a certain change and for implementation of changes)

2. In both FY03 and FY04, how did you determine where to make program changes in order to achieve net expenditure reductions?
 - the legislature specified
 - the Governor's office specified
 - we were given discretion as to how to reduce expenditures
 - a combination of the above (please explain)

If the legislature and/or Governor's office specified, was the potential direct and indirect impact on the managed care system considered by them?

3. If you were given partial or full discretion regarding how the savings would be achieved, explain the process that you followed to develop your recommendations and whether the direct or indirect impact on your managed care program was considered. (probe: *Who, both inside and outside of the agency, participated in the policy development and decision-making process, especially whether representatives interested in managed care were part of the process? Probe for MA, OR and FL: ask interviewees to delineate their responses by the PCCM vs. MCO programs*)
4. Did you employ any overarching principles when deciding where and how to make expenditure reductions? If so, what were they? (probe: *Did any of the principles include considerations relative to the managed care program, e.g., ensuring adequate rates? (for FL, MA and OR ask interviewees to speak about MCOs and PCPs)*)
5. How well do you think the decision-making process worked?

Impact of Program Changes

6. Have you assessed the impact of the changes made in FY03? If so, what were the direct and indirect impacts? Did they achieve budgetary objectives? (ask FL, MA and OR to speak in terms of PCPs vs. MCOs)
7. Were there *indirect* effects of FY03 changes that were not anticipated? For example:
 - a. if there were changes in eligibility, did it make HMO or PCCM contractors less viable due to loss of volume?
 - b. if provider rates were changed, what impact did it have:
 - on plan rates?
 - on the provider rates used by the plans?
 - on PCP reimbursement? (for FL, MA and OR)
 - c. if cost-sharing increased or was imposed, how did the HMOs and state decide to handle this?
 - d. if benefits changed, for example if your pharmacy carve-out moved to a formulary, how did this affect HMO programs, such as disease management? How did it affect the PCPs?
8. What impact are the FY04 changes having on your Medicaid managed care programs?
 - a. Capitated MCO program(s)
 - b. PCCM program
9. As you went through the implementation process, what issues came up (both from the agency and the plans) and how did you work with the plans to address the issues?
10. (For FL, MA, OR) What issues came up with PCPs and how did you work with them to address the issues?

Prospects for Medicaid Managed Care

11. Is your state's Medicaid managed care program stronger or weaker as a result of these program changes? Will it continue to be an important part of your Medicaid program? Why?
12. Looking ahead, do you believe that managed care will be an important cost management strategy for your agency?
13. What cuts do you anticipate making in FY05? What impact will it have on your managed care program?

Questions for Medicaid Managed Care Plans
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I. Impact of Program Changes

1. How have the state's implemented cost reduction measures affected your health plan either directly or indirectly in calendar years 2002 and 2003?
2. How do you anticipate cost reduction measures that will be implemented in 2004 or 2005 might affect you either directly or indirectly?
3. Do you believe that the state contemplated the impact the budget reduction strategies would have on the managed care plans?
4. What steps, if any, have you taken or will you take to respond to the state's budget cutting measures?

I. Prospects for Medicaid Managed Care

5. Is your state's Medicaid managed care program stronger or weaker as a result of these program changes?
6. Have the cuts impacted your interest in participating in Medicaid? How likely are you to continue to participate in Medicaid?

Unlikely_____ Uncertain_____ Likely_____ Very Likely_____

7. What did you think of the state process for determining the cuts? What was your role in that process?
8. Looking ahead, do you believe that managed care will be an important cost management strategy for the state Medicaid agency? Why?