

# **Medicaid and Other State Healthcare Issues: The Current Situation**

**A Supplement to the Fiscal Survey of States**

**May 2002**

**National Association of State Budget Officers  
National Governors Association**

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## Preface

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*Medicaid and Other State Healthcare Issues: The Current Situation* is a special companion feature of the spring edition of *The Fiscal Survey of States*. The Kaiser Commission on Medicaid and the Uninsured provided funding for this report. It is intended to underscore the critical public policy questions states face regarding Medicaid and other healthcare issues.

The information the report reflects was provided by governors' state budget officers based on a survey NASBO completed in May 2002.

This feature highlights state Medicaid expenditures; Medicaid cost containment measures that states are undertaking in fiscal 2002 as well as proposed actions for fiscal 2003; and changes in the State Children's Health Insurance Program (SCHIP) and state-funded prescription drug programs. Fiscal 2001 data represent actual figures, fiscal 2002 figures are estimates, and fiscal 2003 data reflect figures in governors' recommended budgets.

## Medicaid

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As a means-tested entitlement program financed by the states and the federal government, Medicaid provides medical care to about 40 million individuals. Medicaid spending accounts for about 20 percent of all state spending. Medicaid spending has escalated in recent years and combined with the dramatic revenue slowdown in states is the most significant cost issue affecting state budgets.

Based on state spending estimates to date, Medicaid expenditures are increasing approximately 13.3 percent over the fiscal 2001 level. This follows an increase of about 10.6 percent in fiscal 2001. This rate of growth—at about 25 percent over two years—compares to about a 5 percent revenue growth over the fiscal 2000 to fiscal 2002 period.

After growth rates of 10.6 percent in fiscal 2001 and 13.3 percent in fiscal 2002, the percentage growth in the state share is estimated to be 5.9 percent in governors' proposed budgets. This decline in the rate of growth in fiscal 2003 is predicated on extensive cost containment measures that are part of governors' proposed budgets for fiscal 2003 as well as strategies that have been underway during fiscal 2002 (see Table 1).

The reasons for the increase in costs in recent years stems from both increased caseloads due to the downturn in the economy as well as price increases in the healthcare sector generally, especially in pharmaceutical costs. Spending on outpatient prescription drugs, which increased an average of 18 percent annually over the past three years, is continuing to be a significant component in rising Medicaid costs. According to the recently released study by the National Institute for Health Care Management, prescription drugs spending overall climbed by 17 percent in 2001. The study found that the average cost of a prescription rose by 10 percent during this time period.

According to the Centers for Medicare and Medicaid Services, prescription drug spending, nursing home, community-based long-term care costs and payments to health plans have been significant contributors to the recent expenditure growth and are expected to continue to do so in the future.

As the costs have increased, states have experienced Medicaid expenditures exceeding the amount that had been originally budgeted for the program. Of the 49 states who responded to the survey, 39 states experienced Medicaid shortfalls in fiscal 2001 and twenty-eight states are anticipating shortfalls in the current fiscal year (see Table 2). The shortfalls as a percentage of the total Medicaid program ranged from less than 1 percent to over 28 percent of the program costs, averaging 6.2 percent. The total amount of the shortfalls in fiscal 2001 and fiscal 2002 totals approximately \$7.1 billion.

With the escalating growth in Medicaid expenditures coupled with the dramatic revenue slowdown in states, states have been forced to seriously review cost containment options (see Table 3). Forty-seven of the 49 states that responded reported taking action in fiscal 2002 or proposing action in fiscal 2003 to reduce Medicaid expenditures. By far the most frequently reported cost control mechanism was reducing prescription drug costs. Many states also reported reducing or holding flat provider reimbursement rates. The following are examples of governors' proposed cost containment proposals:

- Requiring prior authorization pharmaceuticals;
- Increasing fraud and abuse efforts;
- Reducing optional benefits/eligibility;
- Contracting for services;
- Increasing cost-sharing requirements, including instituting premiums;
- Reducing prescription drug costs by revising the ingredient cost reimbursement rates;

- Reducing provider rates;
- Negotiating additional drug rebate payments;
- Adding statutory authority for additional estate recovery;
- Eliminating special grants to rural hospitals;
- Implementing disease management;
- Entering in multi-agency purchasing arrangements for volume discount savings.

States also reported that they are deferring plans to implement planned expansions or program enforcements. While 47 state are proposing Medicaid cost-containment measures, only 28 states are proposing to generate additional non-general fund revenues for Medicaid, including use of upper payment limit arrangements under Medicaid (see Table 4). This mirrors the trends in overall budget strategies, where states are more concentrated

on reducing expenditures than raising revenues to address budget shortfalls. Unlike the last recession, states cannot rely as heavily on strategies such as provider taxes to generate additional revenues in Medicaid or switching to managed care for cost savings, as was the case in the early 1990s.

States that are seeking additional revenues to fund the Medicaid program are using some of the following proposed strategies:

- Reallocating tobacco settlement funds;
- Increasing a hospital tax;
- Increasing cigarette taxes;
- Adding a quality assurance fee for nursing facilities;
- Using the Medicare upper payment limit to draw down federal Medicaid funds.

**TABLE 1**  
**Annual Percentage Medicaid Growth Rate (Excluding Federal Share)**

<i>Region and State</i>	<i>Fiscal 2001 (Actual)</i>	<i>Fiscal 2002 (Estimated)</i>	<i>Fiscal 2003 (Recommended)</i>
<b>NEW ENGLAND</b>			
Connecticut	7.0%	5.3%	5.2%
Maine	7.9	7.9	8.9
Massachusetts	8.0	15.0	10.0
New Hampshire	7.4	8.1	4.1
Rhode Island	14.3	9.6	1.4
Vermont	11.4	11.1	3.9
<b>MID-ATLANTIC</b>			
Delaware	13.8	14.2	9.8
District of Columbia			
Maryland	17.5	6.7	14.0
New Jersey	1.0	0.0	13.0
New York	3.6	6.8	10.9
Pennsylvania*	8.0	4.0	1.0
<b>GREAT LAKES</b>			
Illinois*	8.5	9.5	9.3
Indiana	9.9	11.7	4.2
Michigan	7.5	2.4	2.6
Ohio*	14.8	21.7	8.0
Wisconsin	4.9	21.0	7.1
<b>PLAINS</b>			
Iowa	5.9	10.4	-0.8
Kansas	3.9	20.0	11.0
Minnesota	10.9	19.0	10.7
Missouri*	14.9	24.2	-20.6
Nebraska	16.5	9.3	6.9
North Dakota	5.1	9.5	8.6
South Dakota	8.5	15.6	8.8
<b>SOUTHEAST</b>			
Alabama	9.0	0.2	4.0
Arkansas	13.5	18.9	10.8
Florida	11.5	10.3	8.5
Georgia	3.8	0.0	15.0
Kentucky	8.6	9.4	11.3
Louisiana	8.7	10.9	11.1
Mississippi	8.0	37.0	9.0
North Carolina*	14.0	28.0	18.0
South Carolina	9.8	5.0	5.0
Tennessee*	22.3	8.6	1.1
Virginia	11.0	6.0	7.0
West Virginia	4.9	7.8	6.5
<b>SOUTHWEST</b>			
Arizona	16.5	49.2	7.6
New Mexico	28.0	38.0	3.0
Oklahoma	11.9	13.1	-1.0
Texas	11.0	22.0	-5.0
<b>ROCKY MOUNTAIN</b>			
Colorado	9.7	6.5	8.8
Idaho	23.2	7.5	5.3
Montana	7.4	7.8	10.4
Utah	14.0	5.0	6.0
Wyoming*	*	*	*
<b>FAR WEST</b>			
Alaska			
California	8.7	6.3	2.7
Hawaii	1.0	15.0	4.0
Nevada			
Oregon	12.8	17.2	5.3
Washington	25.0	38.0	-8.0
<b>Average**</b>	<b>10.6%</b>	<b>13.3%</b>	<b>5.9%</b>

**NOTES:** \*See Notes to Table 1. \*\* Average percent changes are not weighted averages as are other percentage changes in this report.

**SOURCE:** National Association of State Budget Officers

## Notes to Table 1

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Illinois	The growth percentages used are prior to cost control actions in fiscal 2002 and fiscal 2003. If the cost controls are assumed, the growth percentages are; fiscal 2001 8.5 percent, fiscal 2002 6.4 percent, fiscal 2003 3.2 percent.
Missouri	The above percentage changes for fiscal 2002 and fiscal 2003 include one-time revenue from the intergovernmental transfer funds, including cash flow spending. Excluding these funds changes the percentages to 8.3 percent in fiscal 2002 and -5.4 percent in fiscal 2003.
North Carolina	Estimated state share.
Ohio	The 21.7 percent increase in fiscal 2002 is somewhat overstated due to the new line item that was established to improve accounting for the state's receipts of prescription drug manufacturer rebates. Appropriations of \$232 million and \$268 million in fiscal 2002 and 2003, respectively reflect rebate estimates based on prior and current year activity and do not represent new spending. In order to provide a more comparable estimate, the all funds Medicaid growth rate was 13.9 percent.
Pennsylvania	The use of proceeds from prior intergovernmental transfers limit the state growth in fiscal 2003.
Tennessee	For fiscal 2001 actual, capitation rates for the Managed Care Organizations (MCOs) were significantly increased in fiscal 2001 based on an actuarial review commissioned by the Comptroller of the Treasury. Also in fiscal 2001, the state provided \$90 million (non-recurring) in supplemental payments to essential access providers. For fiscal 2003 recommended, the proposed changes to the TennCare Waiver are estimated to be in effect beginning Jan. 1, 2003.
Wyoming	Eight to 10 percent for all fiscal years.

**TABLE 2**  
**Medicaid Expenditures Exceeding Budgeted Amounts**

<i>Region and State</i>	<i>Exceeded Fiscal 2001 Budgeted Amounts by (\$ Millions)</i>	<i>Percentage of Fiscal 2001 Medicaid Budget</i>	<i>Exceeding Fiscal 2002 Budgeted Amounts by (\$ Millions)</i>
<b>NEW ENGLAND</b>			
Connecticut	\$99.0	4.4%	\$45.0
Maine	28.0	6.2	4.0
Massachusetts	303.0	6.0	300.0
New Hampshire	49.0	5.7	33.0
Rhode Island	33.8	6.7	17.6
Vermont			
<b>MID-ATLANTIC</b>			
Delaware	14.3	6.6	2.4
District of Columbia			
Maryland*	73.0	5.4	140.0
New Jersey			
New York	20.0	0.4	63.0
Pennsylvania	293.0	2.6	79.0
<b>GREAT LAKES</b>			
Illinois*	71.4	1.3	134.1
Indiana	5.6	0.5	29.0
Michigan*			
Ohio	608.1	9.7	
Wisconsin	57.0	1.9	37.1
<b>PLAINS</b>			
Iowa	18.6		
Kansas*			
Minnesota*	19.0	1.1	
Missouri*			
Nebraska			
North Dakota	1.1	0.4	10.9
South Dakota			
<b>SOUTHEAST</b>			
Alabama	318.0	4.4	203.0
Arkansas			
Florida	546.2	6.6	238.3
Georgia	11.5	0.0	79.5
Kentucky	230.0	7.0	146.0
Louisiana			
Mississippi			
North Carolina*	100.0	5.5	108.0
South Carolina			
Tennessee*			
Virginia*			
West Virginia			1.8
<b>SOUTHWEST</b>			
Arizona	42.2	5.6	134.2
New Mexico*	68.0	28.0	33.0
Oklahoma*			
Texas	716.7	7.0	
<b>ROCKY MOUNTAIN</b>			
Colorado			
Idaho	43.8	22.5	2.7
Montana	24.0	5.0	13.0
Utah			
Wyoming	8.0	4.0	16.0
<b>FAR WEST</b>			
Alaska			
California	261.0	1.1	349.3
Hawaii			
Nevada	21.0		51.0
Oregon	70.6	6.1	76.0
Washington	232.6	23.0	408.2
<b>Total** Average %</b>	<b>\$4,387.6</b>	<b>6.2%</b>	<b>\$2,755.0</b>

**NOTES:** \*See Notes to Table 2. \*\* Average percent changes are not weighted averages as are other percentage changes in this report.

**SOURCE:** National Association of State Budget Officers

## Notes to Table 2

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Illinois	The \$71.4 million by which Medicaid cost exceeded fiscal 2001 budgeted amounts is net of \$102.5 million in cost controls taken during fiscal 2001. The \$134.1 million by which Medicaid costs are expected to exceed fiscal 2002 budgeted amounts is prior to the application of cost control actions in fiscal 2002.
Kansas	Medicaid costs for fiscal 2002 will exceed the amount budgeted.
Maryland	The amount for fiscal 2001 is total funds. The amount for fiscal 2002 is general funds only.
Michigan	Medicaid expenditures for fiscal 2002 will exceed the amount budgeted by \$50 million all funds (\$21.8 million general fund). This is a current projection; expenditures continue to be closely monitored.
Minnesota	Medicaid expenditures for fiscal 2001 exceeded the amount budgeted compared to original appropriation in 1999 legislative session.
Missouri	Missouri appropriates supplemental funding for the Medicaid budget through the regular budget process. Medicaid spending did/will not exceed the amount budgeted when this supplemental funding is added.
Montana	All funds including federal and state.
New Mexico	Thirty-six million dollars of the fiscal 2001 amount is considered recurring.
North Carolina	Estimated state share.
Oklahoma	<p>Yes, before supplemental appropriation but no, after supplemental appropriation. Medicaid received a supplemental appropriation during fiscal 2001 of nearly \$21 million using a blended state FMAP for fiscal 2001 of 28.8 percent. This translates into a potential shortfall of approximately \$72.7 million in state and federal. This was 3.6 percent of the Medicaid budget.</p> <p>The Medicaid budget was projected to be \$53.1 million short in total dollars. However, the Governor signed a \$15.6 million supplemental Feb. 21, 2002, which when added to the federal match and to cost cuts taken by the agency will cover the shortage.</p>
Tennessee	The TennCare program's projected fiscal 2002 expenditures are not anticipated to exceed the funding available to the program through appropriations and reserve funds. It should be noted that pharmacy growth has significantly exceeded budgeted projections and is anticipated to result in the need to use reserve funds in order to close the current fiscal year.
Virginia	There was a budget impasse in Virginia in fiscal 2001. Therefore, funds had to be transferred from fiscal 2002 budget to cover expenditures in fiscal 2001.

**TABLE 3**  
**Medicaid Cost Containment Actions for Fiscal 2002 and Proposals for Fiscal 2003**

*Region and State*

**NEW ENGLAND**

Connecticut	The Governor's budget proposes to restructure Medicaid coverage for adults with income between 100 percent and 150 percent of poverty by instituting premiums and co-payments; changing prescription drug costs by increasing the average wholesale price (AWP) discount, lowering the dispensing fee and instituting a maximum allowable cost (MAC) system; continuing to develop a data warehousing and fraud detection system; and implementing a pilot community care services for individuals in danger of being institutionalized.
Maine	Medicaid rate reductions include hospital rate cuts and reductions from Medicare Part B crossover repricing as well as other unspecified non-eligibility reductions for fiscal 2002. For fiscal 2003, Medicaid service eliminations would include chiropractic services, occupational therapy services, and podiatric services. Medicaid rate reductions include hospital rate cuts, reduced payments to federal health qualified centers, and enhanced estate recovery and asset transfer recoupment from Medicaid clients. Reductions from Medicare Part B crossover repricing and physician reimbursements, rate cuts in private non-medical institutions and in nursing homes, deferral of expanding access to Medicaid coverage to noncategorical eligible adults and other unspecified non-eligibility reductions are also proposed. Also, includes reduction due to increased prior authorization of prescription drugs.
Massachusetts	The Division of Medical Assistance implements new savings initiatives each year. In fiscal 2002 and fiscal 2003, the cost containment projects include restructuring dental services provided to adults; enhancing program integrity and provider audits; enhancing benefit coordination and third party liability identification; implementing a number of pharmacy savings initiatives including prior approval for brand name drugs with generic equivalents and a MassHealth Drug List, encouraging the use of 340B pharmacies, implementing a mail order program, and other changes related to early refill and re-use; reinstatement of Medicare Part-B claim repricing; and moving to an "income deeming first" policy for nursing home residents with spouses in the community which would require legislative approval. These cost containment efforts will continue in fiscal 2003.
New Hampshire	Actions in both fiscal 2002 and fiscal 2003 include use of a pharmacy benefit manager.
Rhode Island	For fiscal 2003, proposals include increased penetration of managed health care programs to include adopted children, foster care for behavioral health services, SSI disabled children and children's intensive services. Other proposals include revising reimbursement models for neonatal intensive care services, eliminating retroactive coverage for managed care enrollees, capping extension of health insurance to child care workers, and restructuring the pharmacy benefits program.
Vermont	Actions in fiscal 2002 increase the amount of co-payment requirement for certain eligibility classes and institute a Pharmacy Benefit Management program to reduce pharmacy expenditures. Actions in fiscal 2003 decrease freeze reimbursement rates for certain providers, eliminate benefits for certain eligibility groups, institute cost sharing measures, institute a more aggressive preferred drug list, and close loopholes in the transfer of assets for long term care eligibility.

**MID-ATLANTIC**

Delaware	Actions in fiscal 2002 that would continue in fiscal 2003 include entering multi-agency purchasing arrangements for volume discount savings and adding prior authorization for certain prescription drugs. Also exploring the potential use of Federal SCHIP dollars for use in Medicaid for fiscal 2003.
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**TABLE 3 (continued)**

**Medicaid Cost Containment Actions for Fiscal 2002 and Proposals for Fiscal 2003**

*Region and State*

Maryland	Nursing home cost containment is \$10 million for fiscal 2002. Proposals for fiscal 2003 include changing physicians drug prescription patterns (physician profiling, prior authorization of selected brand name drugs), reducing cost (increase the average wholesale price from minus 10 percent to minus 13 percent, increase rebates and co-payments). Other proposals include nursing home cost containment, concurrent hospital review, administrative reductions, disallowance of legal and accounting fees related to appeals, adding an escrow account for provider appeals, and early recovery of unspent nursing funds.
New Jersey	Actions in fiscal 2002 include increased efforts for third party liability (TPL) recoveries. Actions in fiscal 2003 include moving to outpatient hospital prospective payment system and increasing TPL recovery efforts.
New York	The fiscal 2003 budget includes proposals to enhance drug rebates from manufacturers, require mandatory use of generic drugs, lower pharmacy reimbursements, and restructure the reimbursement rate for part-time clinics.
Pennsylvania	Ongoing efforts continue in fiscal 2002 to reduce fraud and abuse. For fiscal 2003, in addition to ongoing efforts to reduce fraud and abuse, several cost containment measures are proposed: including modifying income "spend down" provisions to restrict eligibility, including parental income in determination of eligibility for children with disabilities, and revising income eligibility requirements for nursing home care.

**GREAT LAKES**

Illinois	For fiscal 2002, Illinois' cost control actions include \$1 co-payment for non-institutional services, a reduction in nursing home bed hold rates and hospital payments, a 3 percent reduction to medical practitioners, as well as pharmacy and managed care cost control initiatives. In fiscal 2003, Illinois' proposed cost control actions include pharmacy benefit management, increased co-payments, and rate reductions to nursing homes, medical practitioners and other non-institutional providers.
Indiana	Actions in fiscal 2002 include reducing reimbursement rates for pharmaceuticals and increasing rebates. Other actions include reducing reimbursements to nursing homes, eliminating coverage for dentures, increasing participation in managed care and reducing hospital reimbursements. Actions in fiscal 2003 include ensuring that Medicaid is payer of last resort, closing eligibility loopholes, enhancing system integrity and program effectiveness, and using cost effective drug utilization and reform reimbursement methodologies.
Michigan	Fiscal 2002 cost containment measures include supplementing manufacturer drug rebates for selected drug classes; maintaining long-term care per diem prices and ambulance rates at fiscal 2001 levels; reducing graduate medical education subsidies by 5 percent; eliminating special grants to rural hospitals; eliminating funding for two psychiatric residency programs; and rebasing hospital inpatient payment rates. In addition, no discretionary provider increases are included for fiscal 2002. Fiscal 2003 cost containment measures include full-year savings from maintaining long-term care per diem prices at fiscal 2001 levels and from rebasing hospital inpatient payment rates in fiscal 2002. Rebasing hospital inpatient payment rates will result in reduced payments to health maintenance organizations in fiscal 2003. In addition, implementation of the Long-term Care Plan will require preadmission screening of LTC recipients to ensure services are provided in the most cost-effective setting. For the second consecutive year, no discretionary provider increases are included in the budget.

**TABLE 3 (continued)**

**Medicaid Cost Containment Actions for Fiscal 2002 and Proposals for Fiscal 2003**

<i>Region and State</i>	
Ohio	Actions in both fiscal 2002 and fiscal 2003 include decreasing reimbursement for brand name prescription drugs, increasing fraud and abuse efforts, and moving to a therapeutic formulary model for prescription drugs.
Wisconsin	Actions in fiscal 2002 and 2003, reflect an increase use of prior authorization for prescription drugs (proposed).
<b>PLAINS</b>	
Iowa	Actions in fiscal 2002 include a reduction in some dental services. Proposals in fiscal 2003 include pharmaceutical state maximum allowable cost, Medicare crossover claims, retrospective drug utilization review, disease management initiative, dual certification of nursing facilities, and freezing reimbursement rates.
Kansas	For fiscal 2003, proposals include increasing the pharmacy co-payment from \$2 to \$3, changing the billing system for therapy services, decreasing the pharmacy dispensing fee from \$5 to \$4, reducing the prescription reimbursement to minus 12 percent of average wholesale price, allowing only skilled nursing to bill for home health services, reducing rates on state only mental health services, and adding statutory authority for additional estate recovery efforts.
Minnesota	The Governor's budget proposed rate reductions, prescription reimbursement reductions, cost sharing increases, and eliminating planned benefit expansions.
Missouri	Actions in fiscal 2002 include the following cost containment measures that were instituted in the pharmacy program: hard edits; physician education; disease management; patient profiling; enhanced retrospective drug utilization; prior authorization; requiring additional justification on overrides; utilization management; pill splitting; increasing generic utilization; requiring mail order on certain drugs; and, updating maximum allowable cost list regularly. Actions in fiscal 2003 would eliminate State Medical program for general relief recipients; eliminate over the counter drug reimbursement except for diabetic supplies; institute Medicare Part B repricing; reduce physician cross-over reimbursement; increase point count required to become eligible for in-home or nursing home services from 18-21 points; eliminate optional adult dental program except for dentures; eliminate optional adult optical program; modify spend down policy to require recipients to pay for rather than incur costs in order to be eligible for Medicaid spend down services: reduce rehabilitation and specialty services reimbursement from 125 percent to 100 percent of cost; and reduce reimbursement for durable medical equipment to 80 percent of the average wholesale price.
Nebraska	Actions in fiscal 2002 include a modified prospective payment plan based on cost growth for certain core facilities has been implemented for nursing facilities and intermediate care/mental retardation facilities. This prospective payment methodology replaces a actual cost reimbursement methodology previously used by the Medicaid program. Proposals in fiscal 2003 include freezing practitioner rate increases for one year in lieu of the 4 percent originally planned, reducing payments to hospitals for direct medical education (DME) and disproportionate share (DSH), reducing prescription drug payments to pharmacists to the average wholesale price less 12 percent in lieu of the current discount of 10 percent, and increasing the Medicaid prescription drug co-payment from \$1 to \$2 per prescription for the groups for which the co-payment applies. A prescription drug prior authorization regulation is also being implemented.

**TABLE 3 (continued)**

**Medicaid Cost Containment Actions for Fiscal 2002 and Proposals for Fiscal 2003**

<i>Region and State</i>	
North Dakota	Expenditures are being monitored on a monthly basis.
South Dakota	For fiscal 2003, the state has instituted a prescription drug program, a preferred drug program, to hold down costs.
<b>SOUTHEAST</b>	
Alabama	Actions in fiscal 2002 include prior authorization of additional classes of pharmaceuticals.
Arkansas	Actions in fiscal 2002 include increasing fraud and abuse elimination efforts; reducing optional benefits/eligibility through prior authorization; adding benefit extension authorizations; contracting for services; reducing prescription drug costs by revising the ingredient cost reimbursement rates; and increasing cost-sharing requirements. These actions will continue in fiscal 2003.
Florida	Actions in fiscal 2002 reflect reduced optional benefits/eligibility; reduced prescription drug costs; and increased fraud and abuse efforts. Actions in fiscal 2003 reflect shifting Medicaid recipients from preferred provider organizations to health maintenance organizations; reducing optional benefits; increasing cost-sharing requirements; reducing prescription drug costs; and capping rates for optional programs.
Georgia	For both fiscal 2002 and fiscal 2003, requiring prior approval to reduce prescription drug costs; slowing previously planned enhancements; and increasing cost sharing requirements.
Kentucky	Actions for fiscal 2002 include reducing dispensing fees to pharmacists; changing outpatient hospital interim reimbursement rate from 65 percent of cost to 48 percent (the average amount owed after costs are settled); placing a moratorium on selected certificate of need services; strengthening the enrollment process to improve program integrity; capping the enrollment of some waiver programs; maintaining fiscal 2001 provider reimbursement rates for certain services; implementing pharmacy prior authorization; stepping-up peer review programs to improve outcomes; instituting presumptive eligibility for pregnant women and children to improve outcomes; and enhancing primary care case management activities--Kentucky Patient Access Program. Actions in fiscal 2003 reflect a continuation of fiscal 2002 initiatives. Other actions include restructuring some rate methodologies; implementing pharmacy benefit management program; implementing Pharmacy & Therapeutic committee to address formulary issues; implementing co-payments for pharmacy; and strengthening audit activities to reduce backlog of cost settlements and making additional edits to the Medicaid management information system to reduce the need for future recoveries and increase cost avoidance.
Louisiana	For fiscal 2003, reduction in hospital and services from 5 percent to 30 percent. Also exploring savings potential of eliminating optional programs.
Mississippi	H.B. 1200, in the 2002 regular session will generate approximately \$8 million in cost savings in fiscal 2002 and approximately \$30 million in cost savings in fiscal 2003. Other cost containment measures have not been finalized (legislative session in progress).

**TABLE 3 (continued)**

**Medicaid Cost Containment Actions for Fiscal 2002 and Proposals for Fiscal 2003**

<i>Region and State</i>	
North Carolina	<p>For fiscal 2002, the appropriations bill included the following Medicaid reductions: intermediate care facilities for the mentally retarded rate adjustment, drug utilization management (pharmacy benefit manager), decrease in dispensing fee for brand name drugs from \$5.60 to \$4.00, limit personal care services to 3.5 hours per day/80 hour per month limit, change asset policies, limit Medicare crossover claims payments to 95 percent of Medicare, reduce physician rates to 95 percent of Medicare rate, increase co-payments for prescription drugs from \$1 to \$3, and eliminate new inflationary increases. Proposed reductions in fiscal 2003 include contract for hospital services; defining efficient provider for nursing facilities, intermediate care facilities for the mentally retarded, and adult care homes; establishing daily prospective rates for home care services and personal care services based on level of need; reducing payments for drugs from 90 percent to 85 percent of average wholesale price; contracting for prescription drugs for residents of nursing facilities and adult care homes; contracting for home health supplies, durable medical equipment and home infusion therapy; and reducing provider rates for chiropractors, optical, podiatry and adult care home personal care services, and reducing over expenditure in community alternative programs for disabled adults and mentally retarded/developmentally disabled programs.</p>
South Carolina	<p>Actions in fiscal 2002 include reducing pharmacy fee; expanding pharmacy maximum allowable cost list; expanding pharmacy prior approval program; increasing pharmacy co-payment; limiting Medicaid cost-sharing to Medicaid State Plan amounts; eliminating or restricting certain procedure codes; deferring certain planned rate increases; and reducing rates for certain services. These actions continue in fiscal 2003.</p>
Tennessee	<p>In fiscal 2002, previous reverification efforts of TennCare enrollees were constrained by a Temporary Restraining Order (Rosen). Since then, reverification has been re-implemented resulting in reduced enrollment numbers. Also in fiscal 2002, staffing was increased in the area of fraud and abuse investigations. In fiscal 2003, the TennCare program has proposed a modification to the Centers for Medicare and Medicaid Services (CMS) that includes several features related to cost containment. These features include, but are not limited to: a reduced benefit package for waiver participants; a tiered pharmacy co-payment structure for generic and brand name drugs; more extensive eligibility criteria for waiver participants; and the ability to limit enrollment based on available state funding.</p>
Virginia	<p>Actions in fiscal 2003 reflect the Virginia Department of Medical Assistance Services (DMAS) plans to achieve savings by maximizing federal financial participation through optimizing Medicaid claims, recovering costs, and reducing eligibility determinations. DMAS also plans on achieving savings by reducing pharmaceutical costs further below the average wholesale price by increasing discounts. The savings will be achieved by revising the formula from the average wholesale price (AWP) minus 9 percent to the AWP minus 10.25 percent. DMAS also plans to expand cost containment actions to a broad range of Medicaid providers: hospitals, managed care organizations, pharmacies, pharmaceuticals and nursing facilities.</p>

**TABLE 3 (continued)**

**Medicaid Cost Containment Actions for Fiscal 2002 and Proposals for Fiscal 2003**

<i>Region and State</i>	
West Virginia	For fiscal 2002, actions include increasing fraud and abuse efforts while expanding programs for possible reimbursement rate reductions. For fiscal 2003, cost containment strategies include increasing fraud and abuse efforts, reimbursement rate reductions, and a review of both eligibility and optional services offered under the program for possible reductions.
<b>SOUTHWEST</b>	
Arizona	Actions in fiscal 2002 include the elimination of the Freedom to Work and Prescription Drug Pilot programs and implementation of the Health Insurance Flexibility and Accountability (HIFA) One Waiver. Fiscal 2003 executive recommendations include reduction in graduate medical education program, eliminate Freedom to Work Program, implement HIFA Two Waiver, and eliminate adult emergency dental and circumcision services.
New Mexico	For fiscal 2002, actions include reducing optional benefits. For fiscal 2003, would reduce optional benefits, prescription drug costs, and eligibility to the federal poverty level.
Oklahoma	For fiscal 2002, delaying the SSI cost-of-living adjustment increase to nursing homes; expanding the number of generic drugs on the state maximum allowable cost list (SMAC) and adopting the Texas SMAC when it is lower than Oklahoma's; for other drugs, reducing acquisition allowance to pharmacies to average wholesale price minus 12 percent from minus 10.5 percent; delaying provider increases; and reducing nursing home and intermediate care facilities for the mentally retarded paid days for "reserve beds". For fiscal 2003, proposals are to move from managed care back to fee for service creating a one-time savings by switching from up-front capitation payments to paying in arrears; limiting the number of prescriptions per month in waivers; lowering provider payments; and capping enrollment in waivers.
<b>ROCKY MOUNTAIN</b>	
Colorado	Various program related actions have been initiated through the budget cycle process, including, but not limited to, reductions to pharmacy reimbursement rates and attempts to lower the costs for Medicaid eligibility disability determinations. In fiscal 2003, initiatives are currently in process that potentially will contain Medicaid costs. These initiatives include, but are not limited to, reductions to pharmacy reimbursements rates and requirements to reduce the level of psychotherapy crossover claim payments.
Idaho	Actions in fiscal 2002 include shortening the period from 4 to 3 days before requiring an independent review of the need for inpatient hospital services; changing the discount to the average wholesale price of prescription drugs from minus 11 percent to minus 12 percent; not allowing early refill of prescriptions until 75 percent of the estimated days supply has elapsed; requiring prior approval for non-generic drugs; requiring prior authorization for adults for over 4 prescriptions per month; including prescription drugs for the SCHIP in the drug rebate process; managing the utilization of hospital outpatient services to reduce unnecessary visits and expenses; implementing a statewide commercial demand response transportation rate and reduce personal travel reimbursement from 35 cents per mile to 10 cents per mile; requiring prior authorization for all durable medical equipment to insure purchase of reasonable amounts and most cost effective items; managing utilization of x-ray/lab expenses to prevent unnecessary or duplicative tests; paying Medicare rates for physician services. In fiscal 2003, savings are annualized from the measures implemented in fiscal 2002. In regards to the Medicare alignment, savings are annualized from the fiscal 2002 adjustment of physician rates over 100 percent of Medicare; savings are annualized from the fiscal 2002 adjustment of mid-level practitioners rates to 85 percent of fiscal 2002 physician rates; and the adjustment of certain physician rates below 100 percent of Medicare rates to Medicare rates.

**TABLE 3 (continued)**

**Medicaid Cost Containment Actions for Fiscal 2002 and Proposals for Fiscal 2003**

*Region and State*

Montana	Actions in fiscal 2002 include across-the-board rate provider reduction of 2.6 percent; reducing out-of-state hospital reimbursement; increasing prior authorization requirements; increasing co-insurance requirements; and reducing the use of residential treatment centers. These actions continue in fiscal 2003 with the reduction in pharmacy reimbursement to match changes in the average wholesale price.
Utah	For fiscal 2002, increase client co-payments; reduce the retroactive period to 90 days; and other administrative reductions. For fiscal 2003, reduce increase in reimbursement for providers; increase client co-payments; increase third-party collections; eliminate selective services; reduce retroactive period; limit prescriptions to seven per month (not including those on the exempt list).
Wyoming	Actions for fiscal 2002 include participating in payment accuracy measurement project and reducing pharmacy reimbursement by 7 percent of average wholesale price. For fiscal 2003, proposals are to implement prior authorization for pharmacy and implement a disease management program.
<b>FAR WEST</b>	
California	Actions in fiscal 2002 include increased anti-fraud efforts. For fiscal 2003, proposals are to reduce certain provider rates; increase beneficiary co-payments; and negotiate additional drug rebate contracts.
Hawaii	For fiscal 2002, reducing the increase in nursing home and acute prospective payment system rates by one-half of the increase in the inflation factor supplied by Data Resources, Inc.
Nevada	Actions in fiscal 2002 include delaying program enhancements; eliminating Legislatively approved rate increase; reducing pharmacy reimbursement and reducing health maintenance organizations administrative portion of premiums.
Oregon	In fiscal 2002, please note that Oregon, like most states, must have a balanced budget. Deficits will be addressed by program reductions sufficient to end the biennium without deficit. An Emergency Board made up of legislative members meets during the interim and is authorized to handle certain minor budgetary issues. The Emergency Board met in January 2002 and there have been two special sessions of the legislature since, with a third special session expected in June 2002. Given this context the Medicaid health care reductions to date are adding pharmacy co-payments; requiring the diagnosis on the prescription (this permits editing against the prioritized list of services used under the 1115 waiver); eliminating outlier payments under hospital diagnosis related group (DRG) reimbursement methodology; reducing DRG reimbursement; reducing pharmacy reimbursement to average wholesale price minus 14 percent; and adding resources to improve third party liability (TPL) recoveries. Since Oregon is on a biennial budget cycle the 2002 reductions will likely carry over into fiscal 2003. Additional reductions or new resources may occur at the next special legislative session, expected in early June. The current reductions may be replaced with different reductions by pending court challenges to the governor's use of executive allotment authority.
Washington	For fiscal 2002, actions include prescription drug monitoring, utilization management, rates adjustment, coordination of benefits, field audits, family planning waiver, and primary care case management. For fiscal 2003, these actions would continue along with an increase in the discount on average wholesale price on drugs, defer vendor rate increase, rate reduction on outpatient prospective payments, and eliminate funding for interpreter services.

**TABLE 4**  
**Dedicating Additional Non-General Fund Resources to Medicaid Programs**  
**in Fiscal 2002 and Proposed Fiscal 2003**

*Region and State*

**NEW ENGLAND**

Connecticut	Additional tobacco settlement funds will be diverted to the general fund, though not specifically earmarked.
Vermont	Actions in fiscal 2002 include instituting increased co-insurance premiums for certain eligibility groups and increasing certain provider taxes. Actions in fiscal 2003 include increasing certain provider taxes and the legislature is proposing an increase in the cigarette/tobacco tax.

**MID-ATLANTIC**

Delaware	Tobacco funds for both fiscal 2002 and fiscal 2003, in the amount of \$0.9 million.
Maryland	Cigarette restitution funds in fiscal 2003.
New Jersey	Actions in fiscal 2003 include applying for Pharmacy Plus waiver to increase federal funds and use balances in unemployment trust fund for Medicaid.
New York	The fiscal 2002 enacted budget includes actions to generate additional non-general fund resources through upper payment limit (UPL) savings. The fiscal 2003 proposed budget includes proposals to generate additional non-general fund resources through an assessment on nursing home providers, an increase of the cigarette tax, a 3 percent increase in the Federal Medicaid Assistance Percentage (FMAP) and continued UPL savings.

**GREAT LAKES**

Illinois	Illinois plans to reallocate \$83 million of tobacco funds from the Circuit Breaker Pharmaceutical program to Senior Care, a comprehensive federally matched pharmaceutical program for seniors up to 200 percent of the federal poverty rate. Senior Care will provide a more complete benefit package than Circuit Breaker, at no additional state cost.
Indiana	Actions in both fiscal 2002 and fiscal 2003 include maximizing federal Medicaid funding and adjusting disproportionate share payments.
Michigan	For fiscal 2002 and fiscal 2003, tobacco settlement funds are maintained at \$35 million for Medicaid programs. In addition, creation of a Medicaid quality assurance assessment is proposed by the Governor for fiscal 2003. The assessment is subject to enactment by the legislature. Adoption of this financing option will allow Michigan to earn sufficient federal funding to increase Medicaid payments by 5 percent for health maintenance organizations and 7 percent for nursing homes.
Ohio	Actions in both fiscal 2002 and fiscal 2003 include an increased franchise fee for nursing facilities. Also, the General Assembly has given the Ohio Department of Job and Family Services permission to access up to \$150 million from the state budget stabilization fund (state share) over the fiscal 2002-2003 biennium for Medicaid expenditures that exceed the current appropriation level.
Wisconsin	Actions in fiscal 2002 include the use of funding in our Medical Assistance Trust Fund (intergovernmental transfer revenue) to augment general purpose revenue.

**PLAINS**

Iowa	Actions in fiscal 2002 include tobacco funds, senior living trust funds, hospital upper payment limit. Actions in fiscal 2003 include tobacco funds, senior living trust funds, hospital upper payment limit, and intermediate care facilities for the mentally retarded provider participation fee.
Missouri	For fiscal 2003, a new pharmacy provider tax is proposed. Legislation has been introduced to enact this new tax. Also for fiscal 2003, an increase in the existing nursing home and hospital providers taxes is proposed.

**TABLE 4 (continued)**

**Dedicating Additional Non-General Fund Resources to Medicaid Programs  
in Fiscal 2002 and Proposed Fiscal 2003**

*Region and State*

Nebraska	Actions in fiscal 2002 include a transfer of \$5 million will be made from the State's Tobacco Prevention and Control Cash Fund to a fund used by the Medicaid program. This one-time transfer is made possible by a slower than expected start to the State's new tobacco prevention and control program. The funding would be more than replaced beginning in fiscal 2004 when the equivalent of \$7 million from a cigarette tax increase will be provided annually specifically for tobacco prevention and control programs. A direct appropriation of \$11.2 million of excess unobligated balance from the Health Care Cash Fund has been proposed to offset a general fund appropriation reduction of an equivalent amount in the Medicaid program. Actions in fiscal 2003 include a transfer of \$8.7 million will be made from the excess unobligated balance of a fund established to provide grants to nursing facilities for conversion of nursing beds to less expensive, and lower intensity assisted living beds.
<b>SOUTHEAST</b>	
Arkansas	Pursuant to law passed in the 2001 legislative session, the additional resources are an increase in the cigarette tax; a quality assurance fee imposed on nursing facilities; and tobacco funding as provided in appropriation acts. All new fiscal 2002 resources will be in place for fiscal 2003.
Florida	Actions in fiscal 2003 impose cost sharing requirements for optional programs.
Kentucky	For fiscal 2002, the Commonwealth will aggressively seek intergovernmental transfers (IGT) where possible. The Commonwealth will step up post-payment financial recovery programs, age accounts receivables and write-off uncollectibles. In fiscal 2003, IGT's will be used and step up post-payment financial recovery programs through outside contractors.
Mississippi	For both fiscal 2002 and fiscal 2003, additional sources of Medicaid revenue have not been finalized since the legislative session is still in progress.
South Carolina	For fiscal 2002, additional resources are from retention by the Medicaid agency of revenue resulting from certain cost settlements and rate adjustments with other state agencies and increase in the hospital tax - Medicaid Expansion fund. In fiscal 2003, an additional increase in the hospital tax - Medicaid Expansion fund and the nursing home franchise fee have been proposed.
Virginia	In fiscal 2003, changes will increase access to the program but will not decrease the current benefits.
<b>SOUTHWEST</b>	
Arizona	Actions in fiscal 2002 include a \$10 million dollars transfer from the health education account and a \$37 million transfer from the medical services stabilization fund to cover Medicaid caseload increases. Actions in fiscal 2003 may impose a premium tax on the Arizona Health Care Cost Containment System (AHCCCS) contracted health plans and program contractors. Currently, AHCCCS and its contractors are exempt from the premium tax paid by commercial (Title 20) health plans.
Oklahoma	Actions in fiscal 2002 include beginning to use the Medicare upper payment limit to capture additional federal dollars and a possible introduction of a provider fee for behavioral health. In fiscal 2003, there is a potential for an increase in the cigarette tax; use of the Medicare upper payment limit, and begin collecting birth costs from absent fathers upon paternity establishment through child support enforcement.

**TABLE 4 (continued)**

**Dedicating Additional Non-General Fund Resources to Medicaid Programs in Fiscal 2002 and Proposed Fiscal 2003**

*Region and State*

**ROCKY MOUNTAIN**

Colorado	Various initiatives have been introduced during the budget cycle to utilize the Medicare upper payment limit financing mechanism for both public hospitals and nursing facilities.
Montana	Actions in both fiscal 2002 and 2003 include using 40 percent of tobacco settlement funds placed in trust fund with interest dedicated to funding Medicaid provider rate increases and the implementation of an intergovernmental transfer program.
Utah	Actions in fiscal 2002 include \$2.0 million tobacco settlement funds replacing general fund. Actions in fiscal 2003 include contract for state match of University Hospital to draw down additional disproportionate share funds.

**FAR WEST**

California	Actions in fiscal 2002 include an increase in the state disproportionate share administrative fee by \$55.0 million to offset general fund expenditures in the Medi-Cal Program.
Oregon	For both fiscal 2002 and 2003, the legislature used a variety of non-general fund resources including use of funds from the tobacco settlement to balance the budget. The Governor rejected depletion of the tobacco settlement fund and made additional program reductions across state government. This will likely be debated again at the next special session. The Governor would like to see permanent revenue and has proposed tax increases on beer/wine and a delay in a state income tax reduction.
Washington	For both fiscal 2002 and fiscal 2003, actions include expanding nursing home and hospital proshare claims.

## SCHIP

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The enactment of the State Children's Health Insurance Program (SCHIP) as part of the Balanced Budget Act of 1997 has increased health coverage for previously uninsured children. SCHIP is targeted to children whose families have income too high to qualify for Medicaid but too low to afford private insurance. States receive a federal match for their SCHIP programs ranging from 65 percent to 85 percent within a capped allotment. During fiscal 2001, approximately 4.6 million children enrolled in SCHIP, representing a 38 percent increase over fiscal 2000 levels.

The major legislative proposal for SCHIP at the federal level is the extension of SCHIP funds that are due to expire from fiscal 1998 and fiscal 1999 allotments. Federal costs for

SCHIP are estimated to be \$4.4 billion in fiscal 2003, an 18 percent increase over the previous year. Although a few states are proposing to take cost containment actions in their SCHIP programs, other states are proposing program expansions (see Table 5). Proposed cost containment activities include eliminating dental care for adults without children, reducing payments for health care providers, capping enrollment, and increasing cost-sharing requirements.

Several states are proposing expansions to the SCHIP program. California, for example, is proposing to expand coverage to adults up to 200 percent of poverty of covered children while Connecticut is proposing to use unspent SCHIP funds to establish a small business subsidized health insurance program.

**TABLE 5**  
**Changes to State Children's Health Insurance Programs (SCHIP) for Fiscal 2002 and Proposed Changes for Fiscal 2003**

<i>Region and State</i>	
<b>NEW ENGLAND</b>	
Connecticut	The Governor proposes establishing a small business subsidized health insurance program for families and childless adults by accessing unspent SCHIP funds.
Rhode Island	For fiscal 2002, actions include increasing premiums and co-payment requirements.
<b>MID-ATLANTIC</b>	
New York	Actions in fiscal 2002 include eligibility expansion up to 133 percent of the net federal poverty level and the transition of certain children to the Medicaid program. In response to the September 11th tragedy, the annual recertification requirement was waived for children scheduled to recertify between October 2001 and January 2002 and therefore allowing eligibility to continue for the following 12-month period. The recently enacted Workforce and Retention Act of 2002 simplifies the ability to maintain coverage by allowing applicants to attest to income/resources information, developing a simplified application, providing a 60-day grace period to complete the recertification application and eliminating the face-to-face interview requirement for re-enrollment.
<b>GREAT LAKES</b>	
Illinois	No specific fiscal 2003 cost control actions have been targeted to the State Children's Health Insurance Program (Kidcare). Medicaid provider reimbursement reductions, however, will reduce payments to Kidcare providers as clients use the same provider network. In fiscal 2003, Illinois is pursuing a federal waiver to count spending on current state-only health programs as state-match to draw unused SCHIP allotments to finance FamilyCare. This program will offer health coverage to parents/guardians of Kidcare Medicaid children.
Wisconsin	Actions in fiscal 2002 and 2003 reflect a proposed increase use of prior authorization, the same as in Medical Assistance.
<b>PLAINS</b>	
Kansas	The premium was proposed to be increased, but the Governor recommended adding tobacco settlement funds to replace the fee fund revenue from the premiums. The Governor added \$4.1 million in general funds in fiscal 2003 to fund anticipated increases in caseloads.
Minnesota	For fiscal 2003, the Governor proposed a performance withhold in managed care contracts, a 1 percent ratable reduction for health care providers, and eliminating dental for adults without children.
Nebraska	Actions for fiscal 2003 include proposals include freezing practitioner rate increases for one year in lieu of the 4 percent originally planned, reducing payments to hospitals for direct medical education (DME) and disproportionate share (DSH), reducing prescription drug payments to pharmacists to the average wholesale price less 12 percent in lieu of the current discount of 10 percent, and increasing the Medicaid prescription drug co-payment from \$1 to \$2 per prescription for the groups for which the co-payment applies. A prescription drug prior authorization regulation is also being implemented. Another proposal would change the state's continuous coverage guarantee to six months from the current 12-month continuous coverage period.

**TABLE 5 (continued)**

**Changes to State Children's Health Insurance Programs (SCHIP) for Fiscal 2002 and Proposed Changes for Fiscal 2003**

*Region and State*

**SOUTHEAST**

Florida	Actions in fiscal 2003 include reinstating local match requirements.
Louisiana	For fiscal 2003, the emphasis is on trying to slow growth and reduce provider payments.
North Carolina	For fiscal 2002, additional funding of \$8 million was provided to increase enrollment capacity to 82,000 children. No other changes have been implemented. For fiscal 2003, no changes are currently proposed.

**SOUTHWEST**

Arizona	May increase premiums or co-payments.
New Mexico	For fiscal 2002, holding back on enrollment campaigns. For fiscal 2003, capping enrollment, reducing federal poverty level and increasing cost sharing requirements.
Oklahoma	In fiscal 2002, began use of the "fetus is a child" announcement by the federal Department of Health and Human Services in order to claim pre-natal care costs at the higher SCHIP matching rate. In fiscal 2003, these changes would be for the entire year.

**ROCKY MOUNTAIN**

Utah	Actions in fiscal 2002 and 2003 include capping enrollment to the January 1, 2002 level. Also, eliminating dental benefits other than preventive care.
Wyoming	For fiscal 2002, participating in payment accuracy measurement project and reduced pharmacy reimbursement by 7 percent of the average wholesale price. For fiscal 2003, implementing prior authorization for pharmacy and a disease management program.

**FAR WEST**

California	Expanding program to offer coverage to adults (up to 200 percent of poverty) of covered children for fiscal 2003.
Oregon	For both fiscal 2002 and 2003, SCHIP is considered a capped program based on cost. Once we project we have reached the cost cap, new enrollments will cease.

## **State-Funded Prescription Drug Programs**

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Approximately 30 states operate some type of prescription drug program, often targeted towards low-income seniors. Funding for these programs include state general funds, tobacco settlement funds, tobacco taxes, foundation funds, state lottery as well as funds provided by beneficiaries.

Programs have a variety of payments and deductibles to help fund the programs' costs. Some of the cost containment proposals that are part of the efforts in Medicaid are continued in state funded prescription drug programs (see Table 6). These proposed changes include implementing asset tests, reducing dispensing fees, changing reimbursement formulas, implementing a maximum allowable cost for generic drugs, increasing co-payments, and increasing rebates from manufacturers. Similar to the SCHIP program, states are both pursuing cost containment proposals as well as mechanisms to increase coverage to individuals who lack health insurance.

States, operating in a constrained fiscal environment, are seeking to control the growth rates in health care programs, particularly in Medicaid. Even in the tight fiscal environment, several states are proposing expansions in non-Medicaid programs. With total health care spending accounting for approximately 27 percent of all state spending, state program cutbacks will inevitably include some health programs. The outlook for Medicaid spending, even with the reduced rate of growth assumed for fiscal 2003, will continue to place pressure on state budgets even after an economic recovery is underway.

**TABLE 6**  
**Proposed Changes to Fiscal 2003 State-Funded Prescription Drug Programs (Non-Medicaid)**

<i>Region and State</i>	
<b>NEW ENGLAND</b>	
Connecticut	The following changes are being proposed to ConnPACE: implementing an asset test of \$50,000 for singles, \$75,000 married couples; providing a voluntary mail order option for maintenance prescriptions; reducing the dispensing fee and the average wholesale price reimbursement to pharmacists; and implementing a maximum allowable cost for generic drugs.
Maine	Proposals are for a reduction to drugs for the elderly price and adding a co-payment.
Vermont	Proposes to eliminate the program.
<b>MID-ATLANTIC</b>	
Maryland	Changing the co-payment from \$5 to \$7.5 and increasing rebates received from manufacturers.
New York	The fiscal 2003 budget includes the following proposals to the Elderly Pharmaceutical Insurance Coverage (EPIC) Program: reduce the pharmacy reimbursement from average wholesale price less 5 percent to average manufacturers price less 10 percent; restructure the rebate methodology to align with the rebate methodology used in the Medicaid Program; and require private health insurers to match membership files with EPIC to facilitate coordination of benefits.
<b>GREAT LAKES</b>	
Illinois	Illinois recently received waiver approval to begin SeniorCare, a federally-matched comprehensive pharmaceutical program providing benefits to seniors up to 200 percent of the federal poverty level. Eligible seniors above 200 percent of the poverty level and disabled individuals will remain on the state funded Circuit Breaker Pharmaceutical Program.
Michigan	The fiscal 2003 Governor's proposal includes a three-fold increase, to \$145 million, for the Elder Prescription Insurance Coverage program to serve seniors under 200 percent of poverty. The recommended increase is based on anticipated federal funding from the Medicare Low-Income Drug Assistance and Medicaid Pharmacy Plus Waiver programs.
Wisconsin	The Governor's budget created a new prescription drug benefit for seniors over the age of 65 with income below 240 percent of the federal poverty level. In fiscal 2003, \$49.9 million was appropriated for this program.
<b>PLAINS</b>	
Iowa	The fiscal 2003 Governor's proposal includes pharmaceutical state maximum allowable cost, Medicare crossover claims, retrospective drug utilization review, disease management initiative, dual certification of nursing facilities, and freezing reimbursement rates.
Minnesota	The Governor proposed eliminating two planned expansions for seniors from 120 percent to 135 percent of poverty, and persons with disabilities up to 120 percent of federal poverty. Currently, seniors are eligible up to 120 percent of poverty; persons with disabilities are not covered.
Missouri	Fiscal 2003 is the first year that new benefits under the Missouri Senior Rx Program are recommended for funding. The Governor's budget recommendations include \$75.8 million to implement this new program that helps low-income seniors pay for the cost of prescription drugs. Individuals with incomes below \$17,000 and couples with incomes below \$23,000 are eligible. After a deductible is met, the program pays for up to 60 percent of the cost of prescriptions.
South Dakota	The expansion of the RxAccess program to 19-60 year olds that meet criteria is proposed.

**TABLE 6 (continued)**

**Proposed Changes to Fiscal 2003 State-Funded Prescription Drug Programs (Non-Medicaid)**

*Region and State*

**SOUTHEAST**

Florida	The Governor's budget calls for a new program to provide prescription medications to Florida's elder population on Medicare. Low to moderate income elders in Florida have had difficulty obtaining prescription drugs since Medicare does not provide this benefit. In order to address this critical problem, President Bush's new budget includes a plan to provide states with federal matching funds to offer prescription drug coverage for elders. The federal government will pick up 90 percent of program costs for elders with incomes between 100 percent and 150 percent of the federal poverty level, and 58 percent of program costs (in Florida) for elders with incomes below 100 percent of federal poverty. If passed by Congress and the Florida Legislature, this new drug program will provide 245,000 Florida elders with a comprehensive prescription benefit at no cost to the participant.
Louisiana	Trying to slow the growth in drug costs by establishing a drug formulary to reduce costs and utilize less expensive drugs.
North Carolina	The Governor wants to utilize Health and Wellness trust fund dollars to pay for a prescription drug program for the elderly.
South Carolina	The state is seeking an 1115 waiver to provide pharmacy benefits to seniors up to 200 percent of poverty. The waiver would make it possible to expand the population currently served by the state-funded Silver Card program which is restricted to those up to 175 percent of poverty.

**FAR WEST**

California	In the Golden Bear State Pharmacy Assistance Program, funds from negotiated drug rebate contracts will be used to allow pharmacies to provide prescription drug discounts to Medicare beneficiaries.
Washington	Decrease employer costs for pharmacy benefits for state employees.