A National Challenge: How States Try to Control Medicaid Costs and Why It Is So Hard*

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Abstract:

The challenge of controlling Medicaid costs is at the forefront of every state's budget and policy discussions. For years states have implemented a range of Medicaid cost containment strategies. However, the combination of ongoing budget shortfalls and Medicaid enrollment growth leaves states looking for further cost containing measures. This brief discusses of the Medicaid program generally – what it is, whom it is for, and how Medicaid enrollment and expenditures continue to rise. It also provides an overview of cost containment measures adopted and implemented by states over the last two years, with particular attention to North Carolina. The conclusion presents a brief discussion of what states might expect in the years to come.

Many states entered FY 2005 faced with a mix of good and bad news. After three years of intense fiscal stress, most anticipated an improved revenue picture. At the same time, several factors continued to place pressure on states to contain Medicaid costs. This report is based on a 50-state survey of Medicaid administrators conducted in the summer of 2004 concerning their states' Medicaid spending growth and cost containment plans.

* Most of the material in this brief is taken directly or adapted from *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005* by Smith, V., et al. (October 2004). Additional material comes from the *Medicaid Program Overview* by the Fiscal Research Division, North Carolina General Assembly, March 2005. The brief was adapted to North Carolina from the Michigan Family Impact Seminar brief on the same topic by Jenni Owen, Center for Child and Family Policy, Duke University.

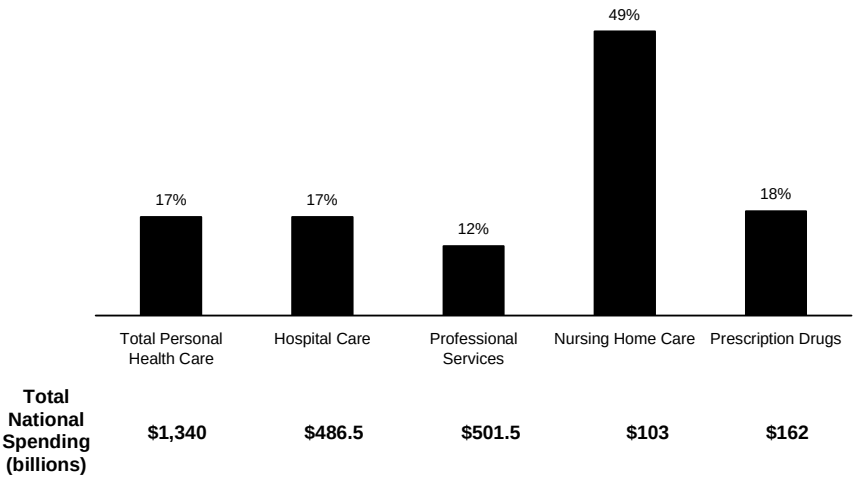
What Is Medicaid and What Role Does It Play in Our Health Care System?

Medicaid is a publicly funded health insurance program that provides coverage to low income children, families, seniors, and people with disabilities. Medicaid also fills gaps in Medicare coverage for many low income seniors, particularly for prescription drugs and long-term care. It is the largest publicly funded health insurance program providing health and long-term care coverage to 52 million low income children and adults in FY 2004, compared to 42 million covered by Medicare. Medicaid also supplements Medicare coverage for seven million low income seniors and people with disabilities enrolled in both programs. Medicaid covered 1.5 million North Carolina residents sometime during FY 2004. This is equivalent to 17.7% of the state's population.

As Figure 1 shows, Medicaid plays a major role in our nation's health care system, paying for nearly half of nursing home care and 18% of prescription drugs.

For FY 2005, Medicaid is 15.9% of the North Carolina General Fund operating budget. Ten years ago that number was 8.2%.

Figure 1: Medicaid's Role in the Health System, 2002



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

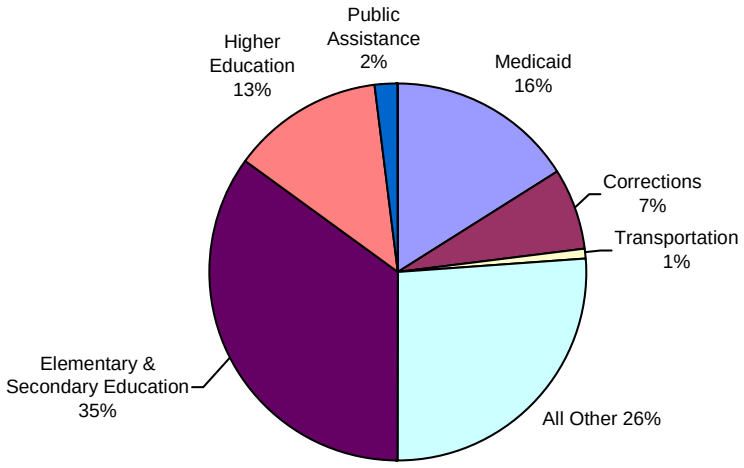
How Does Medicaid Work?

States must design and administer the program according to federal rules. Within the federal structure, states enroll beneficiaries using their own eligibility criteria, decide on some covered services, and set payment rates for providers. States decide key policies such as use of managed care systems. States also may provide coverage for optional services beyond the required core services (e.g., prescription drugs, nonemergency dental and vision coverage for adults). The federal government sets minimum requirements, authorizes deviations (waivers) from these requirements, and audits expenditures and performance.

Medicaid is jointly funded by states and the federal government with the federal government matching state spending on an open-ended basis. The federal match rate, known as the federal medical assistance percentage (FMAP), varies by state from 50 to 77%. North Carolina's FY 2005 FMAP is 63.63%. In 2006 it will be 63.49%. This is lower than the 65.8 matching rate that the state received under Federal Fiscal Relief, which ended on June 30, 2004. (See more in "The Expiration of Federal Fiscal Relief section.")

Because of the matching formula, state spending brings increased federal dollars into the state, providing an incentive for states to increase funding for health and long-term care services. On average, states spend about 16% of their state budgets on Medicaid, making it the second largest program in most state budgets, after education (see Figure 2). For FY 2005 Medicaid is 15.9% of the North Carolina General Fund operating budget. Ten years ago that number was 8.2% (see Figure 3).

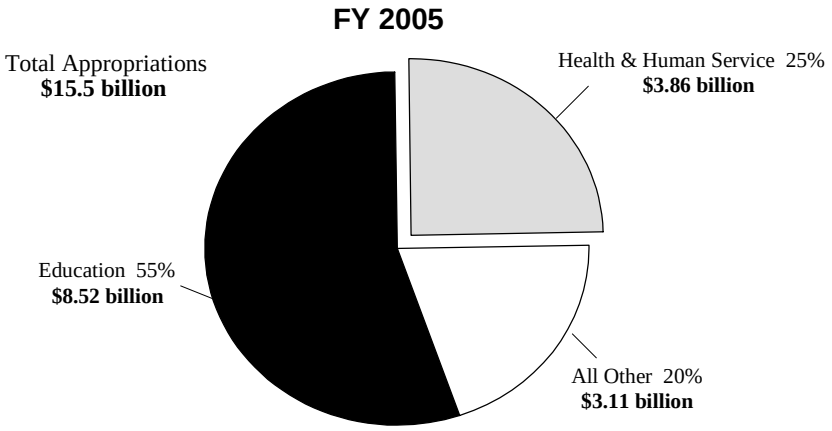
Figure 2: State Medicaid Spending as a Percent of General Fund Expenditures, 2002



Total State General Fund Spending = $496 billion

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

Figure 3: Medicaid Program
HHS Share of General Fund Appropriations



Fiscal Research Division 2/05 *Source: NC General Fund Operating Appropriations SFY 2005*

Where Does Most Medicaid Spending Go?

Medicaid expenditures vary for the different populations served. Although low income children and families represent about three fourths of Medicaid beneficiaries, they account for only one third of the expenditures (see Figure 4). On the other hand, elderly and disabled individuals who represent just one quarter of the beneficiaries, account for 70% of the expenditures, reflecting their intensive use of acute and long-term care services.

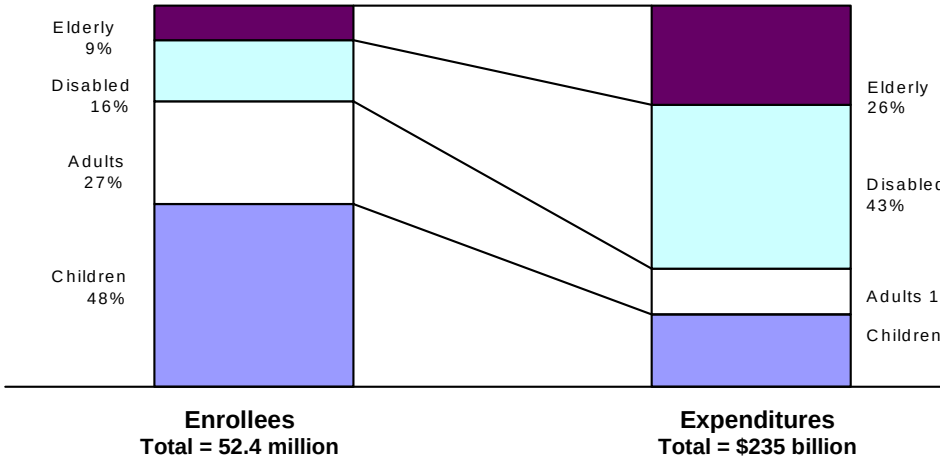
The same is true in North Carolina. In FY 2004, children and families represented 69.7% of the Medicaid recipients while accounting for only 31% of the expenditures. Elderly and disabled recipients combined accounted for 26.3% of the recipients and 68.3% of expenditures for Medicaid.

What Are the Trends in Medicaid Expenditures?

In FY 2004, total Medicaid spending for the U.S. increased an average of 9.5%.[1] Figure 6 shows this increase is slightly more than 2003, but lower than the average annual growth rate of 11.9% that occurred over the 2000-2002 period.

State administrators cite several key factors as top drivers of Medicaid spending growth in FY 2004. The most frequently mentioned factors include:

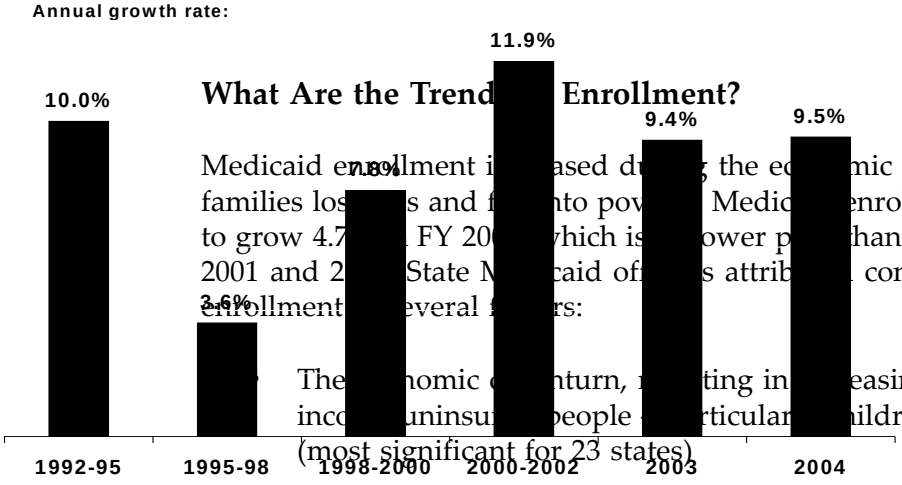
Figure 4: Medicaid Enrollees and Expenditures b Enrollment Group, 2003



Expenditure distribution based on Congressional Budget Office (CBO) data that includes only federal spending on services and excludes DSH (disproportionate share hospital), supplemental provider payments, vaccines for children, administration, and the temporary FMAP (federal medical assistance percentage) increase. Total expenditures assume a state share of 43% of total program spending. SOURCE: Kaiser Commission estimates based on CBO and Office of Management and Budget data, 2004.

- Medicaid enrollment growth
- Increasing costs of prescription drugs
- Rising costs of medical care
- Rising costs of long-term care

Figure 6: Average Annual Growth Rates of Total Medicaid Spending



SOURCE: For 1992-2002: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64); For 2003 and 2004: Health Management Associates estimates based on information provided by state officials.

What Are the Trends in Enrollment?

Medicaid enrollment increased during the economic downturn as more families lost jobs and fell into poverty. Medicaid enrollment is projected to grow 4.7% in FY 2004, which is a lower pace than was seen between 2001 and 2003. State Medicaid officials attribute continued growth in enrollment to several factors:

- The economic downturn, resulting in increasing numbers of low income uninsured people, particularly children and families (most significant for 23 states)
- The effect of eligibility expansions or restorations (ten states)
- Increased numbers of eligible elderly and disabled because of demographic changes (three states)
- Outreach for programs such as the State Children's Health Insurance Program or food stamps, which identify additional persons eligible for Medicaid (three states)

According to North Carolina officials, the key factors in enrollment growth in FY 2005 were the economy and overall population growth.

What Is the Current Revenue Picture?

Since 2001, as the national economy worsened and state revenues slowed, states have been forced to cut back on state programs. They have had to make difficult choices affecting health coverage for millions of low income people across the country.

In FY 2005, revenue has been growing and is expected to continue. However, many individual states, including North Carolina, are experiencing large budget shortfalls while Medicaid costs continue to increase. Additionally, the temporary fiscal relief to states provided by the federal government through the Jobs Growth and Tax Reconciliation Act of 2003 has ended, significantly increasing the state share of Medicaid expenses. Anticipated gaps between revenue and expenditure growth will exert enormous pressures on states to reduce or control costs.

North Carolina officials cited prescribed drugs, physician fees, and inpatient hospital and mental health clinics as key factors contributing to overall spending growth in FY 2004. For FY 2005, they cited increases in the consumption rate, eligibles, and cost per unit of services as the most significant factors.

What Strategies Are States Using to Contain Costs?

FY 2005 is the fourth consecutive year that states have implemented significant cost containment initiatives, although a few states also are adopting modest benefit or eligibility expansions. Most states are implementing not just single cost containment measures, but a more comprehensive set of strategies, including:

- Reducing or freezing provider payments
- Controlling pharmacy costs
- Reducing benefits
- Reducing or restricting eligibility
- Increasing copayments
- Implementing disease management programs
- Implementing cost controls for long-term care
- Targeting fraud and abuse

North Carolina was the only state in 2004 to report plans for using each of the above eight strategies. In 2005, the state reported plans to use four of them: pharmacy controls, disease management/case management, targeting of fraud and abuse, and long-term care cost controls.

Note: Not reporting a strategy for a particular year does not mean the strategy is not in use in the state responding, but that the state has not implemented a new component of that strategy in the year in question. 2004 and 2005 are reported here.

The following sections discuss the range of approaches states are taking in using these strategies.

Strategy 1: Reduce or Freeze Provider Payments

Medicaid rates for payments to providers are generally the lowest of any payer, sometimes below the cost for delivering care. Payment reductions or freezes (which amount to reductions because of cost inflation) can have an impact on the availability of providers who will accept Medicaid and may impact access to care. Some, but not all patients could identify alternative sources of care such as community-based care. Still, when faced with increasing fiscal pressures, many states used this strategy.

Medicaid rates for payments to providers are generally the lowest of any payer, sometimes below the cost for delivering care.

- In FY 2004, all 50 states and the District of Columbia cut or froze payment rates to at least one provider group; 47 states said they would do so in FY 2005.
- States were most likely to cut reimbursement rates for physicians (42 states for 2004 and 33 for 2005).
- Cutting reimbursement rates to hospitals and nursing homes or managed care organizations is more difficult because state statutes regulate reimbursement rates. Nevertheless, a number of states froze rates for one or more of these groups for 2004 or 2005.

North Carolina attempted to freeze some provider payments for FY 2004 by eliminating inflationary increases. The state did not implement reductions or freezes to provider payments in FY 2005.

Strategy 2: Control Pharmacy Costs

States continued to focus significant attention on controlling the cost of prescription drugs, which have been growing at double digit rates for several years. Cost containment strategies were implemented by 47 states and the District of Columbia in FY 2004 and by 43 states in FY 2005 (see Figure 7 drug cost reduction strategies).

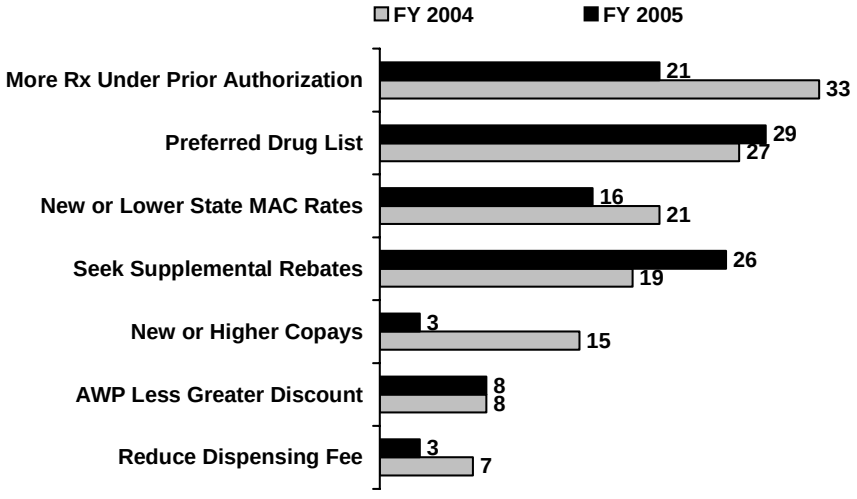
For 2005, the most frequently used strategies included:

- Implementing preferred drug lists (29 states)
- Seeking supplemental rebates (26 states)
- Placing more drugs under prior authorization (21 states)
- Paying a larger discount off of the Average Wholesale Price (AWP) for drugs (eight states)

For FY 2005 only three states adopted new or higher patient copayments; in FY 2004 15 states had done so. Given that Medicaid rules limit patient copayments to a nominal amount (generally $3 per service), this drop may be explained by the fact that many states already reached the upper limit of pharmacy copayments and therefore could not increase them any more.

In FY 2003-04 North Carolina implemented a cost avoidance model for pharmacy claims. Specifically, if a Medicaid recipient has a known third party insurer, the pharmacist must bill that third insurer first. (Having a third party insurer does not preclude Medicaid eligibility.) The North Carolina General Assembly took budget reductions during the 2003 session that were called Drug Utilization Management ($26 million in 2003-04 and $36 million in 2004-05).

Figure 7: Medicaid Prescription Drug Policy Changes FY 2004 and FY 2005



SOURCE: Kaiser Commission on Medicaid and the Uninsured survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2004.

Strategy 3: Reduce Covered Benefits

In FY 2005, fewer states are cutting benefits and more are restoring benefits cut in previous years:

- Only nine states cut benefits in 2005, compared to 19 in 2004
- 14 states intended to restore or expand benefits cut in previous years

In general, benefit cuts involved optional services, particularly those extended to adults, including elderly and disabled persons. Services that were cut included:

- Dental, vision and hearing services for adults
- Chiropractic and podiatry services
- Psychological services
- Physical and occupational therapy
- Personal care services

North Carolina limited personal care services (PCS) to 3.5 hours per day up to a maximum of 60 hours per month for children, parents/adults, the disabled, and aged.

States either eliminated these services entirely or limited the amount of services covered.

In FY 2004, North Carolina limited personal care services (PCS) to 3.5 hours per day up to a maximum of 60 hours per month for children, parents/adults, the disabled, and aged. For the same groups, the state implemented:

- Coverage for certain over-the-counter drugs
- Medical necessity criteria for some recipients to receive 20 hours over the 60-hour limit on personal care services
- Expanded treatment options for age related macular degeneration
- Coverage to promote healing of nonunion fractures (osteogenic stimulators)

North Carolina has cut weight loss and weight gain drugs from 2005 coverage. The state has expanded coverage to include prosthetics and orthotics for adults over age 21. It has also expanded coverage to independent practitioners who serve the mental health population.

Strategy 4: Reduce or Restrict Eligibility

Reducing eligibility for Medicaid is often difficult for states to implement because these reductions affect vulnerable populations who usually have no other access to health insurance. During the recent economic downturn, however, 38 states reduced or restricted Medicaid eligibility over a four-year period (2002-2005). On the other hand, for 2004 and 2005 several states expanded coverage to previously excluded groups, such as the working disabled, people under family planning waivers, or uninsured women with breast or cervical cancers.

Eligibility changes fell into three categories discussed separately below: eligibility rule changes; application and renewal process changes; and premium changes.

Changes to Eligibility Rules

In order to receive the enhanced federal match authorized by the Jobs Growth and Reconciliation Act of 2003, states were required to maintain eligibility through June 2004 at the levels in effect on September 2, 2003. No states made reductions that affected the Medicaid matching rate in 2004. Although fewer states are implementing reductions in 2005, the changes will affect a larger number of people. States planned a variety of eligibility changes such as:

- Eliminating coverage for specific populations [e.g., medically needy adults with incomes above the TANF (Temporary Assistance for Needy Families) level] (two states in FY 2004; three states in FY 2005)
- Eliminating continuous eligibility (two states in 2004)
- Increasing the spenddown threshold level for the aged, blind, and disabled [amount of their own money] they must spend before becoming eligible for Medicaid (one state in 2004)
- Reducing the income eligibility limit for certain groups [e.g, pregnant women with incomes between 200% and 235% of the federal poverty level; aged and disabled persons with incomes between 100% and 133% of the federal poverty level] (six states in 2004; three states in 2005)

At the same time, some states expanded eligibility to previously uncovered groups by:

- Increasing the income eligibility level for aged and disabled individuals (one state in 2004; two states in 2005)
- Eliminating TANF work requirements in determining eligibility for Medicaid (one state in 2004)

- Enabling disabled workers to buy in to Medicaid coverage (two states in 2004)

If a Medicaid applicant or recipient disposes of assets for less than fair value, he or she may be penalized by becoming ineligible for Medicaid long-term care assistance for a period of time. North Carolina extended the application of its transfer of assets policies to recipients receiving in-home personal care services as well as those who reside in a nursing home or other medical institutions. The North Carolina General Assembly did not enact any changes to eligibility requirements for 2005.

Changes to Application and Renewal Processes
Through the late 1990s and into 2001, states had adopted measures designed to simplify and streamline Medicaid application and redetermination procedures. In the face of budget difficulties, some states have reversed this process (ten states in 2004 and four in 2005). Major changes included:

- Instituting more frequent periods for reverification of eligibility
- Eliminating continuous eligibility for certain groups (i.e., requiring periodic reverification of eligibility)
- Eliminating policies that allow for self-declaration of income, in effect increasing the amount of required documentation

North Carolina did not make changes to the application and renewal processes for 2005.

Premium Changes
In a limited number of situations, states can require premiums as a condition of coverage. In 2004 and 2005 a few states implemented premium changes, including:

- Increased premiums for parents and children covered under expansion waivers (Massachusetts and Vermont)
- New or higher premiums for disabled workers (Iowa, Louisiana, Minnesota, and Nevada)
- New premiums on certain disabled children covered under the Katie Beckett[2] rules (Maine)

North Carolina does not impose premiums on recipients.

Strategy 5: Increase or Implement Copayments

When imposing patient copayments, states must comply with the federal Medicaid law. It specifies that payments must be nominal — generally defined as $3 or less per service – and cannot apply to certain services, or certain eligibility groups, such as children or pregnant women. Over the past several years, states have relied more on copayments as part of their cost containment strategies, although a substantial body of research indicates that even nominal copayments can deter low income individuals from receiving needed care (Hudman & O'Malley, p 30).

In FY 2004, 20 states imposed new or higher copayments; nine states did so in FY 2003. The most frequent copayment imposed was for prescription drugs (discussed under containing drug costs). A few states increased copayments for:

- Hospital inpatient and outpatient visits
- Nonemergency use of emergency rooms
- Hearing, vision, dental, and therapy services
- Physician office visits
- Ambulatory services
- Home health

North Carolina did not implement new or increased copayments for 2004 or for 2005.

Strategy 6: Implement Disease and Case Management Programs

An increasing number of states are turning to disease and case management initiatives to help contain costs. Between 2002 and 2004, 42 states began programs. These initiatives are seen as a relatively low cost way to improve health care for people with chronic and disabling conditions, including many adult Medicaid beneficiaries. Quality results from these programs are promising but not conclusive because there are several barriers: 1) participation is voluntary; 2) turnover is high among enrollees; and 3) payment rates to providers are low (Williams, 2004). In a recent health benefits survey of employers (Kaiser Family Foundation, 2004), 15% of firms responded that disease management strategies were very effective in containing costs.

The trend among states is clearly toward more comprehensive care management programs. States have initiated programs to manage asthma, diabetes, hypertension, depression, congestive heart failure, mental and behavioral health, and obesity. In the future, states may have a more difficult time implementing care management programs

because persons eligible for both Medicaid and Medicare will be moving their drug coverage to Medicare.

North Carolina expanded its disease management initiatives to more counties in FY 2004 and 2005 and added conditions such as asthma, diabetes, and congestive heart failure to the included diseases. In addition, in FY 2004 North Carolina expanded the Community Care of North Carolina (CCNC) program in which local networks of primary care providers and public and private community institutions coordinate prevention, treatment, referral, and other services for Medicaid recipients. The program slows the rate at which Medicaid costs would increase through implementation of care management, adoption of best practices, and local providers' accountability to reduce service duplication and fragmentation.[3]

Strategy 7: Implement Cost Controls on Long-term Care and Home- and Community-based Services

Although long-term care represents over one third of Medicaid spending, states did not initially adopt cost containment strategies in this area. However, as other methods of controlling costs have been exhausted, states are beginning to focus on long-term care. Cost containment strategies include:

- Reducing the number of nursing home beds
- Reducing the number of days for which Medicaid will pay a nursing home when the resident is in the hospital
- Reducing payments to nursing homes when a bed is held for a resident who is temporarily away from the facility for a number of days, e.g., visiting for a holiday
- Tightening eligibility criteria
- Downsizing the capacity of intermediate care facilities for the mentally retarded
- Changing formulas for nursing home reimbursement

In the past two years, some states have implemented cost controls on home- and community-based services (HCBS), which are services provided to frail elderly and disabled persons in their own homes to prevent or delay their need for institutional care. Some states have limited the number of available Medicaid waiver slots for HCBS, thus reversing a trend of the past five years when states expanded access to community-based support services in response to the U.S. Supreme Court decision in Olmstead vs. L.C. (June 1999). This decision found that the unjustified institutionalization of people with disabilities is a violation of the Americans with Disabilities Act.

Other cost cutting measures in HCBS included:

- Limiting hours authorized for specific instrumental activities of daily living
- Restricting private duty nursing hours
- Reducing the allowable budget for high cost cases
- Implementing utilization review procedures

For North Carolina's related activity in this area, see mention above of personal care services and subsequent brief by Brian Burwell entitled "State Experiences with Managed Long-term Care in Medicaid."

Strategy 8: Target Fraud and Abuse

Program Integrity (PI) has reduced by 51% the number of days needed by the PI nurses to investigate and close a case.

Many states enhanced ongoing activities or started new activities designed to control fraud and abuse. In some cases these actions were tied to new management information systems, additional staff or an increased number of provider audits. Activities included locking in high use recipients to a single doctor, establishment of a new fraud unit within the state Office of Inspector General, and a greater focus on third party liability recoveries. Between 2002 and 2005, 32 states have put in place new fraud and abuse mechanisms.

North Carolina has implemented new activities designed to control fraud and abuse. Recently, new fraud and abuse detection software (FADS) was added, which has improved performance. Program Integrity (PI) has reduced by 51% the number of days needed by the PI nurses to investigate and close a case, and the average recovered per case of fraud and abuse has increased.

As states moved into FY 2005 with a somewhat improved economic picture, several factors presented new challenges. Following are three of the factors for 2005 and 2006 that will impact states' ability to further contain Medicaid spending growth.

The Expiration of Federal Fiscal Relief

Temporary federal relief that assisted states in 2003 and 2004 has come to an end, vastly increasing the state burden of Medicaid costs. The Jobs Growth Tax Relief Reconciliation Act of 2003 provided states with an enhanced federal match rate (FMAP) for Medicaid expenditures. The enhanced FMAP enabled 36 states to resolve Medicaid shortfalls and helped 31 states avoid, minimize, or postpone Medicaid cuts or freezes. With the expiration of the enhanced FMAP, state spending on Medicaid has grown enormously in FY 2005. Legislatures have authorized an average annual Medicaid growth rate in state general funds of 11.7% for

FY 2005, compared to 4.8% growth in FY 2004. A number of state administrators commented on the fiscal hardship this will impose. However, officials in 20 states indicated that the expiration of the enhanced FMAP had been anticipated and the impact minimized. As noted above, North Carolina's FMAP declined from 2004-2005 and will decline slightly further in 2006.

Increased Scrutiny of Special Financing Arrangements

As states have struggled in recent years to deal with Medicaid shortfalls without undermining essential services to vulnerable populations, some have turned to special financing arrangements to maximize the amount of federal money flowing to states. These arrangements include the use of funds from other governmental units (Intergovernmental Transfers, or IGTs) and/or provider taxes to make up the nonfederal share of Disproportionate Share Hospital (DSH) payments[4] or Upper Payment Limit (UPL) reimbursements. At the same time, the federal Centers for Medicare and Medicaid Services (CMS) has increased its scrutiny of these arrangements, often through the Medicaid State Plan amendment approval process. States that have relied heavily on these special financing arrangements report that the increased scrutiny will have a big impact on their state Medicaid financing.

North Carolina officials, like officials in many other states, cited increased scrutiny of special financing arrangements as a key factor driving Medicaid spending growth in the state. States and the Center for Medicaid Services are engaged in discussions about this issue.

Implementation of the Medicare Prescription Drug Benefit

Implementation of the new Medicare Part D drug benefit that is scheduled to take effect January 1, 2006 has provoked some concern among states regarding people who are eligible for both Medicare and Medicaid (dual eligibles). These concerns apply to all states.

- The greatest concern is about the "clawback" provision of the Medicare law that will require states to make payments to the federal government to help finance the drug benefit for those with dual eligibility.
- Proposed regulations raised the possibility that states may be responsible for enrolling over six million individuals with dual eligibility in the Medicare Part D drug plan. In addition, states were concerned that the Medicare drug plans will not cover all the medications now covered under Medicaid.
- States were also concerned that costs would increase because of a "woodwork effect," as more Medicare beneficiaries discover they

are eligible for Medicaid when they apply for the subsidies available to persons with low incomes.

Only three states (California, New York, and Rhode Island) reported receiving additional administrative resources for FY 2005 to prepare for the implementation of the Part D Medicare benefit. However, all states will be expected to begin determining eligibility for Part D low income subsidies beginning in July 2005 and must marshal the needed resources to accomplish this task.

What Is the Outlook for 2005 and Beyond?

All states will be expected to begin determining eligibility for Part D low income subsidies beginning in July 2005.

Medicaid played a critical safety net role for many vulnerable individuals during the recent economic downturn. The current financing structure of the program, with federal matching dollars and guaranteed eligibility for those who qualify, allowed Medicaid to play this critical role. The challenges discussed above, however, combined with trends of increasing poverty and eroding private insurance will continue to put pressure on Medicaid enrollment and spending growth. States are responding in different ways to these trends:

- Some states are seeking to control costs through Section 1115 waivers, which give them the flexibility to implement enrollment caps and benefit reductions
- Several states have begun to view Medicaid as an effective means to address the issue of the uninsured and to expand coverage

The recent period of fiscal stress has regenerated interest on the state and federal levels in restructuring federal Medicaid law. A major issue is the way the program is financed and the relative role of states and the federal government. The direction this discussion takes will have significant implications for state budgets, program beneficiaries, and the ability of the program to serve as part of the safety net for vulnerable populations.

The Impact of Cost Containment Strategies on Families

Changes to Medicaid naturally affect people other than the individual recipients for whom the changes address. Family members experience the impacts of changes whether related to eligibility expansion or reduction, the requirement of prior authorization for prescription drugs, allowable costs for nursing home care, and the many other dynamic aspects of Medicaid law and policy. As policymakers continue to grapple with containing Medicaid costs, it is important to remain vigilant to the many ways in which potential and actual cost containment measures will impact families.

For more detailed information on the survey on which this brief was based, see the complete report:

Smith, V., et al. (October 2004). *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured. Available online at www.kff.org/medicaid/7190.cfm.[5]

Endnotes

[1] Total Medicaid spending reflects actual payments to medical providers for services rendered to beneficiaries. It includes special payments to providers, such as Disproportionate Share Hospital (DSH) payments but does not include Medicaid administrative costs. (See glossary for definition of DSH payments.)

[2] Rules that allow states to cover certain disabled children under 19 if the child meets SSI standards for disability, would be eligible for Medicaid if in an institution, and receiving home medical care that would be provided in an institution.

[3] North Carolina General Assembly Fiscal Research staff presentation, March 2005.

[4] DSH funds are provided to hospitals that serve a disproportionate share of uninsured patients.

[5] Additional references include:

1. Hudman, J. & O'Malley, M. (2004, March). Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low income Populations. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

2. Kaiser Family Foundation and Health Research and Education Trust. (2004). *Employer Health Benefits 2004 Annual Survey.* Washington, DC: The Kaiser Family Foundation. www.kff.org/insurance/7148/index.cfm.

3. Williams, C. (September 2004). *Medicaid Disease Management: Issues and Promises.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.