AHA Advancing Health in America

TRENDWATCH

The Medicaid Dilemma: Shrinking Budgets, Difficult Choices — *June 2003, Vol. 5, No. 2*

States currently are grappling with their worst budget crises since World War II. Over the last three years, states have had to close budget gaps approaching $200 billion.[1] For fiscal year 2003, state budget gaps averaged 5.2 percent.[2] National manufacturing and stock market declines, the economic impact of terrorism, and a recession have contributed to a sharp decline in tax revenues. At the beginning of the year, every state except three — Arkansas, New Mexico, and Wyoming — was reporting a budget shortfall for 2004[3] and economists expect deficits to continue for the foreseeable future. As tax revenues have fallen, balanced budget mandates in every state but Vermont have forced states to cut spending.

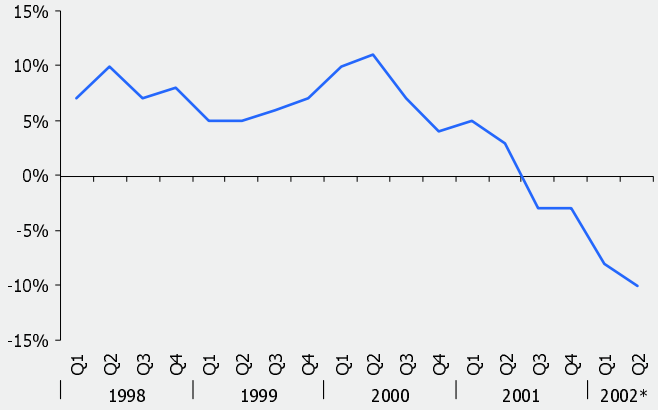
Medicaid is a prime target for budget cuts. Between 1990 and 2002, state Medicaid spending (excluding the federal match) grew from $32 billion to $108 billion.[4] The program now accounts for 15 percent of total state spending — second in size only to education.[5] Yet, while Medicaid spending rose $7 billion more than projected, this growth contributed less to state budget deficits in FY 2002 than the $62 billion unexpected shortfall in revenue collections.[6] The revenue picture, however, is unlikely to change in the short run — pushing nearly every state to take steps to contain Medicaid costs.

In FY 2003, Medicaid spending was estimated at $286 billion from all funding sources — more than Medicare at $279 billion — with about 57 percent funded by the federal government.[7] According to the Congressional Budget Office, Medicaid spending is projected to grow about nine percent annually for the remainder of the decade.

This issue of TrendWatch provides a brief overview of the Medicaid program and considers the difficult choices states are making in response to the state budget crisis (see State Medicaid Facts Appendix). It examines the effects of these choices on Medicaid eligibility, benefits, and provider payment.

As state tax revenues plummet...

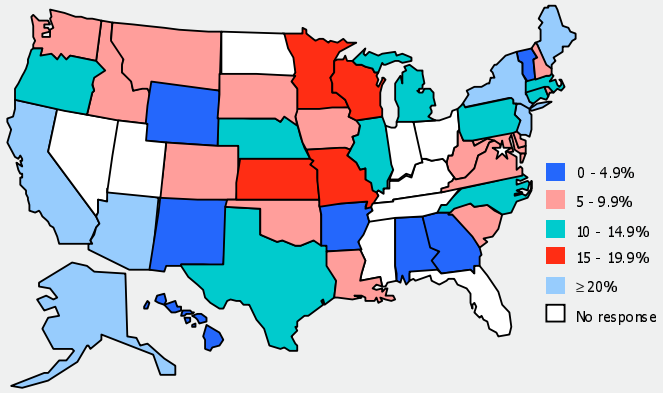
Chart 1: Change in Quarterly State Tax Revenues, 1998 – 2002



*Data for 2002 preliminary

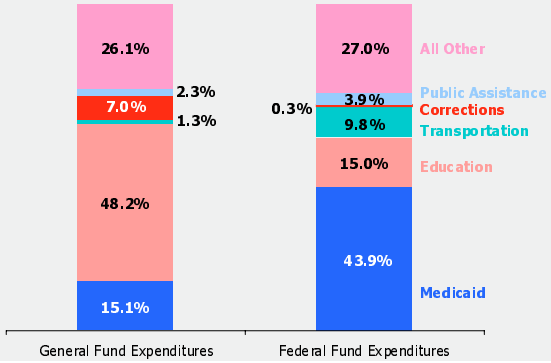
...and budget deficits grow...

Chart 2: FY 2004 Deficit as a Percent of FY 2003 State Budget, Ranges by State, FY 2004



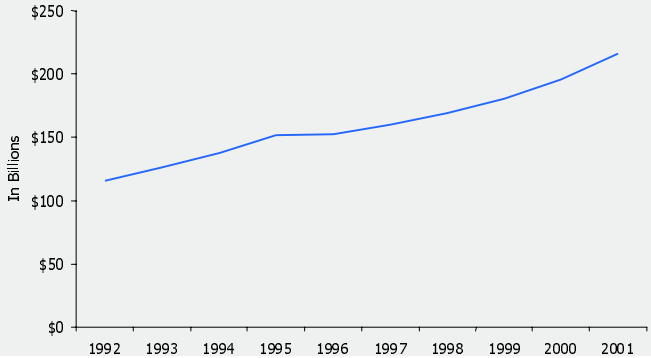
...states are looking to curb expenditures on Medicaid, a large...

Chart 3: Percent of Aggregate State Spending by Category, State General Fund and Federal Funds Provided to States, FY 2001



...and growing component of government spending.

Chart 4: Total (State and Federal) Medicaid Spending, 1992 – 2001

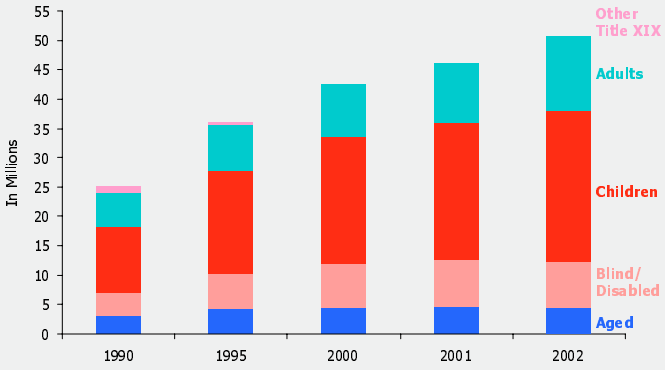


The Lewin Group

Medicaid provides health care coverage for the nation's most vulnerable citizens...

Enrollment in Medicaid has been growing steadily...

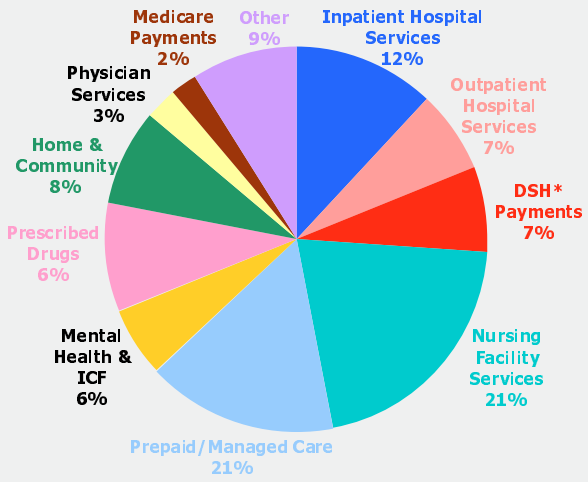
Chart 5: Medicaid Enrollees by Type, 1990 – 2002



S-CHIP not included

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

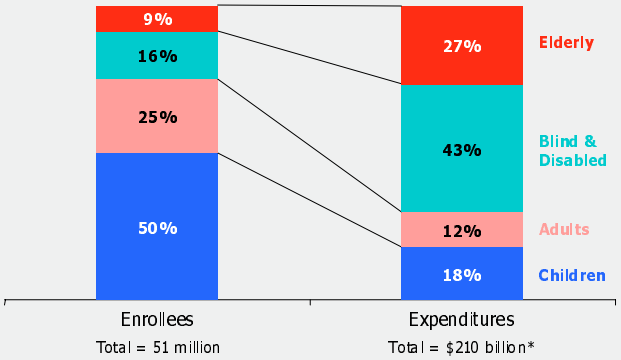
Chart 6: Medicaid Spending by Service, 2001



**Payments to hospitals serving a disproportionate share of low-income patients*

...for the elderly and disabled.

Chart 7: Medicaid Enrollees and Expenditures by Enrollment Group, 2002



**Expenditures on services based on historical state share data.*

In 2002, Medicaid covered 51 million individuals, overtaking Medicare as the nation's largest public insurance program, both in terms of beneficiaries and spending.[1] Medicaid accounts for 17 percent of total personal health care spending in the U.S.[2] and 13 percent of all hospital care,[3] and thus it is an important revenue source for hospitals, clinics, and other providers.

Over time, Medicaid has become a preferred vehicle to fill gaps in health insurance coverage for certain vulnerable populations. As a core component of the nation's health care safety net, Medicaid provides health insurance for over a quarter of all children (the State Children's Health Insurance Program [S-CHIP] enrolled more than 5.3 million additional children in 2002),[4] covers approximately one-third of all births, and finances half of all public mental health care and half of all HIV/AIDS care.[5] Medicaid is also the largest purchaser of prescription drugs and long-term care.

As a means-tested entitlement program, Medicaid covers three main low-income populations that meet the financial criteria for coverage: parents and children, elderly, and individuals with disabilities. Low-income children and their parents make up 75 percent of Medicaid beneficiaries, but they account for just 30 percent of total Medicaid spending. In contrast, the elderly and disabled comprise only a quarter of beneficiaries but account for approximately 70 percent of spending.[6]

More than six million "dual eligibles" — low-income seniors and disabled individuals who are also covered by Medicare — account for more than a third of Medicaid spending.[7] For this population, Medicaid pays Medicare Part B premiums and, for the poorest dual eligibles, it covers other services not covered by Medicare such as prescription drugs and long-term care.

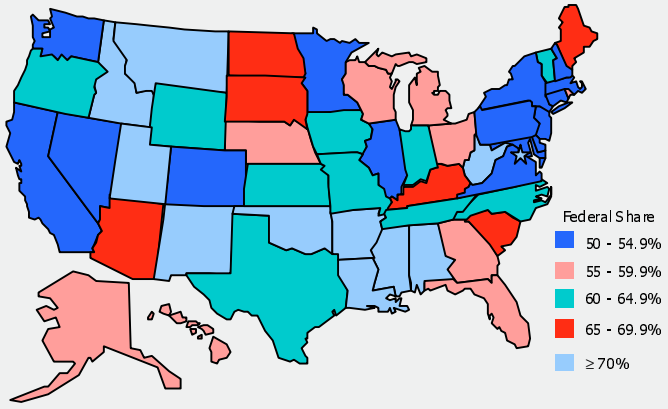
Recently, Medicaid costs have been growing rapidly; program spending grew by 13 percent in 2002.[8] Key drivers of growth include increased caseloads — due to eligibility expansions and outreach efforts — and the rising costs of long-term care and prescription drugs.

Starting in the 1980s, states adopted managed care — primary care case management (PCCM) and risk contracts with health plans — to stem cost growth and improve quality management. These programs now account for over 50 percent of beneficiaries nationwide, though penetration varies considerably by state.[9]

...through a federal-state partnership.

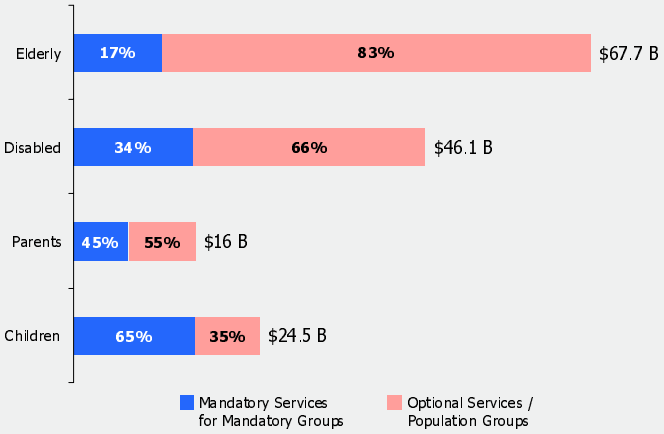
The federal government provides support for Medicaid programs through the federal match which varies across states.

Chart 8: Federal Medical Assistance Percentage (FMAP) Ranges by State, FY 2003



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

Chart 9: Distribution of Medicaid Mandatory and Optional Spending, 1998



While the federal government solely funds and administers Medicare, the federal government and states jointly finance Medicaid and the states administer it.

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

State Medicaid agencies manage enrollment, design benefits, and set and make provider payments. States have the discretion to cover optional groups and benefits. Federal waivers give states added flexibility to provide services to other groups.

There are few federal rules governing how — and how much — states pay providers. As a result, Medicaid payments vary greatly across states. Since the repeal of the Boren amendment, state requirements for hospitals are limited to implementing a public rate-setting process, assuring beneficiary access comparable to the private sector, and ensuring payments do not exceed those under Medicare — its upper payment limit (UPL).

Federal law does require that states consider the special circumstances of hospitals serving a disproportionate share (DSH) of low-income patients when setting hospital payment rates. State DSH programs vary, with some linking payments to provider taxes or intergovernmental transfer payments. Over the past decade, various federal laws have imposed limits on state DSH programs. State DSH allotments for FY 2003 were reduced by an estimated $1.1 billion.

Medicaid Eligibility Groups

Mandatory Groups

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

Optional Groups

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

FPL = Federal Poverty Level

Source: CMS

Budget deficits are forcing some state Medicaid programs to consider options…

State Medicaid agencies face tight fiscal constraints. Sharp declines in tax revenues are challenging states to fund their share of Medicaid at the same time that Medicaid costs are rising and enrollment levels are expanding. During the mid-1990s, with budget surpluses and federal encouragement to use Medicaid expansions to reduce the number of uninsured persons, many states expanded enrollment. Now, enrollment growth is being fueled by rising unemployment and a shaky economic recovery.

To address this challenge, state Medicaid programs are using or considering a number of strategies to control costs and maintain program viability. The goal is to craft a budget strategy that enables continued service to Medicaid beneficiaries without compromising quality of care, but choices are difficult. Each choice represents trade-offs between types of beneficiaries, the scope of services covered, or payments to providers. State decisions hold the potential for unintended consequences for low-income populations, providers, the state economy, and/or the private health insurance market.

At the same time, new federal law provides much needed fiscal relief to states. $10 billion is slated to give each state a 2.95 percentage point increase in its FMAP for 15 months (April 2003 through June 2004). States, however, cannot reduce eligibility levels below those in effect as of September 2, 2003. In addition, another $10 billion is set aside for federal grants to states — not specific to Medicaid — for FY 2003 and FY 2004.

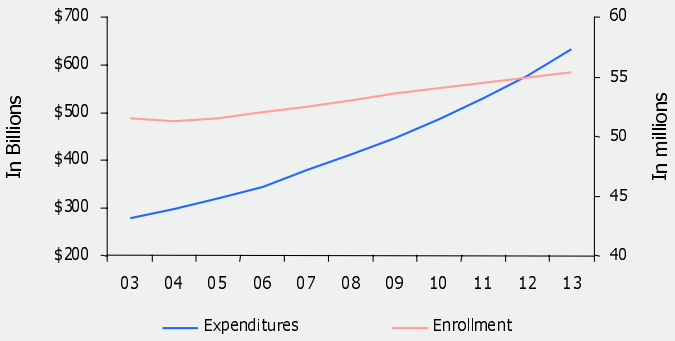
States consider a variety of options when crafting their Medicaid budget strategies.

Chart 10: State Medicaid Budget Options, 2002

Options	Examples
Maximize federal contribution	• Incorporating services formerly funded with state-only dollars into the state's Medicaid benefit package • Increasing provider reimbursement to state and local government-owned providers, e.g., DSH payments or Upper Payment Limit (UPL) approaches • Increasing FMAP funds
Increase revenue	• Increasing tobacco tax and applying towards Medicaid • Collecting revenue from Medicaid providers or beneficiaries
Reduce benefits	• Choosing not to provide certain optional benefits or placing restrictions on them • Obtaining waivers
Reduce eligibility	• Eliminating optional eligibles • Canceling planned expansions • Toughening the eligibility process • Eliminating outreach efforts • Eliminating presumptive eligibility • Obtaining waivers
Manage utilization	• Focusing on the management of high-cost, fast-growing services, e.g., prescription drugs • Increasing premiums and co-payments • Implementing managed care • Controlling fraud and abuse
Reduce provider payments	• Reducing rates (e.g., APCs for outpatient care) for certain services or providers • Delaying or eliminating payment increases • Using selective contracting or volume discounts • Eliminating special treatment of certain provider types (e.g., rural hospitals) • Changing payment structure
Impose provider tax	• Establishing provider assessments to obtain federal match

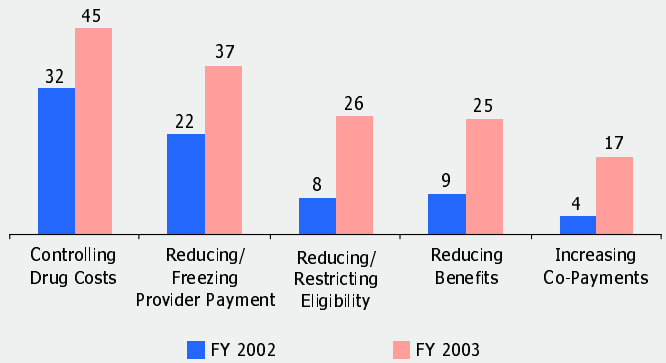
With increases in Medicaid enrollment and expenditures on the horizon…

Chart 11: Projections of Future Enrollment Growth and Spending, 2003 – 2009



…nearly all states took steps to contain costs in FY 2003.

Chart 12: States Undertaking Medicaid Cost Containment Strategies, FY 2002 and 2003



...and make progressively harder choices.

When faced with a budget crisis, states may initially look to draw down reserve fund balances or shift more Medicaid costs to the federal government before cutting benefits or eligibility. Over the last decade, though, federal laws have limited the availability of federal Medicaid dollars going to state DSH programs as well as imposed restrictions on how states structure their use of UPL to maximize federal matching dollars. States may look for new sources of revenues, such as "sin" taxes or tobacco settlement funds, though these funds may only provide a short-term fix that fails to address long run fiscal problems.

States may then decide to reduce payments to hospitals and other providers or eliminate planned payment increases in order to reduce Medicaid spending. However, rate cuts are very unpopular, because in many areas, providers already are paid less than costs of care for Medicaid patients. States may also try to manage utilization through managed care or by controlling use of certain high-cost and fast-growing services.

The choices of last resort usually are cutting covered benefits and limiting eligibility. Federal Medicaid rules require that states provide optional benefits, such as pharmaceuticals, to beneficiaries in both mandatory and optional groups. Thus, states limiting optional benefits must do so by restricting certain benefits for everyone or by cutting benefits entirely. State Medicaid agencies may increase income eligibility limits, or reduce the use of strategies that encourage persons to apply for Medicaid, such as granting presumptive eligibility.

Florida exercised other options before cutting benefits and eligibility.

Chart 13: Medicaid Cost Containment Strategies in Florida

State Fiscal Year 00-01

Utilization Management: Pharmacy Controls

- Established a Preferred Drug List (PDL) with prior authorization required for non-listed drugs
- Required supplemental rebates from manufacturers that want brand drugs on PDL

State Fiscal Year 01-02

Utilization Management

- Established prior authorization requirement for some services

Provider Payment Changes

- Altered methods for setting reimbursement rates
- Limited Medicaid provider payments for dual eligibles
- Temporarily reduced hospital reimbursement rates by 6% (but enhanced "special Medicaid payments" to hospitals that allowed additional hospital payments under UPL programs and compensated for reductions in DSH program)

State Fiscal Year 02-03

Utilization Management

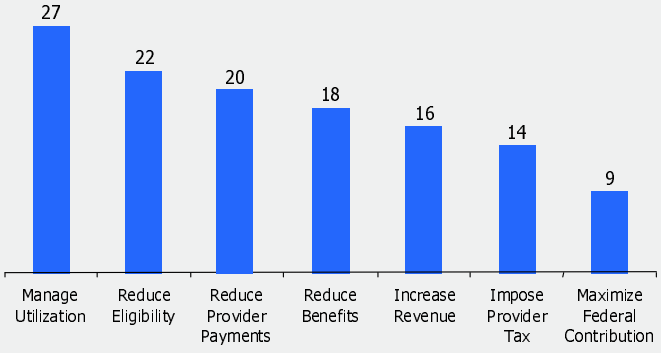
- Expanded fraud and abuse initiatives
- Expanded capitated mental health services pilot program
- Made further changes in pharmaceuticals policy
- Increased HMO enrollment

Benefit and Eligibility Cuts

- Eliminated non-emergency adult dental benefits
- Lowered income eligibility for aged from 90% to 88% of FPL
- Eliminated Ticket-to-Work program for younger working people with disabilities
- Eliminated, then temporarily reinstated, medically needy program

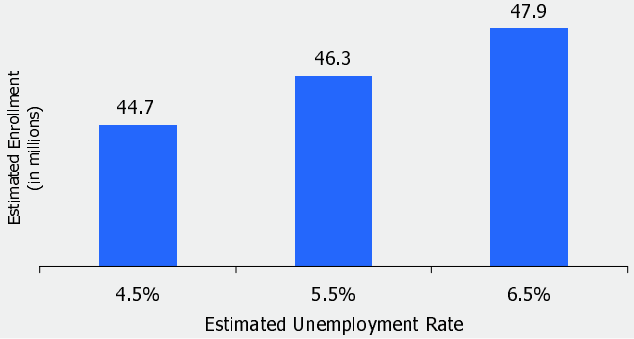
After making cuts in 2003, over a third of states are considering additional reductions for FY 2004...

Chart 14: Number of States Considering Medicaid Cost Containment Options for FY 2004



...even as the need for safety net programs is likely to increase.

Chart 15: Estimates of the Impact of Unemployment on Medicaid Enrollment, 2001



Medicaid cuts hurt beneficiaries and the broader community…

Medicaid has expanded to meet the needs of a wide range of populations with varying health care requirements through a mix of nearly every type of provider. Medicaid serves such disparate populations as low-income pregnant women and persons with serious and persistent mental illness. Cutting Medicaid through more stringent eligibility criteria or scaling back benefits does not eliminate the substantial health care needs of these populations; it merely shifts the costs of their care onto local hospitals, health departments, clinics, and other state-financed programs. These costs must then be met without the benefit of the federal matching dollars states receive for their care under Medicaid.

Many fear that Medicaid cuts, in whatever form they take, will adversely affect access and coverage for the nation's most vulnerable citizens. According to the Center for Budget and Policy Priorities, up to 1.7 million Americans could lose coverage entirely under proposals recently signed or under consideration in state legislatures. Some states, like Ohio, are considering cutting optional services, such as vision and dental, for mandatory populations.[1] Mississippi has limited prescriptions to five per month with a 34-day supply limit, increased their pharmaceutical co-payment, and reduced dispensing fees. Massachusetts is considering eliminating a prescription drug program that covers 80,000 elderly persons.[2]

While it is difficult to establish direct linkages between Medicaid payment levels and access to care for Medicaid beneficiaries, some providers may consider eliminating services or shelving plans for new services as a result of payment cuts. In New York State, for example, proposed state payment cuts and new taxes would reduce Hudson Valley Hospital Center's revenues by almost $400,000. The hospital has already closed several offices that provided physical therapy and radiology services.[3] When hospitals reduce their clinical capacity as a result of Medicaid cuts, the effect may be the loss of services not only for Medicaid beneficiaries, but for the general population that hospital serves.

Other providers may decide to no longer accept Medicaid patients. One study found that more than 30 percent of all physicians are now refusing to accept new Medicaid patients.[4] Some fear that this number will increase with additional cuts in Medicaid payments. If so, some beneficiaries may then seek treatment in hospital emergency departments under the Emergency Medical Treatment and Active Labor Act (EMTALA).

Thousands of state residents lost coverage in 2003…

Chart 16: Effect of Cuts on Eligibility and Benefits, 2003

Florida lowered income eligibility for aged and disabled from 90% of FPL to 88% of FPL	3,500 - 5,000 people cut from program
Michigan suspended Medicaid waiver	200,000 people lost benefits
Idaho limited dental care for nonpregnant Medicaid recipients over age 21 to emergencies only	20,000 of Idaho's poorest residents lost non-emergency and preventive dental care
Oklahoma instituted 5 prescription limit on elderly and disabled	9,100 Medicaid recipients faced additional out-of-pocket expenses of $183 per month

…and there are more cuts on the way for 2004.

Chart 17: Projected Impact of Planned Cuts on Eligibility and Benefits, 2004

Colorado eliminated Medicaid coverage for all legal immigrants	3,500 legal immigrants will lose coverage
Connecticut changed eligibility rules for Medicaid program	23,000 parents and 7,000 children will lose coverage
Massachusetts eliminated coverage for health services such as dentures and prosthetic devices	600,000 low-income beneficiaries will lose benefits

Working Together in South Carolina

South Carolina's Medicaid program provides care to over 800,000 South Carolinians, covering half of the babies born in the state, 40 percent of the children, and 75 percent of the seniors in nursing homes. Yet South Carolina, like many other states, is suffering its most serious state fiscal crisis in decades. In the last 18 months, the state has seen a $982 million revenue shortfall and is expecting an additional $500 million shortfall in the upcoming fiscal year. Believing that a permanent, dedicated source of funding is necessary to protect Medicaid in times of fiscal crisis, a coalition of more than 70 members, including the Palmetto Business Forum and the South Carolina Chamber of Commerce, was formed to lobby for an increase in the tax on cigarettes to fund Medicaid services. The Coalition has been active, arguing in a state known for its tobacco production, that health care expenditures in South Carolina directly related to tobacco use are in the hundreds of millions of dollars per year.

...as well as providers and local economies.

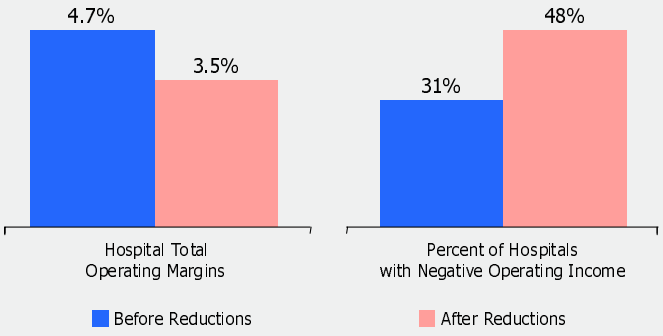
Medicaid payments to providers generally are lower than payments of private insurers and Medicare and are below costs nationally. For hospitals that provide a large share of Medicaid services, below-cost payments are reflected in lower hospital margins. For example, if services to Medicaid beneficiaries make up 15 percent of a hospital's costs and there is a 20 percent shortfall between Medicaid payments and costs, this shortfall would be reflected in a 3 percentage point deficit in total hospital margins.

When public programs fail to cover the cost of care, hospitals rely on the private sector to make up the difference. The so-called "cost shift" may drive up private insurance premiums, possibly even leading to higher rates of uninsurance. The ability to cost shift, however, depends on competitive circumstances and payer mix. For hospitals serving a large share of Medicaid and uninsured patients, the failure of Medicaid, DSH, and other public programs to cover the costs of care can contribute to financial distress, possibly threatening access to care. Detroit Medical Center and Greater Southeast Hospital (Washington, D.C.) provide two recent examples.

More broadly, Medicaid represents an important component of the health sector — one of the largest sectors of the nation's economy. Cuts to the Medicaid program not only take state dollars away from this sector, but also result in the loss of federal matching dollars. A study on the economic effects of Alaska's Medicaid program found that Medicaid expenditures for direct health care services created more than 5,000 health sector jobs and generated about $220 million in health sector income.[1] Since Medicaid funds channel disproportionately to poor urban and rural areas, cutting Medicaid disproportionately hits already economically disadvantaged areas.

Medicaid cuts hurt hospital finances...

Chart 18: Impact of Medicaid Budget Reductions on Oregon Hospital Financial Performance



...and are compounded in state economies by the loss of federal matching dollars.

Chart 19: Economic Consequences of Proposed 2003-2004 Medi-Cal Cuts in California, 2003

Deny Medi-Cal eligibility to two-parent working families	2,449 jobs lost	$102.7 million in lost wages	$280.8 million in economic losses
10% rate reduction to health care providers	7,470 jobs lost	$313.2 million in lost wages	$856.8 million in economic losses
Elimination of medically necessary benefits	5,457 jobs lost	$228.8 million in lost wages	$625.9 million in economic losses

Oregon Hospitals Sue the State

The Oregon Health Plan (OHP) began in the late 1980s to pursue the policy goals of reducing the percentage of Oregonians without health insurance while containing costs and improving the quality of care. At the end of 2001, enrollment in OHP stood at nearly 400,000, about 12 percent of the state population. However, Oregon now is facing its most serious state fiscal crisis in decades, and the State Department of Human Services has reacted by imposing a 12 percent across-the-board reduction in hospital payment rates for Medicaid services and by adopting a rule allowing the state to make further cuts based on state budgetary needs. In addition, the state eliminated retroactive eligibility for a portion of the Medicaid population, now only paying for services after eligibility determination. Oregon hospitals have responded. In March, the Oregon Association of Hospitals and Health Systems (OAHHS) filed suit in state and federal court, an action that reflects the seriousness of the situation. OAHHS has filed suit on the grounds that the state has failed to adhere to the requirements of the Administrative Procedures Act and to reimburse reasonably and adequately under the "equal access provision." OAHHS further charges that the elimination of retroactive eligibility violates OHP waivers. The state of Oregon is among several other states, such as Michigan, North Carolina, and Indiana,* named as defendants in suits stemming from not only Medicaid payment cuts but cuts to eligibility and benefits.

**American Healthline, May 16, 2002 and May 28, 2002*

Policy Questions

How long this current budget crisis will continue is uncertain, but it has inspired renewed interest at the federal level in Medicaid reform. The debate on reform centers around the Administration's plan to provide more flexibility to states and cap the federal government's contribution at 2002 rates adjusted for inflation. The optional plan would provide a much needed cash infusion to states in the short term, but would reduce overall payments to states in the out-years. It also raises concerns by breaking the link between the number of enrollees and federal payments to states. Other reform ideas include federalizing dual eligibles and providing a Medicare prescription drug benefit. Both measures would ease the burden on Medicaid.

Options for longer term restructuring of the Medicaid program are also being discussed. One option is a broad block grant to states. Another is restructuring the program into three programs: one for the uninsured, one for those with low income, and one for those with chronic illness who need long-term care.

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

- What is the appropriate balance between the role of the states and the role of the federal government in the Medicaid program?
- Is it desirable for Medicaid to be the default insurer for long-term care and prescription drugs for the elderly?
- How can the federal government support state flexibility while maintaining accountability and access in the Medicaid program?
- Will giving states more flexibility increase existing disparities in Medicaid eligibility, benefits, and payment across states? Is this a desirable outcome?
- What would be the long run implications of the capped federal funds requirement in the Administration's Medicaid reform proposal on coverage and access to care?

Quotes from the Field

"States are facing the most severe fiscal crisis since World War II, and nearly every state has either proposed or enacted cuts to its Medicaid program. Any reduction in federal funding would place millions of vulnerable Americans who rely on Medicaid in jeopardy of losing their health coverage altogether." — Senator Charles Grassley, Chairman, Senate Finance Committee

"When you cut Medicaid, this isn't telling a child he's not going to summer camp. It's about telling a child that he's not going to be able to breathe without a struggle. It's about telling an elderly person they're going to miss their blood pressure medication." — Mike Huckabee, Governor of Arkansas

"The time to modernize Medicaid is here. The states' budget crises are threatening progress we've made in expanding health insurance. The old Medicaid rules are a straitjacket, restraining creative new approaches that could preserve coverage and expand it to more Americans in need." — Tommy Thompson, U.S. Secretary of Health and Human Services

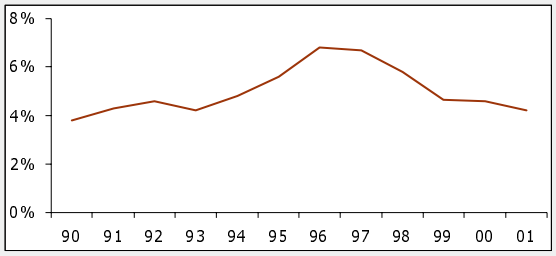
"States are short of money for Medicaid at a time when rising costs of health care and a recession are making it harder for many Americans to pay their medical bills." — Jim Tallon, Chairman, Kaiser Commission on Medicaid and the Uninsured

"It's a pretty dire outlook for states. Unfortunately, even when the economy comes back, it will help, but I think states are going to continue in a very, very difficult situation for at least the next two or three years until, in particular, we get some major reforms in the Medicaid program." — Raymond C. Scheppach, Executive Director, National Governors Association

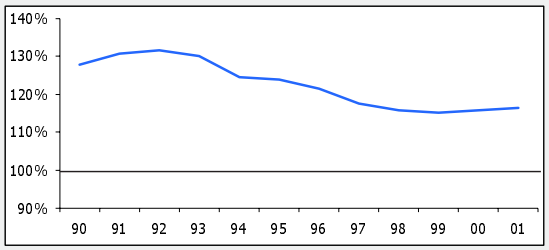
Stats to know

Hospital Sector

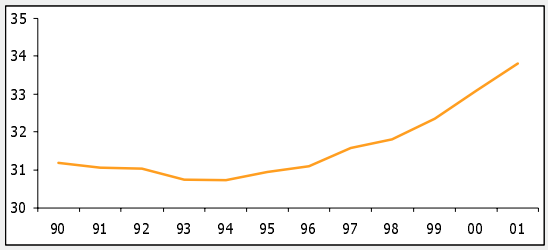
Total Margin: 90 to 01 Trend	1999	2000	2001
	4.7%	4.6%	4.2%



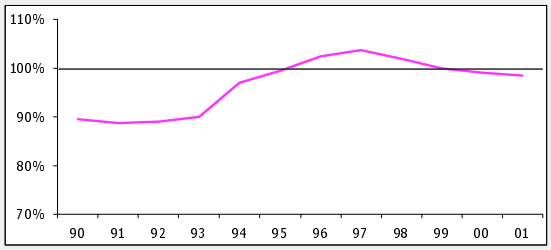
Private Pay Payment-to-Cost Ratio: 90 to 01 Trend	1999	2000	2001
	115.1%	115.7%	116.5%



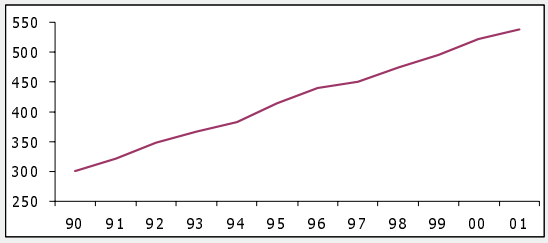
Inpatient Admissions (in mil.): 90 to 01 Trend	1999	2000	2001
	32.4 M	33.1 M	33.8 M



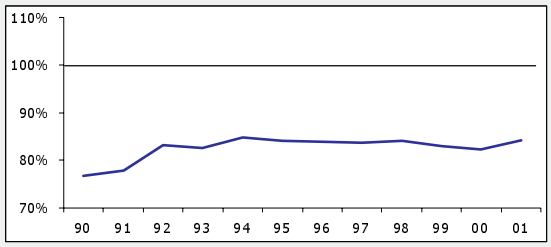
Medicare Payment-to-Cost Ratio: 90 to 01 Trend	1999	2000	2001
	100%	99.1%	98.4%



Outpatient Visits (in mil.): 90 to 01 Trend	1999	2000	2001
	495 M	521 M	538 M

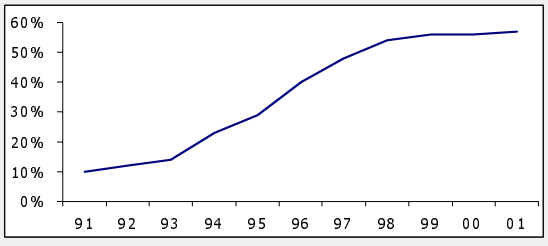


Medicaid/Charity Care Payment-to-Cost Ratio: 90 to 01 Trend	1999	2000	2001
	82.9%	82.2%	84.2%

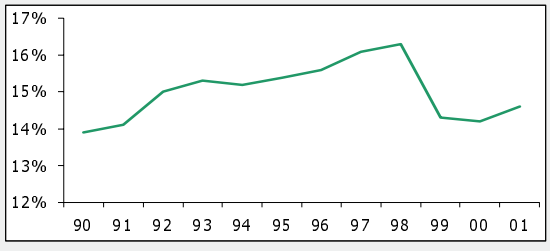


Health Sector

Percent of Medicaid Beneficiaries In Managed Care: 91 to 01 Trend	1999	2000	2001
	56%	56%	57%



Percent Uninsured: 90 to 01 Trend	1999	2000	2001
	14.3%	14.2%	14.6%



Endnotes:

Page 1: [1] National Conference of State Legislatures, State Budget Update, April 2003
[2] National Conference of State Legislatures, State Budget Update, February 2003
[3] National Conference of State Legislatures, State Budget Update, April 2003
[4] National Association of State Budget Officers, 2001 State Expenditure Report
[5] Kaiser Commission on Medicaid and the Uninsured, Issue Paper, January 2003
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[7] Centers for Medicare and Medicaid Services, Office of the Actuary, Trustees Report 2003 and President's FY 2004 baseline budget

Page 2: [1] Centers for Medicare and Medicaid Services (CMS)
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[3] Based on The Lewin Group analysis of 2001 American Hospital Association Annual Survey data
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[5] Smith, Vernon K. Presentation to American Hospital Association, April 25, 2003
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[3] The Healthcare Association of New York State. "New York's Health Care on the Brink: Hudson Valley Hospital Center"
[4] 2002 Survey of Physicians About the Medicare Program, The Medicare Payment Advisory Commission, April 2003

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Chart 2: National Conference of State Legislatures, *State Budget Update*, April 2003

Chart 3: National Association of State Budget Officers, 2001 State Expenditure Report

Chart 4: CMS, CMS-64 Report: Financial Management Report, 1992-2001

Chart 5: CMS. For 2002 data, CBO March 2003 baseline

Chart 6: CMS, CMS-64 Report: Financial Management Report, 2001

Chart 7: Kaiser Commission on Medicaid and the Uninsured, *Key Facts*, May 2003 based on March 2003 CBO data

Chart 8: Families USA, *Preserving Medicaid in Tough Times: An Action Kit for State Advocates*

Chart 9: Kaiser Commission on Medicaid and the Uninsured, *Key Facts*, May 2003 based on Urban Institute estimates

Chart 10: The Lewin Group, *Medicaid Budget Options*, Prepared for Princeton Conference, June 6-8, 2002

Chart 11: CBO March 2003 Baseline. Expenditures assume a 57 percent federal share.

Chart 12: Vernon Smith, Kathleen Gifford, Rekha Ramesh, Victoria Wachino, *Medicaid Spending Growth: A 50-State Update for Fiscal year 2003*, Kaiser Commission on Medicaid and the Uninsured. Publication 4082. January 2003.

Chart 13: Kaiser Commission on Medicaid and the Uninsured, *The State Fiscal Crisis and Medicaid: Will Health Programs be Major Budget Targets?* January 2003

Chart 14: See footnote 9 for State Medicaid Facts Appendix.

Chart 15: Kaiser Commission on Medicaid and the Uninsured, *The State Fiscal Crisis and Medicaid: Will Health Programs be Major Budget Targets?* January 2003

Charts 16-17: Same as Chart 15. Idaho Mountain Express, *For Some Medicaid Cuts Could Mean No Teeth*, April 17, 2002. Community Action Project of Tulsa County, *New Medicaid Prescription Drug Cuts Would Shift $183 Monthly Prescription Drug Burden to Low-Income Seniors and Disabled*, October 9, 2002. Center on Budget and Policy Priorities, *Proposed State Medicaid Cuts Would Jeopardize Health Insurance Coverage for 1.7 Million People: An Update*, revised March 21, 2003

Chart 18: The Lewin Group, *Analysis of Medicaid Reimbursement in Oregon*, Prepared for the Oregon Association of Hospitals and Health Systems, February 26, 2003

Chart 19: Families USA, Good Medicine for California's Economy, January 2003

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TrendWatch is a series of reports produced by the American Hospital Association and The Lewin Group highlighting important and emerging trends in the hospital and health care field.

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