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Community Health Centers, Inc.*

State Policy Report #5

**Unkindest Cuts:
The Impact of State Medicaid Reductions
on Health Centers and Their Patients**

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Prepared for the National Association of Community Health Centers By

Sara Wilensky, JD, MPP
Mara McDermott

The George Washington University School of Public Health and Health Services
Center for Health Services Research and Policy

For more information, please contact

Dawn McKinney
Assistant Director, State Affairs
National Association of Community Health Centers, Inc.
Department of Federal, State and Public Affairs Office
2001 L Street, NW Suite 300
Washington, DC 20036

dmckinney@nachc.com
202/296.3410 voice ~ 202/296.3526 fax

~or~

Roger Schwartz, JD
Legislative Counsel and Director of State Affairs
National Association of Community Health Centers, Inc.
Department of Federal, State and Public Affairs Office
2001 L Street, NW Suite 300
Washington, DC 20036

rschwartz@nachc.com
202/296.0158 voice ~ 202/296.3526 fax

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Executive Summary

In this report, we review a variety of ways states are cutting Medicaid and reforming the insurance system in an effort to balance budgets and contain ever increasing health care costs. Recognizing that reductions in Medicaid are likely to continue, it is important that health centers advocate for the least damaging changes possible. While the variety of cuts imposed will impact each health center differently, this analysis should provide health centers with the tools to identify the unkindest cuts for them - those that will have the greatest impact on their ability to serve all their patients and remain financially viable.

While further research is warranted, we have identified the following consequences based on various types of Medicaid cuts.

Benefit and Eligibility Cuts: With two-thirds of spending on optional benefits and an estimated one-third of health center patients in optional populations, reductions in benefits may significantly impact health centers. Newly uninsured or underinsured patients will continue to seek care at health centers, but health centers will not longer receive Medicaid reimbursement for those patients or for certain services. Elimination of medically needy programs are a particular concern given the high health care needs of those patients.

Enrollment and Procedural Barriers: States may make it more difficult for *eligible* individuals to enroll in Medicaid initially and maintain their eligibility by increasing the documentation required, reducing the time of continuous eligibility, requiring face-to-face interviews, and other similar measures. If eligible patients either choose not to enroll or become disenrolled because they do not comply with more stringent requirements, health centers may be unnecessarily treating patients with their grant to cover the uninsured when Medicaid should be providing reimbursement.

Provider Reimbursement Cuts: Even though health centers currently have a protected reimbursement rate through the Prospective Payment System, cuts in other provider reimbursement levels is still a concern. If providers refuse to see Medicaid patients due to further cuts, access points for those patients will be reduced and health centers may see an influx of new patients. Combined with benefit cuts, this could cause financial or service capacity concerns for health centers. In addition, there may political pressure to reduce or change the PPS system if other providers have their reimbursement levels reduced.

Cost-Sharing Increases and Prescription Drug Restrictions: Many states are imposing and increasing cost-sharing requirements for patients through premiums, deductibles, and co-payments and limiting prescription drug coverage by reducing formularies, requiring “fail first” protocols using less expensive drugs, or limiting the number of prescriptions covered. Numerous studies have shown that added cost-sharing reduces utilization even among medically necessary services. In addition, prescription drug limits may result in patient-driven changes in care due to high costs of drugs, reduction in taking necessary drugs, and increased adverse events. The increased financial burden may cause some beneficiaries to disenroll from Medicaid while others will remain covered but find it too expensive to use. Either way health centers may suffer financially because they will see some combination of additional uninsured patients, fewer Medicaid patients, and/or Medicaid patients for whom they are unable to be reimbursed for certain services but who also do not count as uninsured for purposes of federal grant dollars.

Downstream Effects: Downstream effects refer to ways that Medicaid cuts harm the already fragile safety net. The most common downstream effects include increases in the number of Emergency Room visits for primary care needs or needs that became acute due to lack of access to primary care, increased preventable hospitalizations, reduced participation in Medicaid by other community providers, and diversion of scarce resources to make-up for losses from the Medicaid program.

Premium Assistance Waivers: Some states are using the Medicaid and SCHIP funds to help beneficiaries pay for premiums through employer-sponsored coverage. When waivers are implemented to effect this change, the budget neutrality requirement means that some other cuts in benefits or eligibility will be necessary. Health center patients are quite poor, with 90% earning less than 200% FPL and 69% earning less than 100% FPL. While health center patients may suffer from such benefit or eligibility cuts, it is unlikely they will take advantage of premium assistance waivers because they are employed in jobs that do not offer health insurance or because the waivers do not provide enough coverage to make the insurance affordable.

Introduction: States in Fiscal Crisis

In recent years, a stagnant national economy, shrinking state revenues, and mounting spending pressures have created massive budget shortfalls placing nearly every state in fiscal crisis. State end of year balances have fallen by 70% since fiscal year (FY) 2000.¹ Even though the economy has shown signs of improvement and revenue projections for FY 2005 are the best in recent memory, states continue to wrestle with serious budget concerns. According to the National Conference of State Legislatures, “[S]tate legislatures will still have to make difficult

decisions due to increasing Medicaid costs and demands from other programs weakened by four years of significant budget cuts.” Over half of the states have indicated that budget problems remain and 30 states have identified Medicaid, health care costs, and other health issues as most likely areas for further reduction.²

Even though some states are taking positive steps to enhance their Medicaid programs, the dangers of widespread reductions in the program remain. This report will provide a basis for health centers to determine the “unkindest cuts”, those which will have the greatest impact on their ability to serve Medicaid beneficiaries as well as their other patients.

From 2002 to 2004, Medicaid spending grew faster than state revenues though slower than private health insurance premiums. Enrollment in Medicaid grew rapidly from 1998 to 2002, and continued to grow, but at a much slower rate, from 2002 to 2004. States cut many areas of the Medicaid program consecutively for four or five years to address their budget concerns.³

The risk of further cuts to Medicaid programs remains great. On the federal level, President Bush’s budget proposal included \$45 billion in net savings from Medicaid over 10 years through better efficiency, changes in rules regarding asset disposal, and eliminating state practices that shift costs to the federal government, among other things. The House included \$20 billion in Medicaid cuts over 5 years in its budget, while the Senate struck \$14 billion in Medicaid cuts originally included in its budget. The budget resolution that was passed by Congress includes a \$10 billion Medicaid reduction, but at the time of this report it is unclear what form cuts will take. Outside the federal budget process, former Utah governor and new Secretary of Health and Human Services, Mike Leavitt is pushing for more flexibility for states, asking "Wouldn't it be better to provide health insurance to more people, rather than

comprehensive care to a smaller group? Wouldn't it be better to give Chevies to everyone rather than Cadillacs to a few?"⁴

This year governors have indicated that Medicaid is again on the chopping block, while others are looking for ways to increase coverage through waivers and other means.⁵ Some states facing cuts include:

Missouri Governor Blunt signed legislation that will scale the state's Medicaid program back to the minimum levels required by federal law. If fully implemented approximately 100,000 parents, elderly and disabled are expected to lose coverage. The changes include eligibility reductions, elimination of programs and reduction of optional benefits including: all families in the children's insurance plan will begin paying premiums up to 5% of family income; eligibility for the elderly and disabled could be reduced from 100% to 74% FPL (\$579 per month), affecting approximately 14,607 elderly and disabled; and elimination of services such as dental and eyeglasses.⁶ Health centers estimate that they could lose \$16 to \$20 million or close to half of their Medicaid revenue.

Tennessee Governor Bredesen plans to eliminate coverage for 323,000 adults to reduce costs by \$1.7 billion annually. These adults include 121,000 previously insured, 67,000 with pre-existing medical conditions that prevent them from obtaining private insurance, 97,000 medically needy, and 38,000 dual eligibles. Those adults who retain coverage will have restricted benefits, including caps on physician visits (including health centers), lab, x-ray use, inpatient days, outpatient days, and prescriptions per month. At the time of this report, enrollment has been closed but disenrollment is being delayed by the courts.

Some states looking for ways to maintain or expand their Medicaid program include:

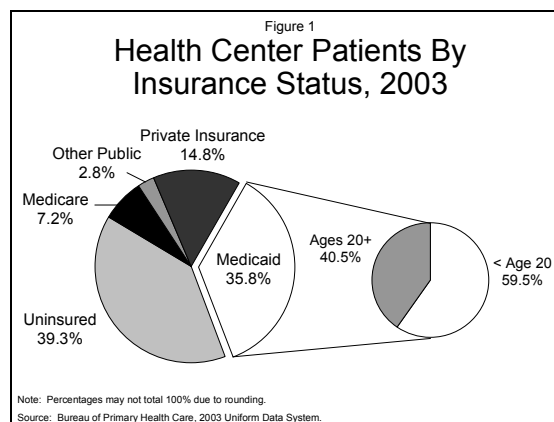
Utah Legislature passed, with the support of newly elected Governor Huntsman, legislation to appropriate \$5 million in Medicaid funding on a one time basis to restore dental and vision coverage to beneficiaries who had recently lost coverage for those services.

Colorado Governor Owens signed a bill that will allow about 3,500 legal immigrants who were going to be dropped from the program to remain eligible for Medicaid. Tobacco revenue will be tapped to cover the \$2.6 million cost for these beneficiaries. In addition, the Colorado legislature restored Medicaid presumptive eligibility for uninsured pregnant women with the exception of undocumented women.

Medicaid Cuts in the States

A strong Medicaid program improves state economies by insuring a healthier workforce and bringing in significant federal funds.⁷ The Medicaid program is also vital to the success of health centers. Health center patients are disproportionately low-income, uninsured, or publicly insured. Health centers serve nearly 5.4 million Medicaid beneficiaries and approximately 36% of all health center patients nationwide are on Medicaid.

In addition, Medicaid is the largest source of revenue for health centers (see Figure 1 below).⁸ Medicaid accounts for roughly two-thirds (64%) of total third-party collections for health centers and 36% of total revenue.⁹ As such a large revenue source, Medicaid coverage is key to health centers' ability to serve more of the low-income population. Medicaid cuts not only infringe on the ability of health centers to provide much needed services to patients, but they also hamper health center expansion efforts. While health centers have enjoyed increased federal funding over the last several years, changes in Medicaid payments could have significant impact on the ability of health centers to survive.



The National Association of Community Health Centers (NACHC) is currently analyzing the cost impact of various Medicaid cuts. Many of these cuts could only occur with federal consent, i.e. through new legislation or an approved waiver, and presumably all of the changes below would not occur simultaneously. Even so, health centers should be monitoring the political strategies being discussed on the state level to detect which types of cuts could gain a consensus among the governors who are currently attempting to negotiate a “restructuring” of Medicaid with the Administration. Some of the options to achieve the Administration and Congress’ goal of Medicaid savings could come at the expense of health centers. (See Appendix A) The estimated cost impacts of various cuts to health centers nationally are:

- **Annual Deductible:** Adding a \$100 annual deductible could result in a \$540 million loss to health centers due limited collection of self-pay charges.
- **Co-Payment:** Imposing a 20% per visit co-payment could result in a \$591 million annual loss.
- **FQHC Reimbursement:** Eliminating Prospective Payment System (PPS) and managed care wraparound payments could result in a \$976 million annual loss. These reimbursements (in place of Medicaid fee-for-service reimbursement) currently account for 33% of health center Medicaid revenues.
- **Optional Reimbursement: Assuming 30% of health center Medicaid patients are in optional populations,** eliminating PPS for optional populations could result in a \$289 million annual loss.
- **Optional Coverage:** Eliminating Medicaid coverage for all optional Medicaid beneficiaries could result in a \$781 million annual loss, assuming they did not find coverage elsewhere.

It is unclear what changes will be proposed at the federal level, but some of these changes have already taken effect on a state-by-state basis, which this report will address. Health centers should consider the impact of Medicaid cuts from two points of view – the effect on the health of the patient and the financial impact on the health center. From the patient’s health standpoint, those cuts that result in a patient losing their Medicaid coverage will have a more severe impact

than those cuts that reduce, but do not eliminate their coverage. Losing Medicaid often means losing coverage and access altogether due to the high costs of private insurance. Thus, changes in eligibility may be the highest priority from a patient's perspective. Almost as important, some changes, such as increased cost sharing, may increase the cost of using Medicaid to such an extent that patients are unable to take advantage of Medicaid's benefits even though they remain eligible. For that reason, changes that increase the cost to patients should also be viewed with great concern.

It is more difficult to make a general statement about how various types of benefit cuts may impact patients because the answer may depend on the patient's particular needs. For example, one patient may be more affected by the loss of mental health services while another would feel a greater impact if prescription drug co-payments increased. While medical services¹ account for about two-thirds of total health center costs, it may be useful to consider which particular services are needed most by consumers in your state. For example, if a state's health centers have a greater proportion of patients under the age of 12 and a lower proportion of patients over 45 as compared to the national average for health centers, health centers in that state may decide to rate any benefit cuts to children's services as more of a concern than other types of benefit cuts.

In addition to patient outcomes, health centers also must be concerned about maintaining financial viability. Since Medicaid provides such a large proportion of the revenue base, health centers must protect both the rate they are paid for services as well as the services which are covered by that rate. Clearly, health centers must remain vigilant against any rate reductions or against states attempting not to use the federally qualified health center (FQHC) reimbursement

rate for optional services or populations – an action that would require a waiver from the federal government. However, it may be equally important to oppose benefit reductions. Even when patients lose benefits, they will continue to seek those services from health centers. The difference is that health centers will no longer be reimbursed by Medicaid for providing those services. It may be more financially problematic for health centers to have patients who remain eligible for Medicaid in a state that chooses to cover limited benefits because the health center will not see an increase in grant funding to cover the uninsured because the patients still have Medicaid, while at the same time the health center continues to provide services but not receive Medicaid reimbursement.

Even against the backdrop of Medicaid’s health related and economic benefits, many states have been cutting back their Medicaid program as the economy has faltered. Common reductions include cuts in provider reimbursement, limits on prescription drug coverage, benefit cuts, increased cost-sharing requirements (co-payments, premiums, annual deductibles), reductions in nursing and long term care, scaling back disease management programs, and reduction in eligibility. In fact, all states have chosen to enact a combination of these cuts, in some cases multiple times, to achieve their cost cutting goals. The table in Appendix B provides a national overview of the most frequent types of Medicaid cuts from 2003 to 2005.

Benefit and Eligibility Cuts

States often reduce benefits and cut eligibility in an attempt to lower program costs. Since nationally two-thirds of Medicaid spending is related to optional benefits, reduction in services may provide significant savings for states. While the Uniform Data System (UDS), the reporting tool used by health centers, does not provide data to determine exactly which health

¹ Medical services include medical staff, lab/x-ray, and medical other. It does not include mental health and substance abuse. “Other professional services” include mental health, substance abuse, dental, pharmacy and other,

center patients are eligible for Medicaid and are part of Medicaid optional populations for each state, the pool of patients impacted by Medicaid cuts could be significant. Nationally, 14% of health center patients have incomes between 101%-150% FPL, 6% have incomes between 151%-200% of poverty, and another 10% have incomes above 200% of poverty.¹⁰ Assuming health centers have the same proportion of Medicaid patients in the optional population as nationally, states can eliminate coverage for 29% of health centers' Medicaid patients without a waiver.¹¹

Patients who lose their Medicaid coverage are likely to remain uninsured or become underinsured given the high cost of private insurance policies. Even when coverage is affordable, it is likely that the benefits are limited and not nearly as comprehensive as those available under the Medicaid program. Health centers may experience financial difficulties if they see a significant increase in uninsured and underinsured patients who do not bring a revenue source with them. In addition, health centers may not have the capacity, i.e. physical space and providers, to see a significant increase in the number of patients.

Both premium level and cost sharing requirements for non-employer based private insurance vary greatly by region of the country. The average national premiums for non-employer based individual health insurance are \$1,786 for singles and \$3,331 for families.¹² These figures are lower than average premiums for group health insurance, likely reflecting the younger age of individual insurance purchasers and less generous benefit packages. Cost sharing requirements range from \$0-\$49 co-payments for single policies, with 53.4% under \$20 and 43%

and account for an additional 22% of costs.

² Kaiser Family Foundation. Update on Individual Health Insurance. August 2004 (revised) accessed April 6 2005 at <http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=44678>

between \$20-\$40. Deductibles³ range from under \$500 to over \$3, 000, with almost 40% costing \$2,000 or higher.

Average Monthly Premiums for Single and Family Coverage by Region, Jan.-Aug. 2003¹²		
	Monthly Single Premium	Monthly Family Premium
Atlantic	\$147.85	\$296.75
Mountain	\$135.44	\$265.30
New-England and Mid-Atlantic	\$267.54	\$489.20
North Central	\$127.40	\$240.74
Pacific	\$143.09	\$276.89
South Central	\$123.29	\$227.46
Total	\$148.80	\$277.62

Since low-income individuals cut from Medicaid probably cannot afford these amounts, Medicaid cuts may result in an increase in both uninsured and underinsured patients seeking care at health centers and an increase in the use of emergency departments for primary care needs. In fact, the number of uninsured patients at health centers has doubled from 1990 to 2002¹³ while the per patient funding from federal grants has remained flat. Not only have the per person grant funds remained flat, they are not sufficient to cover the needs of the uninsured patient. In 2003, health centers received an average of \$268 per uninsured patient, but those patients cost an average of \$479.¹⁴ Health centers have used other sources of revenue to cover the gap in the cost of caring for the uninsured, but these sources are limited. As states cut their Medicaid program, health centers will likely see more uninsured patients while simultaneously experiencing a reduction in their Medicaid revenues and grant dollars per patient.

³ Deductible figures are from single and family policies combined.

While FQHC services are a mandatory service under federal law, there are a number of optional benefits covered by Medicaid that are important to health center patients, such as prescription drugs, dental services, vision services, case management, and TB-related services. From 2003 to 2005, 25 states reduced their benefit packages. Cutting benefits threatens health centers' ability to continue to offer these services, especially if Medicaid is the primary payer for these services.⁸

Several states have begun to cap or eliminate Medicaid reimbursement for dental services. One study, examining the effects of eliminating dental coverage in the Maryland Medicaid program, showed that while the rate of dental claims in physician's offices decreased by 8 percent, there was a 12 percent increase in dental-related claims in the emergency department.¹⁵ In 2003, health centers provided nearly 4.5 million dental visits with a per dental encounter cost of \$124. Since it is a costly service to provide, it is possible that a health center would not be able to continue offering dental services if there was a significant reduction in or elimination of dental coverage by a state Medicaid agency. While the percentage of these visits made by Medicaid patients is unknown, it is certainly a considerable amount of health centers' dental business.

States often first choose to cut services and eligibility for non-disabled adults. However, reductions in adult coverage may also have significant repercussions for children's health coverage. These are important issues for health centers since nearly 40% of health center patients are under age 20. It is well known that children of parents who are uninsured are less likely to receive adequate health services.¹⁶ In addition, having an uninsured parent is related to a decrease in the likelihood of the child having a usual source of care, and a decreased likelihood of having a medical provider visit or well-child visit.¹⁷ Even if parents remain insured through

Medicaid, significant reductions in adult services may negatively impact the care a covered child receives. Parental experience with the health care system and consequent beliefs about health care and their ability to negotiate the system for their kids is an important factor for child health.¹⁸ In short, barriers to health care exist even when children are insured, if their parents are not.

Eligibility cuts may also take the form of eliminating a whole category of optional beneficiaries, such as the medically needy. In 2000, 35 states and the District of Columbia had medically needy programs,¹⁹ a decrease from the 42 states with such a program in 1992.²⁰ These 35 programs covered 3.6 million people at a cost of almost \$24 billion. The medically needy programs provide a way for states to cover people who have high medical expenses but whose income levels make them ineligible for Medicaid. States subtract the costs of these individuals' medical expenses from their income level. As soon as they "spend down" enough money, they qualify for Medicaid based on their reduced income level. Not surprisingly, medically needy beneficiaries are high cost individuals. While the medically needy population represents only 8% of Medicaid enrollees, they account for nearly 14% of spending.¹⁹ Even though most of these beneficiaries (66%) are children and their parents, the highest cost beneficiaries are the elderly and disabled who account for 84% of the \$24 billion spent on medically needy populations. This is a concern for health centers whose fastest growing population is the near-elderly.

As is evident by the table in Appendix C, the patient population served by and the cost incurred under the medically needy program varies greatly from state to state. Accordingly, the impact on health centers from any reduction or elimination of a medically needy program will vary as well. Some health centers may see a large influx of newly uninsured patients while others may not. However, since the medically needy are patients with high medical needs and

associated costs, treating patients who formerly qualified as medically needy could strain health center resources, even in those states with relatively restrictive medically needy programs. A number of states are considering dropping their medically needy programs, some in the context of seeking broad Section 1115 waivers. Medically needy programs, however, are voluntary to the states, consequently a waiver is not required in order to drop this program.

STATE SPOTLIGHT: TEXAS

Texas combined a variety of cuts in its Medicaid and SCHIP programs in an attempt to reduce spending by over \$1.6 billion for the FY 2004-2005 biennium budget. The state's actions focused on reducing eligibility and benefits. These actions are of particular concern since Texas has one of the lowest rates of employer-sponsored insurance and one of the highest rates of uninsured in the country. The Texas Health and Human Services Commission projected that the changes to the SCHIP eligibility process would reduce enrollment by 32% in FY 2005. As a result of these cuts, fewer children are being enrolled in SCHIP. The 29% decline in enrollment since the beginning of FY 2004 has occurred disproportionately among children in families with incomes below 150% FPL. Virtually all of the reduction has been among those families between 101%-150% of poverty.

The Medicaid and SCHIP cuts and changes include:

The 2005 budget eliminated the **medically needy** program for adults with dependent children. Previously, the income level of families qualifying for that program ranged from 22%-31% of poverty after medical spending was deducted. This cut is expected to result in a loss of coverage for 9,328 adults.

Several **optional benefits** for adults were eliminated, including: services of licensed professional counselors, social workers, psychologists, license marriage and family therapists, podiatrists, and chiropractors. Also, some vision services are no longer covered.

Pharmacy related restrictions include supplemental rebates, preferred drug lists, and prior authorization requirements.

Hospitals' and doctors' reimbursement rates were cut in 2004, but FQHC rates were not changed.

Medicaid termination sanctions were imposed on Temporary Assistance for Needy Families (**TANF**) parents and caretakers in 2003. These sanctions plus other restrictive policies reduced the average monthly enrollment in TANF and Section 1931 Medicaid coverage by 25,000 in 2004.

SCHIP **eligibility changes** included a reduction in continuous coverage from 12 months to 6 months, establishing a 90-day waiting period, increasing premiums for families

between 101%-150% FPL, and changing the asset test and income deductions used to determine eligibility.

Benefit reductions included the **elimination of services** such as dental, hospice, skilled nursing, tobacco cessation, and vision care. There was also almost a 50% reduction in coverage of mental health and substance abuse services. **SCHIP cost-sharing** obligations for those below poverty include a co-payment of \$3 for an office visit, \$10 for hospital admission, and a 1.25% of income annual cap on co-payments. Families with incomes between 101%-150% poverty now have a \$15 monthly premium instead of a \$15 annual enrollment fee, a \$5 co-payment and a 1.25% of income annual cap on co-payments. Families with incomes between 151%-185% of poverty had their monthly premiums increased to \$20 and their co-payment increased to \$7. Those with incomes between 186%-200% of poverty had their monthly premiums raised to \$25.

Source: Kaiser Commission on Medicaid and the Uninsured. Anne Dunkelberg and Molly O'Malley. "Children's Medicaid and SCHIP in Texas – tracking the impact of budget cuts." July 2004.

Enrollment/Procedural Barriers

While eligibility changes, increased cost-sharing, provider reimbursement reductions, and benefit cuts receive the most attention from the public, procedural changes affecting how *eligible* individuals enroll and remain in Medicaid can be equally detrimental to beneficiaries. Common procedural barriers include shortening continuous coverage length and having more frequent renewal periods, requiring more rigorous verification documentation, limiting outreach efforts, using separate Medicaid and SCHIP applications, and requiring face-to-face interviews.

Thus, after several years of easing administrative burdens, an increasing number of states have tried to pare their Medicaid rolls and reduce costs by adding these types of procedural barriers. As of October 2004, eight states had reinstated procedural barriers – Connecticut, Colorado, Florida, Mississippi, New Mexico, Texas, Washington, and Wisconsin. Six of those states have lowered their continuous eligibility period to less than 12 months. Furthermore, many states have curtailed their outreach efforts for enrolling new beneficiaries and almost all states spend well below their legal limit (10 percent of SCHIP expenditures) on SCHIP outreach efforts.¹¹

States are more restrictive with parental coverage than children's coverage. Only six states continue to count assets to determine children's eligibility for Medicaid and/or SCHIP, while 28 states and the District of Columbia continue to use asset tests to determine parental eligibility for Medicaid. Similarly, states are more likely to require enrollment interviews for parents (16 states) than children (6 states), and more likely to require renewal interviews for parents (9 states) than children (3 states). In addition, fewer states have a 12-month renewal period for parents (37 states) as compared to children (40 states).¹¹

These efforts to complicate eligibility procedures have achieved their intended effect of reducing enrollment. For example, Texas imposed numerous procedural barriers, including reducing continuous coverage from 12 months to 6 months and establishing a 90-day waiting period after children are deemed eligible. These restrictions combined with other changes such as increased premiums, resulted in a 29% decline in SCHIP enrollment – or a reduction of more than 149,000 children. Similarly, as of 2003, Washington State required income verification documents and reduced continuous coverage from 12 months to 6 months. As a result, over 40,000 children have fallen off the state's Medicaid rolls. The trend continues with Wisconsin's Medicaid expansion program, BadgerCare. In May 2004, Wisconsin began requiring income verification documents and employer verification of insurance status. Following these changes, enrollment in BadgerCare declined by over 11 percent. In contrast, Wisconsin's regular Medicaid program which was not subject to these restrictions showed an enrollment increase during the same timeframe.¹¹

It is ironic that states are adopting complicated enrollment procedures to limit costs even though having complex procedures increases the resources needed to administer the program. A recent study compared state costs associated with New York's application process before and

after September 11th. Because of damage to Medicaid’s central computers on September 11th, New York adopted a simple one-page enrollment form and relied on applicants to swear to the veracity of the information provided. A study comparing pre- and post September 11th administrative costs showed that up to 80 percent of enrollment costs are related to “complex rules, proofs, and calculations surrounding eligibility.” It is estimated that states adopting a simplified application could almost halve the costs used for eligibility screening, application completion, and document gathering, and reduce quality assurance costs by 70%, for an overall enrollment cost reduction of 40%. Savings may be even greater because it would reduce the costs of re-enrolling children who are disenrolled at one point but still eligible. In New York, 66% of children that failed to recertify at one time were back on Medicaid within one year.²²

Clearly, health centers, other advocates, and states must be aware of the difficulties imposed by these restrictions. Due to these procedures, *currently eligible* families may be unable to comply with the requirements to gain or maintain eligibility. As a result, health centers may be encountering significant and avoidable financial difficulties because they are providing services to Medicaid eligible patients who are currently uninsured.

Provider Reimbursement Cuts

Provider reimbursement levels are a frequent target for cuts when states seek to reduce program costs. Over the last three years, 49 states and the District of Columbia cut provider payments in some form. (See Appendix B). Research has shown that these decreases have harmful consequences for beneficiaries by increasing barriers to access. As a result of the cuts to provider reimbursement, providers limit the number of Medicaid patients they care for, and may stop accepting Medicaid patients altogether. Those providers who still accept Medicaid patients are overburdened by the patient flow into their offices. As a result, patients may experience

difficulties accessing providers, or may go without treatment until their conditions are more serious, leading to otherwise avoidable hospitalizations and worsened health status.

Overall, physicians are paid less for Medicaid beneficiaries than for Medicare or privately insured patients, making physicians less likely to accept new Medicaid patients.²³ While about half of all physicians surveyed were accepting new Medicaid patients, one-fifth of providers were not accepting any. In comparison, less than 5% of doctors were not accepting new Medicare or privately insured patients. Thus, many low income Medicaid beneficiaries have difficulties finding physicians who are willing to accept them as patients.²⁴ Approximately 40% of physicians in a MedPAC study said they restricted access due to reimbursement and billing concerns.²⁵ Not surprisingly, acceptance of new Medicaid patients is higher in states with high Medicaid reimbursements than in states with lower Medicaid payments. Among all physicians, 52% in low-fee states, compared with 68% in high fee states, were accepting new Medicaid patients.²³

The decrease in reimbursement to mental health providers is creating a crisis in access to these services, even among the privately insured. Despite rising health care costs, the reimbursements to mental health providers do not match these cost increases. Mental health is just one example, but this is a trend among many providers. In response to low payment rates, clinics and mental health providers cut back their services. As a result, patients may be unable to access the services they need for their mental health conditions and may deteriorate to the point where urgent intervention is required.²⁶ In 2003, health centers had nearly 2.9 million behavioral health encounters. That year, behavioral health was the number one known reason for a health center visit.

How will these cuts in provider payment impact health centers? Health centers may experience an influx of Medicaid patients who had previously been seen by other providers who restricted their practice because of the Medicaid cuts. For example, as other mental health providers restrict access, it is possible that the demand for these services will increase at health centers. Health centers experience increased demand as is and may have limited capacity, making it important for other providers to continue serving the Medicaid patients they currently see. If health centers have the capacity to meet the increased demand, this may not pose a problem by itself because Medicaid patients provide an important source of revenue to health centers. However, problems may occur if provider reimbursement cuts are combined with benefit cuts or reductions in eligibility. Patients will continue to seek health center services even after a state drops benefits, resulting in the funding concerns previously described. If eligibility is also cut, more patients who were previously insured by Medicaid are likely to become uninsured, placing a greater financial burden on the health centers.

Provider cuts may also place increased political pressure on states or the federal government to alter PPS and other reimbursement policies favorable to health centers, changes that may only be made by obtaining 1115 waivers or revising federal law. As it stands currently, health centers under PPS are guaranteed an annual increase in their rate based on the Medicare Economic Index. The PPS formula represents the lowest amount a health center may receive, that is, a state can pay an FQHC no less than its PPS rate. For this reason, even health centers in states that continue to use cost based reimbursement have a stake in keeping the PPS system intact as a way to guarantee a rate increase each year. Were states to eliminate PPS, Medicaid payments to health centers would fall by 33% on average. As a result of PPS, and related reimbursement mandates (such as the PPS wraparound payment in managed care scenarios),

Medicaid payments to FQHCs is usually better than payments to private providers. As other providers are facing reimbursement cuts while health centers receive annual grant increases and other additional payments, political pressure may grow to eliminate the PPS system. In fact, two states have already waived PPS for expansion populations as part of their Section 1115 waivers. First, the state of Utah sought and received a Section 1115 HIFA waiver in order to expand Medicaid to low-income uninsured adults. To maintain budget neutrality the state created a limited benefit package and waived PPS for this new population. In the case of Michigan, the state secured approval of a SCHIP waiver which expands coverage to low-income uninsured adults. Although it did not require a waiver because FQHC is not a required SCHIP service, the state chose not to pay health centers PPS for this population. While health centers receive fee-for-service for a population they previously were not receiving any reimbursement for, as you can see from the Michigan state spotlight below, this can put pressure on health centers because these are high cost populations that many other providers do not see.

STATE SPOTLIGHT: MICHIGAN

In Fall 2000, the State approached Kalamazoo County health care community leaders and proposed that the community take over care for the States Medical Program (SMP) enrollees in the county. The State indicated that the community could obtain matching money for the medical care in a funding formula, not otherwise available. At the time, there were about 700-800 Program enrollees in this county. Family Health Center, Inc., two hospital systems, the Kalamazoo County Human Services Department and Medical Referral Access Network, formed a Task Force to expand medical coverage to uninsured adults (focusing on low-income individuals and the working uninsured). The community developed an organization called the Kalamazoo County Health Plan (KCHP): a non-Medicaid, non-SCHIP, HMO. Under the plan there are two coverage options. Plan A enrollees are those previously eligible under the Michigan SMP. Plan B covers the working uninsured, and others that do not qualify for public or private insurance. All of the new users of this plan will be below 200% of poverty.

Five major providers care for about 20% of the KCHP membership. The fees these providers receive are 15% higher than those paid under SMP fees. The SMP fees were 85% of the Medicaid fee screen, whereas KCHP would be at 100% of the Medicaid fee screen. While the organizers of the plan believed that the additional money would increase community-wide provider participation, the complete opposite occurred. All of the other providers, with one exception, closed their panels to KCHP population, and some asked SMP patients to find another provider.

The development of KCHP uncovered a more significant unmet need for basic primary medical care than the plan organizers realized. While the total estimate of users was 2000, in their preparation of the "Expanded Medical Capacity" Grant for the Bureau of Primary Health Care, FHC learned that the county has an estimated 23,800 uninsured. The market was drastically under-assessed and the result was that the Family Health Center became a repository for the county's uninsured population.

FHC went from 336 KCHP patients at the end of January 2003, to 1,006 patients in Plan A. The total enrollment as of February 2002 was 1,395. By the end of the first year, FHC expected to see 2,100 patients and by the end of the second year, 900 additional patients. Neither SMP status nor the KCHP patient status qualifies as a Prospective Payment System, so the estimated loss at the 100% Medicaid screen rate would be \$432,000 in 2002. As hospitals and private practices continue to be unwilling to accept any significant number of uninsured patients, and there are no other HRSA funded programs in the County service area, FHC is the only option for services for the County's uninsured. While FHC negotiated a temporary increase in capitation reimbursement in addition to the Medicaid fee screen under the "Disproportionate Share Revenue," this temporary help will not be extended beyond June 2002.

Source: Memo by Kim Sibilsky; Michigan Primary Care Association. March 8, 2002.

Cost-Sharing

From 2003 to 2005, 22 states turned to increased cost-sharing through greater co-payments, annual deductibles, and monthly premiums as a means of Medicaid cost-containment. (See Appendix B). These forms of cost-sharing have different impacts on patients. Premiums may make it unaffordable for patients to remain insured, while deductibles and co-payments may make it unaffordable for patients to use the insurance they have. Burdens of co-payments may be most severe among those with chronic conditions or serious health problems because of their higher need for health care services. It follows that health centers will also be impacted differently depending on which type of cost-sharing a state imposes. A patient who disenrolls from Medicaid because of high cost premiums or enrollment fees will likely come to the health center as an uninsured patient. Conversely, the patient who cannot afford a co-payment or deductible will either forgo care or come to the health center but the health center may not be able to recoup the required payment.

Increasing out-of-pocket costs for patients decreases the likelihood that patients will use health care services.^{18;27} While co-payments are assumed to reduce the use of unnecessary care, research points to reductions in essential care as well.²⁸ If patients delay or forgo needed care, they may experience worse health outcomes and health centers may have to provide costlier and more complex services.²⁹

While the majority of existing co-payment research focuses on middle class privately insured patients, Medicaid patients are particularly vulnerable to increased cost-sharing because they have low incomes and often are in poor health.²⁸ Co-payments especially cause problems for Medicaid patients with incomes below the poverty line even when co-pays are nominal. High out-of-pocket costs were found to impact low-income⁴ insured, as well as uninsured families, especially where cost-sharing was increased. About one-fifth of low-income families had problems paying medical bills, while only 7.4% of those above 400% FPL reported these types of problems. Those families with medical bill problems were four times more likely than families without bill problems to delay seeking care because of cost concerns. Not surprisingly, families with medical bill problems were five times more likely to report unmet medical need in the past year because of costs when compared with families without bill problems.³⁰

Findings from studies in Oregon, Massachusetts, Connecticut, Texas, and Washington show that increasing premiums for Medicaid or SCHIP patients leads to disenrollment due to lack of payment and that the lowest income patients are impacted the most. In Oregon, 47,000 people were disenrolled from April 2003 to October 2003 due to non-payment. Enrollment dropped the most (59%) among those with no monthly income and at a very high rate (44%) among those between 85-100% of poverty. In Massachusetts, enrollment declined from one of

⁴ Low-income was defined as under 200% of the Federal Poverty Limit.

their health coverage programs⁵ between 34% and 48% one month after premiums were instituted. Similarly, Connecticut found that one-fifth of children enrolled in the state's SCHIP program were set to be disenrolled due to non-payment of premiums. Both Massachusetts and Connecticut reversed their decisions to institute premiums.³¹ Preliminary findings from a survey conducted by the Institute for Child Health Policy examining the new cost-sharing requirements in Texas suggest that many parents in the 101%-150% FPL group have difficulty making the \$15 per month premium payments. Parents indicated a reluctance to make monthly payments since their children did not use health care services every month.³² Focus groups discussing Washington state's plan to move immigrants to its Basic Health Plan revealed that premiums made obtaining health care too expensive.³³

Based on the study results described above, it is clear that any cost sharing increases, including premium increases, have a negative impact on the patients health centers see most often, such as Medicaid beneficiaries and low income individuals. While 90% of health center users are below 200% of poverty, 69% are below 100% of poverty.⁹ If these patients delay or forgo care due to cost sharing requirements, health centers and other safety net providers may encounter patients at the latter stages of a disease or illness when patients require costly and complex care. Health centers may be most affected by those patients who drop their Medicaid coverage due to high cost-sharing requirements. These patients may continue to seek the care at health centers without bringing the important revenue source provided by Medicaid. Given the severe implications of cost-sharing for the poor and uninsured, these types of cuts are a major concern for all health centers.

⁵ Massachusetts has a state-funded health insurance program to provide insurance on a temporary basis to people who have lost their jobs and are receiving unemployment insurance benefits.

Because health centers are required to cover prescription drugs, co-pays adversely effect all health centers regardless of whether they have on-site pharmacies or 340B drug programs. Approximately 7% of health center patients nationally are elderly and almost 25% have some type of chronic disease, such a diabetes, hypertension, asthma, or behavioral health disorder. These groups of patients are likely to have high pharmaceutical needs. Thirty-four percent of health centers have a staffed pharmacy on-site, 32% refer patients for pharmacy services and pay for these services, and some do both. While pharmacy represents only 7% of health center costs nationwide, for health centers that either provide on-site or pay for referrals the percentage is 9.5. It is also noteworthy that in 2003, pharmacy costs in at least 44 health centers was over 25% of total costs.⁹

STATE SPOTLIGHT: UTAH

In 2001, **Utah** implemented co-payments for parents, seniors and people with disabilities (pregnant women exempt) in an attempt to contain Medicaid costs. The state imposed co-payments for traditional Medicaid recipients. As of November 2004, co-payments are \$2 for prescription drugs with a maximum of \$15 out of pocket per month, \$3 for physician visits, \$2 for outpatient hospital visits, and a maximum out of pocket payment of \$220 for inpatient hospitalizations per year. For non-traditional Medicaid recipients the co-payments are \$2 for prescription drugs, \$3 for physician visits and outpatient hospital visits, and a maximum out of pocket of \$500 for inpatient hospitalizations per year, per person.

Utah applied for and received a Section 1115 waiver to establish the Primary Care Network (PCN). The PCN imposes a \$50 annual enrollment fee on adults under 150% FPL with higher co-pays of \$5 per physician visit. For those under 50% of FPL the enrollment fee was reduced in 2004 to \$25 and for individuals on general assistance the enrollment fee is \$15. The PCN functions as a primary care plan with no coverage for hospitalization and specialty services.

A study released in November 2004 by the Center on Budget and Policy Priorities found that the imposition of co-payments led to a gradual reduction in the number of inpatient hospital visits and a reduction in the utilization of outpatient hospital services.

Additionally, the study found that co-payments imposed on physician visits resulted in a significant reduction in the number of physician visits by Medicaid patients. Of those surveyed for the study, 43% indicated that although the co-payments seem small they are a “huge problem.” Furthermore 39% indicated that co-payments cause “serious financial difficulties” for them. The \$50 enrollment fee for PCN also presents a substantial barrier for PCN applicants; 23% of application denials were related to failure to pay the fee.

There has been significant debate over the impact of these changes. A Utah Department of Health report conflicted with the findings of the study, concluding that Medicaid beneficiaries in the state did not use less health care after co-payments were imposed. The state has cited this finding as evidence that co-payments do not adversely affect Medicaid beneficiaries. The study responds to the state's findings by suggesting that portions of the state's analyses were technically flawed and found the conclusions cited above to be a better reflection of the impact of co-payments.

Source: Ku L, Deschamps E, Hilman J. *The Effects of Co-payments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program*. The Center for Budget and Policy Priorities. November 2, 2004.

Prescription Drug Restrictions

States may try to contain costs through other strategies relating to prescription drug coverage. Two possible tactics include (1) exclusion of certain drugs and (2) spending caps for drugs or limiting the number of prescriptions allowed. Both of these strategies may follow the pattern associated with increased cost-sharing – a reduction in short term outlays for the state in exchange for reduced health status of its citizens and possible costly health care needs due to lack of care.

Discontinuing reimbursement for entire categories of drugs does not change the perceived need for these drug categories, and can result in inappropriate substitutions. One study examining the risks and benefits associated with restricted access to expensive prescription drugs found that formulary differences can have repercussions on health outcomes. This “fail first” prior authorization requires that a low-cost treatment option fails before a more expensive option can be administered. Formulary differences may result in poorer treatment responses and reduced quality of care, reduced use of medication, particularly preventive medications.³⁴ While “fail first” prior authorization is cost effective in the short term, there are long-term health risks for the Medicaid population that can result from this policy.

Another study examined the impact of drug spending caps on Medicare beneficiaries. The majority of the medications were for chronic conditions and a generic equivalent was not available for many of the prescriptions. In this study beneficiaries who exceeded their caps saw a two to three fold increase in their median out-of-pocket costs.³⁵ As noted above, when costs to beneficiaries increase, it is much more likely that patients will forgo needed medicines and possibly incur complicated and costly health conditions.

Restrictions on prescription drug benefits, either through drug exclusions, spending caps, or the number of prescriptions, will have an adverse effect on health centers since they are required to cover pharmacy services. Those centers that serve a large number of elderly patients or patients with chronic diseases whose drugs are affected by these restrictions may feel an even greater impact. Health centers in states that are contemplating these types of reductions will need to compare the restriction with the number of prescriptions and type of drugs used most often by their patients to assess the impact of these cuts.

Downstream Effects

In addition to the impact that Medicaid cuts have on health centers and their patients, health centers and other advocates should also be concerned about the effects Medicaid cuts have on the entire health care system. These “downstream effects” of Medicaid cuts may produce long-term damage to an already fractured and fragile safety net system.

One of the most well known downstream effects is the rise in emergency room visits and hospitalizations by individuals who were previously covered under Medicaid or other public programs or by those who remain covered but at higher costs or for fewer benefits. Several studies have tracked this trend. After Maryland eliminated dental coverage from its Medicaid program, there was a 12% increase in dental-related claims in emergency departments.¹⁵ Studies

that evaluated the effects of limiting the number of prescriptions and/or increasing cost-sharing of prescription drugs found that these limits reduced the use of clinically essential drugs (e.g., insulin) and increased the use of hospitals, emergency mental health services, and nursing homes. This is true for low-income and elderly populations even when the cost-sharing is moderate.³⁴ A Canadian study that reviewed the impact of prescription drug cost sharing policies on low-income and elderly found similar results - individuals reduced the use of essential drugs as a cost-saving measure, with the sicker patients who use the most medications being the most likely to do so. As the use of essential drugs decreased, adverse events and visits to the emergency room increased.³⁶

An initial review of changes to the Oregon Medicaid plan shows that similar results have occurred there as well. Oregon used a Section 1115 waiver to implement sweeping changes to its program, including reduction of some benefits such as substance abuse services, elimination of the medically needy program, and imposition of higher premiums and cost-sharing requirements. In the first three months following these changes, visits to the emergency department by uninsured patients increased by 17% while visits by patients covered by the plan declined by 20%. In addition, emergency room visits for alcohol and chemical dependency related reasons increased by 26% and 46% respectively. The rise in substance abuse related emergency room visits was most pronounced among the uninsured, whose visits increased by 136% for alcohol related treatment and by 200% for chemical dependency treatment.³¹

While these studies cannot eliminate other factors that may have been related to the increase in emergency use visits, logic and timing (that the change in policy occurred shortly before the increase in visits) strongly suggests that these policy changes are effecting emergency department use in an adverse way. With the loss of benefits or coverage, these patients are no

longer able to access providers in other settings. By using emergency rooms as their usual source of care these patients are straining the resources of those departments, not able to receive continuous care, and likely delaying treatment until their health problems are more severe.

Unfortunately, emergency departments are not the only providers impacted by cuts in Medicaid program. The entire safety net system feels the ripple effects of patients losing their coverage or receiving reduced benefits. In Oregon, the Medicaid changes also resulted in other safety net providers diverting resources to patients who lost their Medicaid prescription drug coverage or could not afford the cost sharing requirements. There was a higher number of appointment “no-shows” due to new co-payment charges.³¹

Nearby Washington State experienced similar problems when it eliminated three state-funded programs (“Medical Assistance”) for 28,000 individuals whose immigration status barred them from receiving Medicaid. While these programs were not part of Medicaid, they offered the same benefits as the state’s Medicaid plan. These families could apply to enroll in the Basic Health plan, another state-funded program that had premiums, cost-sharing, and fewer benefits than the Medicaid-like state programs. Only about half of the Medical Assistance beneficiaries switched to Basic Health due to enrollment barriers and concerns about affordability. It is likely that many of the individuals who did not switch to Basic Health became uninsured. As a result of the elimination of the Medical Assistance programs, there was an increased demand on the Alien Emergency Medicaid program, a federal program to help individuals who have an emergent condition but do not qualify for Medicaid due to their immigrant status. In addition, providers experienced an increased demand in charity care requests and an increase in emergency room usage.³³

These experiences suggest that the impact of Medicaid cuts will reverberate throughout a state's health care community. Other resources that are used by safety net providers will be further strained and emergency departments will become a more frequent medical home to the newly uninsured and underinsured.

STATE SPOTLIGHT: OREGON

In response to budget pressures, Oregon has used a section 1115 waiver to implement benefit reductions, increased cost sharing, eliminate its medically needy program, and refinance a previously fully state-funded program known as the Family Health Insurance Assistance Program. This experiment highlights the dangers of implementing multiple cuts simultaneously.

In February 2003, the state reduced OHP (Oregon's Medicaid program) enrollees' benefits and increased cost sharing. The reduced coverage is called OHP Standard. Adults covered by OHP Standard lost benefits including mental health services (due to significant public outcry, mental health and chemical dependency benefits were reinstated for this population in August 2003), durable medical equipment, dental and vision. A \$250 deductible was added for inpatient hospital coverage. Premiums in the OHP Standard program range from \$6/month per person below 10% of poverty to \$20/month per person at 100% of poverty. The administrative policies for payment are also strict: those who are late or miss one payment are unable to re-enroll for 6 months. However, in July 2004 enrollment in OHP Standard was closed, so those who are late or miss a payment are unable to re-enroll at all. Attrition of OHP Standard is projected to reach the target enrollment of 24,500 by August 2005. The OHP standard program is no longer funded by the state's general fund and was saved from elimination when MCO's agreed to a 6% tax and hospitals agreed to a 1% tax which is able to cover the target number of 24,500. (Pregnant women, children, and the blind and disabled are considered OHP Plus and their benefits remained for the most part intact.)

Oregon also eliminated its medically needy program. The majority of those assisted by the program were low-income Medicare beneficiaries who relied on this coverage for services not covered by Medicare (i.e. prescription drugs, mental health services, and durable medical equipment). Nearly 9,000 people lost coverage as a result of the termination of this program. Those who lost coverage under the medically needy program reported suffering from conditions that prevented them from working including multiple sclerosis, severe diabetes, post traumatic stress disorder and Crohn's disease. Many were taking multiple medications, several needed regular mental health care, and many relied on the program to cover services that Medicare did not cover. Although these dual eligibles did not become uninsured, they lost coverage for critical services. Because Medicare does not yet cover their prescriptions, the loss of drug coverage has created problems, particularly for those taking multiple prescriptions. Being unable to afford medications, some engage in rationing practices to make their prescriptions last longer.

A recent study looked at the impact of these changes. Key findings included:

- Many of the affected people had very limited income, including some as low as 43% FPL for a childless adult and 52% FPL for a parent.
- Many of the affected people had significant health care needs. Over half of the adults with reduced coverage had a chronic condition other than depression or anxiety and over a third were diagnosed with depression or anxiety.

- As of March 2005, OHP Standard enrollment has fallen by over half, from about 100,000 in December 2002 to about 30,000 enrollees. Nearly three-quarters of the disenrolled became uninsured.
- Premium increases played a significant role in enrollment declines and the decline was steepest among people in the lowest income level. Focus groups revealed that increased premiums made it difficult to maintain coverage.
- Co-payments appear to have created barriers to care.
- Individuals who lost coverage were more likely to have unmet health care needs and more likely to use the Emergency Room as their usual source of care.
- Most of the former medically needy patients were unable to access needed care after losing coverage. They had significant health care needs, with over 85% reporting they had two or more chronic conditions and 68% saying they were in poor or fair health. Most had skipped doses of medicines and failed to fill prescriptions after losing coverage.
- Increased pressures on health centers including: finding resources for those who lost prescription drug coverage, increasing “no-shows” due to co-payments, and private physicians retreating from Medicaid, and an increasingly sicker population with increased mental health issues.

Sources:

LeCouteur G, et. al. *The impact of Medicaid reductions in Oregon: focus group insights.*

Kaiser Commission on Medicaid and the Uninsured. Dec 2004

Mann C, Artiga S. *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program.* Kaiser Commission on Medicaid and the Uninsured. June 2004.

Medicaid Waiver Issues

Premium Assistance

In an effort to promote private coverage, the Bush Administration's Health Insurance Flexibility and Accountability (HIFA) initiative offers expedited federal review of certain Section 1115 waiver applications that include premium assistance as a component. Premium assistance is the use of federal and state Medicaid/SCHIP funding to subsidize private coverage on the individual market or through employer-based plans for Medicaid and SCHIP beneficiaries. Since HIFA waivers must be budget neutral, any resources applied to premium assistance must be taken from other parts of the state's program or balanced by cost savings.

The Centers for Medicare and Medicaid Services' (CMS) HIFA guidelines weakened the benefit and cost-sharing protections for families participating in premium assistance programs and relaxed the cost-effectiveness test. States with HIFA waivers are permitted to subsidize private coverage for parents and children under Medicaid or SCHIP who are “optional” beneficiaries without regard to the minimal benefits that may be in the private coverage or the cost-sharing requirements.³⁶

To this point, state adoption of premium assistance programs has been limited. Massachusetts, Maryland, New Jersey, Oregon, Rhode Island, Virginia, and Wisconsin have created Section 1115 premium assistance programs for Medicaid or SCHIP beneficiaries. Illinois and Oregon already had state-funded premium subsidy programs and were able to refinance some of their costs with federal dollars. New Mexico, Tennessee and Utah could establish a new premium assistance program as a result of receiving waiver approval from CMS, but all three have delayed implementation. Arizona, California, Colorado, Oklahoma and Vermont are considering applying for premium assistance waivers. Arizona and Colorado studies cite several impediments to implementation: limited availability of employer-based coverage for low-wage workers, rapidly rising costs of coverage in the private market, high cost sharing, and state fiscal and administrative challenges.³⁶

Premium assistance waivers pose multiple threats to health centers. As noted above, waivers must be budget neutral so any resources used to create a new program must be taken out of the existing Medicaid budget. Any and all of the concerns related to eligibility reductions, benefit cuts, and lower provider reimbursement rates could be implicated with such a waiver. In addition, it is likely that low-benefit plans will be made available at a cost targeted to the premium assistance level. Individuals may enroll in these plans only to find out that many

benefits are excluded. If they seek care at a health center for the uncovered benefits, it is likely health centers may have to cover their costs by using federal grant dollars for the uninsured to subsidize Medicaid. These plans may have high cost sharing requirements, which will bring about the concerns with cost sharing noted above. Finally, it is likely that many health center patients will not benefit from a premium assistance plan because their employers do not offer health insurance or their income is too low to afford available plans even with premium assistance. Thus, health centers will feel the negative consequences relating to Medicaid cuts necessitated by the waiver while their patients may not receive the benefits of the new program.

Health Savings Accounts

Several states are currently considering 1115 waiver proposals that would create some form of a health savings account for their Medicaid populations. Florida, South Carolina, New Hampshire and Iowa have all expressed interest in providing a set amount of funding for Medicaid beneficiaries to use to purchase health services. Details vary on how to deal with unspent funds, which populations would receive accounts, the adequacy of the accounts, and how catastrophic care and chronic diseases would be handled. In general, these types of proposals appear to eliminate the entitlement nature of Medicaid by only promising beneficiaries a limited amount of funds, not a set benefit package. Because these accounts have not been used before with the Medicaid population, it is unclear what the impact would be on patients and health outcomes, however it appears there could be an incentive for beneficiaries to delay care which could result in higher costs and poorer outcomes.

These proposals also present specific challenges for health centers by circumventing the state's obligation to pay health centers PPS. Federal statute prohibits health centers from charging Medicaid patients a sliding fee (except with regard to cost-sharing). At the same time

health centers may find themselves in a position where they have to collect PPS so that federal 330 grant dollars are not used to supplant Medicaid dollars. Health centers therefore would have to charge patients PPS. The costs to patients may be higher because the rate is based on the bundle of services provided including enabling services such as translation and transportation. This would be a disincentive for Medicaid beneficiaries to seek care at health centers, regardless of the benefits health centers provide as medical homes.

Conclusion

Reductions in Medicaid have two overarching results: negative impact on the health of Medicaid beneficiaries and negative impact on the financial viability for health centers. Health centers must be concerned about both consequences. When Medicaid beneficiaries lose coverage, they are likely to become uninsured or underinsured due to the high cost of private insurance. As a result, they will delay seeking care and possibly suffer worse health outcomes. As uninsured and underinsured health center patients increase, health centers may serve more patients who are unable to pay for care, either from their own pocket or through insurance coverage. Furthermore, the already inadequate number of providers who serve Medicaid patients are likely to be reduced if further reimbursement and benefit cuts occur, possibly straining the capacity of health centers to provide care to these additional patients. By considering the various impacts of the most frequent types of cuts and insurance system changes adopted by states, health centers should now be able to identify and respond to the unkindest cuts that may occur in their state.

**APPENDIX A:
MEDICAID POLICY OPTIONS AFFECTING HEALTH CENTERS
ESTIMATING THEIR COST IMPACT NATIONALLY**

This worksheet serves as a model for states, localities, and health centers to use in determining local impact. This worksheet estimates impacts on all health centers, and therefore assumes that changes happen on a national level. Thus, estimates are maximum possible losses. Other key assumptions are clarified below. These estimates do not take into account rising numbers of new uninsured patients that will turn to health centers should they lose Medicaid coverage. Such patients tend to delay seeking care until their health problems are severe, and experience serious physical and behavioral health problems.¹ Estimated losses related to cutting certain benefits are not provided.

Policy Option	Key Assumptions	Data Needed	Calculation	Medicaid Revenue Loss
Imposing an annual deductible of \$100	All visits prior to meeting the deductible are made to a health center. It is not likely that low income Medicaid patients would be able to pay.	Annual deductible (\$100) Total Medicaid patients (5.4 million) ²	\$ Deductible × # of Medicaid patients \$100 × 5.4 million	\$540 million annual loss
Imposing per visit co-payments of 20%	Current federal law prohibits more than nominal charges, therefore assumes that federal legislation affords states greater flexibility in cost-sharing or all states receive an 1115 waiver. It is not likely that low income Medicaid patients would be able to pay co-pays on their charges.	Total Medicaid patients (5.4 million) Average billable visits per Medicaid patient (3.7) ³ Average visit cost (\$144) ⁴ adjusted for inflation (\$148) ⁵	# of Medicaid patients × ave. # of billable visits × visit cost × co-pay 5.4 m × 3.7 visits × \$148 cost × 20% copay	\$591 million annual loss
Total loss of PPS for FQHCs	Current law provides health centers (FQHCs) with a cost-related Prospective Payment System (PPS) rate for each visit. If PPS is waived or repealed, health centers would revert to fee-for-service payments,	Total Medicaid patients (5.4 million) Average billable visits per Medicaid patient (3.7) Average visit cost adjusted for	# of Medicaid patients × ave.# of billable visits × visit cost × PPS loss 5.4 m × 3.7 visits × \$148 cost × 33% loss	\$976 million annual loss

Policy Option	Key Assumptions	Data Needed	Calculation	Medicaid Revenue Loss
	losing an estimated 33% of their PPS rate for each visit.	inflation (\$148) PPS loss rate (33%) ⁶		
Flexible benefit package for optional Medicaid populations (i.e., no PPS for optionals)	Assume 30% of Medicaid health center patients are optional ⁷ and are provided with a coverage plan (private or otherwise) that does not include FQHC services (and therefore health centers are paid at a fee-for-service rate, and not their PPS payment rate)	Total optional Medicaid patients (5.4 million * 30%) Average billable visits per Medicaid patient (3.7) Average visit cost adjusted for inflation (\$148) PPS loss rate (33%)	# of optional Medicaid patients × ave. # of billable visits × visit cost × PPS loss 1.6 m optionals × 3.7 visits × \$148 cost × 33% loss	\$289 million annual loss
Elimination of Medicaid coverage for all optional Medicaid recipients	Assume 30% of Medicaid health center patients are optional and are dropped from Medicaid coverage due to either federal limits or state financial crises. Assumption is that these individuals would not find affordable coverage elsewhere.	Total optional Medicaid patients (5.4 million * 30%) Average billable visits per Medicaid patient (3.7) Ave Medicaid payment per Medicaid patient visit (\$129) ⁸ adjusted for inflation (\$132)	# of optional Medicaid patients × ave. # of billable visits × Medicaid payment per visit 1.6 m optionals × 3.7 visits × \$132 payment	\$781 million annual loss

Sources: Data are extrapolated based on 2003 UDS except as indicated.

¹ A recent Kaiser Commission on Medicaid and the Uninsured study found that uninsured health center patients – many of them new patients after having recently lost insurance coverage – tended to experience serious physical as well as mental illness, and new uninsured patients tended to delay seeking care until their health problems were severe. Moreover, nearly every health center interviewed reported increased volumes of patients with mental illness and alcohol and other addiction disorders among all uninsured patients, often causing longer wait times for appointments. Many of these patients needed a level of intervention beyond their health centers' capacity. Rosenbaum S, Shin P and Darnell J. *Economic Stress and the Safety Net: A Health Center Update*. Kaiser Commission on Medicaid and the Uninsured. June 2004. www.kff.org/uninsured/7122.cfm.

² Applied 2003 UDS percent of Medicaid users as a percent of total users (36%) to 15 million estimated total health center patients currently served.

³ Based on the number of billable visits per Medicaid managed care health center patient. Billable visits include medical, dental, behavioral health visits. Nationally, patients in general on average have four visits per year, but not all may be billable.

⁴ Based on total cost over total number of billable encounters. Billable encounters are those provided by physicians, nurse practitioners, certified nurse midwives, dentists, dental hygienists, mental health professionals, and substance abuse professionals.

⁵ Adjusted for inflation because cost is based in 2003 UDS. Uses CPI, not medical inflation which tends to be higher. Inflation can only be adjusted to 2004 dollars, not 2005. Therefore these estimates are conservative. See Bureau of Labor Statistics inflation calculator at www.bls.gov.

⁶ Based on the percent of Medicaid managed care revenue attributable to wrap around payments. Assumes that this proportion is roughly equivalent to FFS PPS.

⁷ Assumes that the proportion of Medicaid health center patients that are optional is equal to the proportion of all optional Medicaid beneficiaries. According to the Kaiser Commission on Medicaid and the Uninsured, 20% of Medicaid children are considered optional and 43% of Medicaid parents are. (In total, 29% of total Medicaid beneficiaries are considered optional) See Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Optional Populations: Coverage and Benefits," February 2005, www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=51052. According to 2003 UDS, 41% of health center Medicaid patients are adults (20 and over), and 59% are kids (ages 0-19). Thus, of the 5.4 million Medicaid patients currently, 3.2m are kids and 2.2m are adults. Because we assume that 20% of kids are optional and 43% of adults are, we find that 640,000 kids are optional ($20\% \times 3.2m$) and 946,000 adults are ($43\% \times 2.2m$), for a total of 1,586,000 optional Medicaid patients, or 29.4% of all Medicaid patients.

⁸ Total Medicaid revenue divided by total Medicaid patients divided by average billable encounters.

NACHC Working Document, March 2005

For more information, email mproser@nachc.com

APPENDIX B

TABLE 1: State Medicaid Cuts by Type of Cut, Fiscal Years 2003-2005

State	Provider Payments	Prescriptions (limiting type or number)	Benefits Cut	Cost-Sharing	Nursing home & long term care	Disease/case management	Eligibility
Alabama	X	X	X				X
Alaska	X	X			X		X
Arizona	X	X		X		X	X
Arkansas	X	X					
California	X	X	X			X	X
Colorado	X	X	X	X	X	X	X
Connecticut	X	X	X	X	X		X
Delaware	X	X		X	X		
D.C.	X	X				X	
Florida	X	X	X	X	X		X
Georgia	X	X	X			X	X
Hawaii	X	X					
Idaho	X	X			X	X	
Illinois	X	X					
Indiana	X	X	X	X	X	X	X
Iowa	X	X		X	X	X	X
Kansas	X	X				X	
Kentucky	X	X					X
Louisiana	X	X				X	X
Maine	X	X	X	X		X	X
Maryland	X	X	X	X	X	X	X
Massachusetts	X	X		X	X	X	X
Michigan	X	X	X	X	X	X	
Minnesota	X	X		X	X		X
Mississippi						X	X
Missouri	X	X	X			X	X
Montana	X	X				X	
Nebraska	X	X	X				X
Nevada	X	X	X				X
New Hampshire	X	X		X		X	
New Jersey	X	X	X		X	X	X
New Mexico	X	X	X	X	X	X	X
New York	X	X			X	X	X
North Carolina	X	X	X		X	X	X
North Dakota	X	X	X				X
Ohio	X	X	X	X	X	X	X
Oklahoma	X	X				X	
Oregon	X	X	X			X	X
Pennsylvania	X	X				X	
Rhode Island	X	X				X	
South Carolina	X	X		X	X	X	X
South Dakota	X	X				X	X
Tennessee	X	X	X			X	X
Texas	X	X	X		X	X	X
Utah	X	X	X	X		X	X
Vermont	X	X	X		X	X	X
Virginia	X	X		X		X	X

Washington	X	X	X	X		X	X
West Virginia	X	X		X	X	X	
Wisconsin	X	X	X	X	X	X	X
Wyoming	X	X		X		X	
Total	50	50	25	22	22	38	36

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APPENDIX C

Table 2: Enrollment and Spending by States with Medically Needy Programs, 2000

State	Enrollees (2000)	Spending in thousands (2000)
Arizona	26,212	57,700
California	952,240	3,986,042
Connecticut	40,123	344,803
D.C.	25,897	245,721
Florida	69,532	169,565
Georgia	9,874	59,471
Hawaii	2,549	52,712
Illinois	368,653	3,216,078
Iowa	9,747	37,875
Kansas	13,189	63,711
Kentucky	50,413	132,145
Louisiana	8,197	35,474
Maine	1,451	16,887
Maryland	83,838	1,018,430
Massachusetts	21,906	214,160
Michigan	12,3197	231,227
Minnesota	10,327	88,969
Montana	85,66	118,143
Nebraska	38,626	350,163
New Hampshire	11,495	133,299
New Jersey	5,145	76,331
New York	1,236,496	10,861,780
North Carolina	39,679	514,208
North Dakota	17,184	199,149
Oklahoma	9,057	11,316
Oregon	7,236	34,594
Pennsylvania	131,005	675,182
Rhode Island	4,897	100,717
Tennessee	110,666	169,348
Texas	50,284	123,186
Utah	6,646	22,809
Vermont	12,246	38,324
Virginia	10,177	98,541
Washington	13,421	103,422
West Virginia	4,729	26,319
Wisconsin	36,857	124,487

Source: Crowley J. *Medicaid Medically Needy Programs: An Important Source of Medicaid Coverage*. Kaiser Family Foundation, Commission on Medicaid and the Uninsured. January 2003.

APPENDIX D

TABLE 3: Summary of Research Findings on Changes to Medicaid and Potential Impacts on Health Centers

Issue/Author	Research Area	Study Findings	Potential Effect on Health Centers
Economic Impact			
Doesken and St. Clair, 2002	Medicaid's impact on Alaska's economy	Medicaid expenditures impact health care businesses' purchases of goods, services and labor. Medicaid has a positive impact on job creation and generates income in health sector.	States have economic incentives to maintain strong Medicaid programs which are essential to health center survival.
Kilpatrick and Luger, 2002	Medicaid's impact on North Carolina's economy	Medicaid cuts result in job loss and decreased output in the state economy.	A weakened Medicaid program hurts the states economy and poses financial risks for health centers which will most likely see more uninsured and low-income users.
Miller, 2002	Medicaid's impact on Rhode Island's economy	Rite Care reduces the number of uninsured, reduces preventable hospitalizations, improves health outcomes, and saves money in the health system. Medicaid contributes to the economic stability of low-income families, decreases personal bankruptcies. Medicaid reduces the burden of providing free care. Medicaid increases flow of federal dollars into the state and stimulates spending by participating families.	States have economic incentives to maintain strong Medicaid programs which are essential to health center survival. A weakened Medicaid program hurts the states economy and poses financial risks for health centers which will most likely see more uninsured and low-income users.
Moore School, 2002	Medicaid's impact on South Carolina's economy	Medicaid federal match creates jobs and stimulates the economy.	States have economic incentives to maintain strong Medicaid programs which are essential to health center survival.
Benefit and Eligibility Cuts			
Cohen, et al., 2003	Effect of elimination of Medicaid reimbursement to dentists for treatment of adult dental problems on patient's visits to physicians.	Visits to physician offices for dental care decreased, increase in dental visits in emergency departments.	Dental is costly, reduction or elimination of Medicaid coverage could result in discontinuing dental services to patients.

Issue/Author	Research Area	Study Findings	Potential Effect on Health Centers
Crowley, 2003	Overview of medically needy program.	Several states have eliminated their medically needy programs as a cost-containment strategy. Formerly covered patients could face a greater financial burden and limited access to providers.	Health centers may experience an influx new high-cost uninsured patents who were formerly covered by the state's medically needy program.
Davidoff, et al., 2003	Effects of having an uninsured parent on access to health care for low income children.	Having an uninsured parent decreases likelihood that a child has any medical provider, decreases likelihood of well-child visit, and reduces likelihood of having any provider visit.	Health centers' ability to serve their large child patient population will be affected by the insurance status of the parents.
Rosenbaum, Shin and Darnell, 2004	Profile of health centers and challenges they face in responding to economically stressed communities; examines how increases in federal appropriations relate to demand on health center services.	Health center growth has been significant. Number of uninsured users virtually doubled from 1990-2002. Health centers have considerable impact on communities they serve, and accessibility and quality of care for low-income populations. Health centers are experiencing increase in number of uninsured, patients are losing coverage, surge in new patients who lost coverage as a result of job cutbacks or unemployment. Newly uninsured may wait longer before seeking care. Federal funding increases have failed to keep up with expanding need.	Health centers are at-risk financially by the increasing number of uninsured patients and need additional federal grants to keep pace with the cost of serving uninsured patients.
Provider Reimbursement Cuts			
Appelbaum, 2003	Effects of a failure to reimburse mental health providers for the cost of care in Massachusetts.	Hospitals are closing psychiatric units, and mental health outpatient services are contracting or closing. Providers are withdrawing from public mental health services. Inability to receive care leads to sicker individuals.	Health centers may experience an increased demand for mental health services and may see patients with more severe mental health needs.
Cunningham, 2002	The relative effects of insurance coverage and health center capacity on access to care.	Communities with both high insurance coverage and extensive CHC capacity have the best access.	Health centers should continue to advocate for both health center expansion and reducing the number of uninsured.

Issue/Author	Research Area	Study Findings	Potential Effect on Health Centers
Finkelstein, 2002	Decrease in the proportion of physicians accepting Medicaid patients and the decrease in the charity care provided by physicians from 1997-2001.	Correlation between Medicaid payment rates and the proportion of practices closed to those patients. Decrease in the number of physicians offering charity care may impact access for the uninsured.	Health centers may see an influx in Medicaid patients as other providers limit access. If combined with benefit or enrollment cuts, this could pose financial risks for health centers.
Schoenman, Feldman2002	Impact of changes in Medicaid physician fees on physician participation.	Many physicians are closing or limiting their practice for new Medicaid patients due to low reimbursement and other billing concerns.	Health centers may see an influx in Medicaid patients as other providers limit access. If combined with benefit or enrollment cuts, this could pose financial risks for health centers.
Zuckerman, McFeeters, Cunningham, and Nichols, 2004	Impact of changes in Medicaid physician fees on physician participation.	States with lowest Medicaid fees had physicians who were less willing to accept new Medicaid patients.	Health centers may see an influx in Medicaid patients as other providers limit access. If combined with benefit or enrollment cuts, this could pose financial risks for health centers.
Cost Sharing			
CHSC Issue Brief 85, 2004	Impact of out-of-pocket costs on low-income families.	Low-income families have problems paying medical bills, making it more difficult for them to access care.	Health centers may experience an increase in uninsured patients or uncompensated care if employees find new cost sharing requirements too burdensome. Patients may wait longer and have more serious conditions when they do seek care.
Dunkelberg, O'Malley, 2004	Summary of Medicaid and SCHIP policy changes and the impact on children's coverage in Texas.	SCHIP enrollment decreased. Those who are affected by changes in SCHIP are predominately low-income.	Health centers may see an influx of uninsured children who were previously covered by SCHIP.
Gardner, Varon, 2004	Assess the impact of the elimination of the Medical Assistance programs for immigrants in Washington State.	Declines in enrollment, affordability problems, delayed or denied care for specific health problems not covered by narrowed scope of program, cost shifting to other private and public providers and agencies.	Health centers may experience an increase in uninsured patients or uncompensated care if employees find new cost sharing requirements too burdensome. Patients may wait longer and have more serious conditions when they do seek care.

Issue/Author	Research Area	Study Findings	Potential Effect on Health Centers
Ku, Deschamps, Hilman, 2004	Effects of instituting co-payments on use of drugs and medical services in Utah.	Co-payments reduced hospital admissions, led patients to see doctors less often, reduced patients' use of prescription drugs, and lowered the number of outpatient visits when applied in each of these categories.	Health centers may experience an increase in uninsured patients or uncompensated care if employees find new cost sharing requirements too burdensome. Patients may wait longer and have more serious conditions when they do seek care.
Lee, Tollen, 2003	Impact of increasing employee cost-sharing and reducing benefits.	Savings from eliminating specific benefit categories were greater than those from paring down benefits. Similar premium savings from eliminating categories of coverage or modestly increasing cost-sharing. Increased cost-sharing produced estimated savings greater than those available from eliminating benefits.	Health centers may experience an increase in uninsured patients or uncompensated care if employees find new cost sharing requirements too burdensome.
Mann, Artiga, 2004	Impact of Oregon's changes to Medicaid program – including benefit reductions, higher premiums and cost-sharing for poor adults, and elimination of state's medically needy program.	Premiums led to significant coverage losses, most of those who lost coverage became uninsured. People who lost coverage faced difficulties obtaining care. Cost-sharing made it harder for people to enroll. Access problems for people with significant medical needs. Increased pressure on other parts of the health care system.	Health centers may experience an increase in uninsured patients or uncompensated care if employees find new cost sharing requirements too burdensome. Patients may wait longer and have more serious conditions when they do seek care.
Wong, et al., 2001	Effects of cost sharing on medical use among chronically ill adults.	Cost sharing was associated with less use of medical care for minor symptoms and lower rates of seeking care for serious symptoms.	Health centers may experience an increase in uninsured patients or uncompensated care if employees find new cost sharing requirements too burdensome. Patients may wait longer and have more serious conditions when they do seek care.
Prescription Drug Restrictions			
Piette, Heisler, Wagner, 2004	Cost-related under-use of medications.	Many chronically ill patients take less of their medication than prescribed, especially low income patients, those with multiple chronic health problems, or no prescription drug coverage.	Health center patients may wait longer and have more serious conditions when they do seek care.

Issue/Author	Research Area	Study Findings	Potential Effect on Health Centers
Soumerai, 2004	Effects of preferred drug lists and prior authorization, drug category exclusions, and increased patient cost-sharing.	Fail first prior authorization might induce physicians to avoid the hassle of seeking preauthorization of medications. Low income patients may give up on filling prescriptions instead of seeking authorization. May reduce quality of care for some illnesses. Drug Category exclusions did not reduce overall drug use or spending but may result in inappropriate substitution effects. Patient cost sharing may create side effects in some patients and may effect appropriateness of care.	Health centers that provide pharmacy services may face increased uncompensated care costs if necessary medications are not covered or patients become uninsured or remain insured but cannot afford the co-payments.
Tamblyn, 2001	Impact of cost-sharing for prescription drugs among poor and elderly persons on the rates of emergency department visits and serious adverse events associated with drug use.	Increased cost-sharing was followed by reductions in the use of essential drugs and a higher rate of serious adverse events.	Health centers that provide pharmacy services may face increased uncompensated care costs if necessary medications are not covered or patients become uninsured or remain insured but cannot afford the co-payments. Patients may wait longer and have more serious conditions when they do seek care.
Tseng, 2003	Impact of an annual dollar cap on drug benefits for Medicaid beneficiaries.	At lower cap levels, 1 in 5 patients exceeded their cap and faced increased out-of-pocket costs. Patients will have coverage for only part of the year. May be at risk for decreasing medication use because of cost.	As out of pocket costs increase, patients may begin to compensate by taken less of their prescribed medications, making them sicker over longer periods of time.
Voelker, 2004	A discussion of the need for physicians to inform patients about the danger of under-use of medications as a cost-saving mechanism.	Paying for medications creates financial strain. Most patients don't tell their doctors that they are noncompliant with medication instructions. Higher risk of side effects.	Health centers should be aware of prescription drug underuse and make sure their providers are trained to discuss this tactic with their patients.

Premium Assistance Waivers			
Kaiser, Oct 2003 (Serving low-income families through premium assistance)	HIFA waiver initiative – examines new federal policies associated with using Medicaid and/or SCHIP to promote private insurance options and the ways states responded to new policies within first 18 months of HIFA launch.	States may face different circumstances or assess the facts differently. States express concerns about administrative costs of the programs. May not reduce number of uninsured.	Health centers may experience negative consequences of waivers (cuts due to budget neutrality requirements) while health center patients are unlikely to benefit from premium assistance programs.

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