# The Florida Senate

*Interim Project Report 2008-132* *December 2007*

Committee on Health and Human Services Appropriations


## FLORIDA MEDICAID EXPENDITURE SAVINGS INITIATIVES


### SUMMARY

Florida's Medicaid program provides health care coverage and long-term care assistance to over 2.1 million individuals. Florida, as well as many other states, struggles each year to fund the growth in Medicaid expenditures, which continually outpaces growth in state revenue. When crafting budgets, states are left with the difficult task of developing strategies that can achieve immediate and long-term expenditure relief. With the pressure to control program costs and growth, all states, including Florida, have implemented a variety of cost containment strategies in their Medicaid programs.

This report provides insight into the areas where cost containment activities have been implemented or may be considered in Florida and in other states. The review determined that the opportunities for Medicaid cost containment generally fall into one of the following six expenditure or revenue categories: prescribed drugs; provider rates; eligibility; services; service delivery systems; and provider taxes.

There is no single strategy for controlling expenditure growth. The entitlement nature of the Medicaid program and its link to medical inflation make it difficult to control expenditures. No new strategies were identified to control expenditure growth based on staff research of findings from surveys of state Medicaid program cost containment strategies. Professional staff recommends that the Legislature:

- Continue to implement policies to reduce the rate of increase for provider rates, reduce benefits, reduce eligibility, and control prescription drug spending.
- Continue managed care initiatives that coordinate care and result in cost savings.
- Continue policies to change the delivery of long-term care services utilizing managed care.
- Provide education to increase participation in the long-term care partnership program.
- Review the additional benefit flexibility provisions made available through the federal Deficit Reduction Act (DRA) of 2005 to redesign Medicaid benefit packages.
- Review the use of other provider taxes to generate revenue to support the Medicaid program.

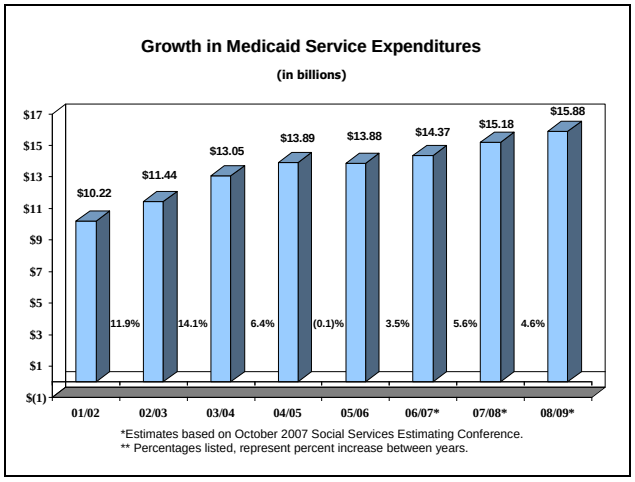

### BACKGROUND

Authorized through Title XIX of the United States Social Security Act, Medicaid is the largest publicly funded program providing medical and health-related services to the nation's poorest citizens. The program is an entitlement, requiring payment for the covered health services for all individuals deemed eligible. The eligible population consists mostly of low-income families and children, the elderly, and persons with disabilities.

Within broad federal guidelines, states define their own program and establish eligibility standards; determine the type, amount, duration, and scope of services; set the rate of payment for services; determine the delivery system; and administer the program. States must cover certain eligibility groups and services (mandatory eligibles and services). States may also elect to provide coverage for other eligibility groups and services (optional eligibles and services). If a state elects to cover optional services, federal rules require the state to provide the optional services to the entire eligible population.

Florida's Medicaid program provided health care coverage and long-term care assistance to over 2.1 million Floridians in Fiscal Year (FY) 2006-07. Elderly and disabled recipients account for an estimated 23 percent of the total caseload yet they account for almost 70 percent of Medicaid spending. Medicaid expenditures were $14.4 billion in FY 2006-07 and are projected to increase by 5.6 percent to approximately

$15.1 billion in FY 2007-08.[1] Medicaid plays a significant role in Florida's health care system, financing a broad range of services, including 51.2 percent of all births in the state, and 63 percent of all nursing home days.[2]




The Medicaid program is jointly financed with state and federal funds. The federal government provides matching funds through the Federal Medical Assistance Percentage (FMAP), calculated each year by the Secretary of Health and Human Services. Florida's FMAP is 56.83 percent in FY 2007-08. This means that for every dollar the state spends on Medicaid services, it will generate one dollar and thirty two cents of federal funds. The state share of Medicaid program expenditures is directly affected by changes in the FMAP percentage.

A decrease in the FMAP percentage requires the state to increase its state share to maintain the same spending level for the same services. For the last several years, Florida's state share of Medicaid spending has increased more rapidly than the total Medicaid spending as the FMAP has declined. Florida's FMAP has decreased by 2.06 percent between FY 2005-06 and FY 2007-08, from 58.89 percent to 56.83 percent. This change in FMAP required Florida to increase state funding for the program by more than $250 million over the two year time period. An additional decrease in FMAP of 1.43 percent is expected for FY 2008-09. The state share is primarily funded from general revenue, but also includes revenues from tobacco settlement, cigarette taxes, supplemental drug rebates, provider assessments, and local/county contributions. Despite the enactment of a multitude of policy changes designed to reduce expenditures, Medicaid expenditures continue to increase in all states. Nationally, Medicaid expenditures are at an all-time high of $320 billion, and are projected to grow approximately 8 percent per year through the year 2017.[3] Florida's Medicaid total projected expenditures for FY 2007-08 are $15.1 billion, second only to Education at $24.2 billion. Florida Medicaid expenditures have increased by 121 percent in the last ten years, from $6.3 billion in FY 1996-97 to $13.9 billion in FY 2005-06. Medicaid spending growth continued in FY 2006-07, but at slower pace of 3.5 percent. Recent estimates, as of October 2007, project a growth rate of 5.6 percent in FY 2007-08 and 4.6 percent for FY 2008-09.

Florida, as well as many other states, struggles each year to fund the growth in Medicaid expenditures, which continually outpaces growth in state revenue. From FY 1996-97 to FY 2005-06 Florida Medicaid general revenue expenditures increased by 91 percent, while state general revenue net collections and transfers increased by 72 percent.[4] The entitlement nature of the program naturally drives expenditures through changes in demographics, utilization, and health care inflation. During periods of economic downturn, and falling tax revenues, the program's enrollment and expenditures tend to increase as more people fall into poverty and are in need of public assistance, thereby increasing the demand on state budgets.

The Medicaid program competes with other programs, such as education, for state revenue dollars during the budget development process. The additional general revenue needed for the Medicaid program is estimated to be over $458 million in FY 2008-09. When crafting budgets, states are left with the difficult task of developing savings strategies that can achieve immediate relief, such as reducing provider reimbursement rates, and strategies to mitigate future growth, such as preferred drug lists and disease management programs.

## METHODOLOGY

Senate professional staff conducted interviews with key Medicaid administrators in the states of Texas, Georgia, Illinois, California, Michigan and New York and several key policy experts regarding their current

[1] Social Services Estimating Conference, October 2007.
[2] *Florida Medicaid Program: An Overview*. January 9, 2007.
[3] The Budget and Economic Outlook, August 2007, *Congressional Budget Office* - Estimated increase in federal Medicaid outlay.
[4] Medicaid expenditure history file, and Florida revenue analysis volume 22

and past experiences with Medicaid cost containment strategies. Staff reviewed and researched state and national literature regarding Medicaid program expenditures and cost containment strategies. Staff also reviewed Florida Medicaid expenditure data obtained from historical reports from the Social Services Estimating Conference as well as the Legislative Appropriation Planning and Budgeting System.

## FINDINGS

With the pressure to control program costs and growth, all states, including Florida, have implemented a variety of cost containment strategies in their Medicaid programs. In FY 2006, all fifty states adopted at least one initiative to control costs.[5] Over the last ten years, Florida has been a leader in the development of strategies to control costs and has implemented over $3.8 billion in cost containment/reduction initiatives since FY 1996-97. These Medicaid cost control measures are primarily related to prescription drugs, freezing or reducing provider payment rates and modifications to services or service delivery. A ten year history of Florida Medicaid cost containment strategies is provided in Appendix 1.

The objective of this interim project is to review and assess current and future savings opportunities in Florida's Medicaid Program. This review and other studies have determined that Medicaid cost containment opportunities generally fall into one of the following six expenditure or revenue categories: prescribed drugs; provider rates; eligibility; services; service delivery systems; and provider taxes.

**Prescribed Drugs**

Prescribed drug programs are areas in which states have aggressively implemented cost containment strategies. A May 2003 issue brief by the National Health Policy Forum stated that state Medicaid prescribed drug cost containment strategies can be grouped into two general categories: strategies directed at beneficiary drug utilization and strategies directed toward drug pricing. [6]

Strategies directed at beneficiary drug utilization include the following:

- Prior Authorization – Requiring prescribers to obtain approval before a prescription can be dispensed by a pharmacist to a patient.
- Preferred Drug Lists (PDL) – Listing of drugs approved by the state that can be dispensed without prior authorization.
- Generic Drug Use – Increase generic drug utilization through mandatory laws or prescriber education.
- Increase Copayments/Limits on Number of Prescribed Drugs.

Strategies directed at drug pricing include the following:

- Supplemental Rebates – Used in conjunction with a PDL. States require a pharmaceutical manufacturer to provide supplemental rebates, in addition to the federally required rebate, in exchange of their drug being included on the PDL.
- Changes in Dispensing Fees and Reimbursement Formulas – Directly impacts the reimbursement a pharmacy receives.
- Purchasing Pools – Increase bargaining power to secure lower prices with manufacturers.

The Florida Medicaid program has been a leader in the development of strategies to control costs in the prescribed drug program. From FY 1996-97 to 2004-05, Florida's Medicaid prescribed drug expenditures were increasing at a rate of 16 percent per year, which included a four year period with average annual increases of 22 percent[7]. Recognizing this as an area of unsustainable growth, the Florida Medicaid program, under direction from the Legislature, developed and implemented multiple cost-saving initiatives. Some of these initiatives include: a preferred drug list (PDL), supplemental rebate agreements, prior authorization, a four brand name drug limit, and reducing reimbursement to pharmacies.

Thirty states in FY 2007 and 24 states in FY 2008 have implemented or are planning to implement similar initiatives designed to slow the growth in Medicaid spending for prescription drugs.[8] As of FY 2006, 44

[5] The Kaiser Commission on Medicaid and the Uninsured, Medicaid budgets, spending and policy initiatives in state Fiscal Years 2005 and 2006, results from a 50-State survey, October 2005.

[6] National Health Policy Forum Issue Brief No. 790/ May 2003, Medicaid prescription drug coverage: state efforts to control cost.

[7] Florida Medicaid Expenditure History File: *percentage calculations are net of rebates; FY 1996-97 – 1999-00 averaged 22% annual increase net of rebates.*

[8] Kaiser Commission on Medicaid and the Uninsured; as tough times wane, states act to improve Medicaid

states and the District of Columbia have implemented preferred drug lists.[9] States have also reduced reimbursement to pharmacies, increased recipient copayments and increased requirements for generic drugs.

Although prescribed drug expenditure growth has slowed, states continue to look for additional ways to contain costs in their prescribed drug programs. These include the expansion of PDLs, prior authorization, seeking additional rebates from the manufactures of physician administered drugs, and increasing state maximum allowable cost (MAC) programs. The Florida Medicaid program continues its efforts to control costs in the prescribed drug program through maximizing its current initiatives, and evaluating other opportunities for potential savings.

**Provider Rates**

Reductions in provider reimbursement rates are the most utilized mechanism to control Medicaid expenditures during a fiscal crisis to achieve immediate savings. These modifications include cutting or freezing rates, or the suspension of, or reduction in automatic rate increases that occur for different provider types. States generally target reimbursement rate modifications to the major Medicaid providers: hospitals; nursing homes; HMO's; pharmacies; and physicians because of their large share of Medicaid expenditures. The following table reflects estimated expenditures for some of Florida Medicaid's major provider types for FY 2007-08.

| Provider | Expenditures |
|---|---|
| Hospitals | $2,799,495,239 |
| Nursing Homes | $2,432,109,188 |
| HMO's | $1,895,905,949 |
| Pharmacies | $1,064,526,652 |
| Physicians | $695,879,836 |
| *SubTotal* | *$8,887,916,864* |
| All Other Services | $6,289,936,146 |
| Grand Total | $15,177,853,010 |

*October 2007 Social Services Estimating Conference

Florida Medicaid's provider rate reimbursement methodologies fall into three categories: cost based; capitation; and fee-for-service. The cost based and capitation methodologies each contain automatic price level increases for each fiscal year, as provided in the Medicaid state plan.[10] Federal rules require reimbursement rates to be reasonable and adequate to meet the cost of efficiently and economically operatedg facilities. Services provided by nursing homes, hospitals, rural health clinics, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) and county health departments are reimbursed through the cost based method. HMO's and non-emergency transportation services are reimbursed through capitation payments. Providers such as physicians, dentists, pharmacies, laboratories, home health agencies and durable medical equipment providers are reimbursed through the fee-for-service methodology.[11]

In Florida, the most commonly pursued method of reimbursement rate modification has been to reduce the level of automatic increases for certain provider rates rather than a direct cut, resulting in lower reimbursement rates. However, cuts to directly lower reimbursement rates have occurred (i.e., pharmacy reimbursement rate reduction, Average Wholesale Price (AWP) minus 13.25 percent to AWP minus 15.4 percent, July 1, 2004, Chapter 2004-268 L.O.F.).

The Florida Legislature has frequently implemented provider rate modifications to control the rate of increase for hospitals, nursing homes, HMOs and pharmacies over the past several years and most recently during the 2007 Special Session "C".

In 2006, 46 states froze or cut reimbursement rates for at least one provider type.[12] While reductions or modifications to Medicaid provider reimbursement rates are a mechanism to achieve immediate savings for state Medicaid programs, states must remain cautious when exercising these reductions to ensure that recipients continue to have adequate access to providers.

**Eligibility**

As a condition of receiving federal matching funds, states must provide Medicaid coverage to certain mandatory eligibility groups and may provide coverage to various optional eligibility groups.

coverage and quality; results from a 50-State Medicaid budget survey for State Fiscal Years 2007 and 2008.

[9] National Association of State Medicaid Directors, s*tate perspectives on emerging Medicaid pharmacy policies and practices.*

[10] Prescribed drug reimbursement rates include automatic increases even though they are considered fee-for-service.

[11] Pharmacy reimbursements receive automatic increases that are related to national prescription drug prices.

[12] Kaiser Commission on Medicaid and the Uninsured; low Medicaid spending growth amid rebounding revenues; results from a 50 State Medicaid budget survey state Fiscal Years 2006 and 2007, October 2006.

Mandatory eligibility groups include:

- Children age 6 and older whose family income is below 100 percent of the Federal Poverty Level (FPL),
- Children under age 6 whose family income is below 133 percent of the FPL,
- Parents whose family income is below the state's Aid to Families with Dependent Children (AFDC) income level as of July 1996 (24 percent of the FPL in Florida),
- Pregnant Women whose family income is less than 133 percent of the FPL,
- Elderly and disabled SSI individuals whose income is less than 75 percent of the FPL,
- Certain working disabled individuals, and
- Dual Medicare/Medicaid eligible groups.

Optional eligibility groups include:

- Children age 6 and older whose family income is above 100 percent of the FPL,
- Children under age 6 whose family income is above 133 percent of the FPL,
- Parents whose family income is below the state's AFDC income level as of July 1996,
- Pregnant women whose family income is above 133 percent of the FPL,
- Elderly and disabled individuals whose income is between 75 percent and 100 percent of the FPL,
- Nursing home residents whose income is between 75 percent and 300 percent of Social Security Income (SSI) level,
- Medically Needy, and
- Intermediate Care Facilities for Mentally Retarded and Developmentally Disabled.

The ability to achieve cost savings through eligibility reductions is generally limited to the optional eligibility groups and is achieved by directly eliminating certain eligibility groups or reducing eligibility requirements within the groups. For example, in 2005, Tennessee eliminated over 170,000 individuals from its TennCare Medicaid program with associated state budget savings of over $1 billion. The TennCare program virtually eliminated all of its optional eligibility groups (adults age 19 and older) and placed strict enrollment criteria on its optional medically needy population.

The Florida Medicaid program is estimated to serve approximately 2.1 million recipients in FY 2007-08, of which the majority (94 percent) are mandatory eligibles. The following table reflects the estimated mandatory and optional caseload and corresponding expenditures for FY 2007-08.[13]

| Category | Caseload | Expenditures |
|---|---|---|
| Mandatory Eligibles | 1,972,486 | $12,967,912,329 |
| Percent of Total | 94% | 94% |
| Optional Eligibles | 132,592 | $867,360,771 |
| Percent of Total | 6% | 6% |
| Total Direct Payments for Recipients | 2,105,078 | $13,835,273,100 |
| | | |
| Other: (LIP, DSH, SMP's) | | $ 1,342,579,910 |
| Total Medicaid Services Budget | | $15,177,853,010 |

*October 2007 Social Services Estimating Conference; Other includes Low Income Pool (LIP) payments, Disproportionate Share Payments and Special Medicaid Payments to hospitals that serve high levels of indigent patients.

Medicaid eligibility reductions are difficult for states to implement because they impact vulnerable populations. Only two states in FY 2007 and one state in FY 2008 implemented or plan to implement eligibility reductions.[14]

Over the past ten years, Florida has made minimal reductions in Medicaid eligibility and some eligibility reductions were restored at a later date. As represented by the table above, the overwhelming majority of Florida Medicaid expenditures are associated with the mandatory population, thereby reducing the opportunity to achieve significant savings through reductions in the optional groups. Florida's optional eligibility groups include the elderly and disabled with incomes between 75 and 88 percent of the FPL; medically needy; and pregnant women and children with incomes between 150 and 185 percent of the FPL. The Florida Legislature attempted to eliminate coverage for the Medically Needy program in 2001 by funding it with non-recurring funds; however, recurring funds were subsequently restored. Expenditures for Florida's Medically Needy and Elderly and Disabled optional eligibility groups represent over 82 percent of the spending for all optional eligibility groups.

**Services**

Reflecting the federal rules on eligibility, state Medicaid programs must provide certain mandatory services to recipients and may provide optional services to recipients.[15] However, federal rules do not set

[13] Expenditure and caseload projections from October 2007 Social Services Estimating Conference.

[14] Kaiser Commission on Medicaid and the Uninsured; as tough times wane, states act to improve Medicaid. coverage and quality; results from a 50-State Medicaid budget survey for state Fiscal Years 2007 and 2008.

[15] Section 1902(a)10, 1905(a), S.S.A. and 42 Code of Federal Regulations 440.

specific minimum levels for each service. Instead, states are allowed to establish reasonable standards of the amount, duration, and scope of all services provided.[16] For example, Florida Medicaid only pays for 45 days of inpatient hospital days per person per year. One exception to this state variability is the federal Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirement that states provide all medically necessary services to children enrolled in their Medicaid programs. Florida's Medicaid program covers over 35 optional services, including: prescribed drugs; intermediate nursing home care; dialysis treatment; adult dental, visual, and hearing; and speech, occupational, and respiratory therapy. Although these are optional services, many are only provided to children under the federal EPSDT requirement.

Limits on, or the elimination of, certain Medicaid services have been one of many mechanisms states have utilized to reduce Medicaid expenditures. The majority of these changes are targeted toward optional services for adults. States may choose to place direct limits on services, such as, the number of allowed prescriptions per month or the number of visits per month by a home health aide. States also use prior authorization techniques as a mechanism to ensure the service requested is the proper one for the circumstance. Most prior authorization programs require the physician or service provider to call a help desk where a professional evaluates the request and either approves it or recommends a less costly alternative about which the physician or service provider may not have known. As stated earlier in this report, the prescribed drug program, which is an optional service, is an area where states have aggressively pursued cost-saving measures by implementing various utilization management and prior authorization techniques.

In FY 2003-04, Florida eliminated coverage of adult dental, visual, and hearing services, but restored the coverage in FY 2005-06. The majority of reductions or savings Florida has achieved in the area of services has been derived from initiatives designed to streamline the delivery of services and eliminate waste through utilization management tools.

Most recently, the federal Deficit Reduction Act (DRA) of 2005 gave states additional flexibility to structure the delivery of services. The DRA provides states the opportunity to vary the services offered across eligibility groups and geographic areas. This is similar to the structure of the Florida Medicaid Reform pilot implemented in September 2006. The states of Kentucky and West Virginia have utilized the authority under the DRA to offer different benefit packages across various populations. While in theory the tailoring of benefit packages for certain populations should streamline the delivery of necessary services, there is little information available at this time to determine if any cost savings can be achieved through this mechanism.

Medicaid programs provide a large array of services, many of which are not offered under commercial plans, for some of the most vulnerable individuals. Florida, and many other states, have implemented multiple savings techniques that directly affect services while maintaining appropriate care. States have shown a willingness to achieve savings in this area, while maintaining the delicate balancing act of maintaining the appropriate level of services without inhibiting access to care.

**Service Delivery Systems**

*Managed Care Initiatives*

States have continued to shift Medicaid recipients away from fee-for-service payment systems toward different types of managed care systems with the goal of increasing coordinated care that will ultimately result in cost savings.

According to the Centers for Medicare and Medicaid Services (CMS), as of June 30, 2006, 65 percent of Medicaid recipients throughout the country were enrolled in a type of managed care system.[17] These systems include; Health Insuring Organizations, Commercial Managed Care Organizations, Medicaid-only Managed Care Organizations, Primary Care Case Management, Prepaid Inpatient Health Plans, Prepaid Ambulatory Health Plans, and Programs of All-inclusive Care for the Elderly. In Florida, approximately 66 percent of Medicaid recipients receive services through one of these systems.[18] However, the majority of managed care in Florida is delivered through three types of service delivery systems: Primary Care Case Management (MediPass),

[16] 42 U.S.C. Section 1396.

[17] Medicaid managed care enrollment as of June 30, 2006; CMS; http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp

[18] Agency for Health Care Administration; October 2007, managed care enrollment; http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/MC_ENROLL/Comp_RF-NRF_Enroll/COMP-Enroll.xls

Capitated Managed Care Organizations (HMOs) and Provider Service Networks (PSN).

Florida's MediPass program is a type of Primary Care Case Management Program. In the MediPass program, all services to a recipient must be provided by, or referred from, the recipient's primary care physician. The physician is paid a $3 monthly fee for each recipient managed under his or her care. The physician acts as a "case manager" for the recipient's care, coordinating and approving referrals for services. Many other states operate similar programs and are often the only type of managed care provided in rural areas.

Florida purchases health care services for many Medicaid recipients through contracts with managed care organizations (HMOs). The managed care organization is paid a monthly capitation rate to manage the delivery of services to meet all the recipients health care needs. The capitation rate is calculated at a discount off the fee-for-service system, thereby generating savings to the state as recipients are moved into the capitation environment.

Florida also contracts with PSNs to provide managed care to recipients enrolled in their networks. A PSN is a network established or organized and operated by a health care provider or group of affiliated health care providers, including minority physician networks and emergency room diversion programs, that meet the requirements of s. 409.912 (4) (d), F.S. The PSN receives payment through the fee-for-service system, but is responsible for cost savings in a cost effectiveness reconciliation process at the end of each contract period. PSNs provide a substantial portion of the health care items and services contracted directly through the provider or affiliated group of providers. The health care providers must have a controlling interest in the governing body of the PSN.

In recent years, Florida has increased the number of recipients in capitated and PSN managed care delivery systems. Most recently, under the 1115 waiver authority granted by the Center for Medicare and Medicaid Services, the Florida Medicaid Reform pilot project moved all recipients in Broward and Duval counties into managed care plans. The goal of the pilot is to provide Medicaid recipients better coordinated care thereby reducing the rate of growth of expenditures in the program. The project is currently under evaluation and results are not available at this time.

*Disease Management*

Disease management programs are another strategy used by states to manage the care of their Medicaid recipients. Medicaid disease management programs focus on managing recipient health by utilizing an outside vendor with expertise in the specific disease area(s). States tend to focus on the most costly chronic diseases. The Florida disease management program was first implemented in FY 1997-98. Florida currently operates two disease management programs covering the following eight disease types: HIV/AIDS, sickle cell, renal disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertension, and asthma. A May 2004 report by the Office of Program Policy Analysis and Government Accountability (OPPAGA) states that disease management is expected to reduce the high rate of complications experienced by patients with chronic illness, improve overall health, and reduce patient use of high-cost health services, thereby reducing costs. However, OPPAGA's analysis and other independent analyses identify the difficulty in calculating and determining cost savings for these programs.[19]

*Long-Term Care*

Medicaid plays a critical role for low-income people of all ages with long-term care needs. Medicaid currently covers a wide range of long-term care services including nursing home care, home and community-based care or other types of home health care services. A November 2006 analysis of Medicaid Long-Term Care Beneficiaries by the Kaiser Commission on Medicaid and the Uninsured states that although long-term care accounts for less than 10 percent of all health care expenditures in the U.S., these services account for 40 percent of all Medicaid spending. Additionally, Medicaid accounts for almost half of all nursing home expenditures in the U.S., making Medicaid the nation's largest single payer of long-term care services.

Over the past several years, states have had to balance their long-term care delivery systems by reducing reliance on institutional services and increasing access to home and community-based service (HCBS) options. In Florida, funding for home and community-based services has increased by more than 380 percent from FY 1996-97 to FY 2006-07.[20] Generally, recipients who receive long-term care services in the community have lower overall per enrollee spending compared to individuals in institutional settings; however, it does not necessarily mean that individuals

[19] Analysis of literature on disease management programs.
[20] HCBS expenditures 1996-1997= $206 million; 2006-2007 = $1 billion.

would cost less if they were moved to the community. Much of the shift to home and community-based services has been based on demand, rather than for cost containment reasons, as individuals prefer to receive their services in a non-institutionalized setting.
Florida implemented the nursing home diversion program in December 1998 to provide frail elders with community-based alternatives to nursing home placement at less cost than Medicaid nursing home care. The program is administered through contracts with managed care organizations that are paid monthly capitation rates. Services provided include long-term care services and Medicaid-covered medical services.

In 2006, the Florida Legislature established a qualified state long-term care insurance partnership program to provide incentives for the purchase of long-term care insurance and to alleviate the financial burden on the Medicaid program by encouraging pursuit of private coverage. Florida is also experimenting with an effort to control long-term care costs by utilizing managed care organizations through the Integrated Managed Care pilot project adopted during the 2007 Legislative session. The program is expected to begin in 2008 and participation in the program will be voluntary.

States are increasing their focus on managing the care of their Medicaid recipients, while maintaining quality care for those individuals who have very complex, extensive and specialized needs. States are utilizing all of these cost containment approaches mentioned above to hedge against future Medicaid expenditure growth.

**Provider Taxes/Assessments**
Provider taxes or assessments are a tools states use to generate revenue for their Medicaid programs. States generally tax a provider and, in turn, use the revenue as part of the state share to draw down federal matching funds to help finance their Medicaid expenditures. Under federal rules, provider taxes or assessments must be broad based (across all providers in the industry) and may not contain a "hold harmless" provision by which the state directly or indirectly holds the providers paying the tax harmless for any portion of the costs of this tax.[21] The assessments are generally applied to a provider's operating revenue or as a per-bed tax.

As of the end of FY 2007, 44 states had a Medicaid provider tax for at least one type of provider, including 33 nursing home provider taxes, 28 ICF/MR-DD taxes, 20 hospital taxes and 15 managed care organization taxes.[22] In Florida, the Medicaid program receives revenue generated from hospital assessments equaling 1.5 percent of the annual net operating revenue for inpatient services and 1 percent of the annual net operating revenue for outpatient services for each hospital in the state.[23] In FY 2006-07, Florida received approximately $380.2 million in revenues from these assessments, which were used to supplement the state share of the $2.5 billion in Medicaid hospital inpatient expenditures.

Recently, CMS has proposed reducing the ceiling on provider taxes from 6 percent to 3 percent. Although the reduction proposal has not been adopted at this time, CMS has proposed implementing this through its federal rule making authority. If this reduction is imposed many states will face a loss of revenue. This proposal is one of many areas in which the federal government has recently increased its scrutiny of state Medicaid financing arrangements.

## RECOMMENDATIONS

There is no single strategy for controlling expenditure growth in the Medicaid program. The entitlement nature of the Medicaid program and its link to medical inflation make it difficult to control expenditures. No new strategies were identified to control expenditure growth based on staff research of findings from surveys of state Medicaid program cost containment strategies. Professional staff recommends that the Legislature:

- Continue to implement policies to reduce the rate of increase for provider rates, reduce benefits, reduce eligibility, and control prescription drug spending.
- Continue managed care initiatives that coordinate care and result in cost savings.
- Continue policies to change the delivery of long-term care services utilizing managed care.
- Provide education to increase participation in the long-term care partnership program.
- Review the additional benefit flexibility provisions made available through the Deficit Reduction Act (DRA) to redesign Medicaid benefit packages.
- Review the use of other provider taxes to generate revenue to support the Medicaid program.

[21] Section 1903 of the Social Security Act, 42 U.S.C. 1396b(w).

[22] As tough times wane, states act to improve Medicaid coverage and quality: results from a 50-State Medicaid budget survey for state fiscal years 2007 and 2008; Kaiser Commission on Medicaid and the Uninsured.

[23] Section 395.701, Florida Statute

# APPENDIX 1
# Florida Medicaid Expenditure Reductions and Savings Initiatives
# FY 1996-1997 through FY 2007-2008

| Issue | General Revenue | Trust Funds | Total All Funds |
|---|---|---|---|
| **Fiscal Year 1996-1997** | | | |
| Medicaid Administrative Reduction | ($2,000,000) | $4,000,000 | $2,000,000 |
| Reform Medicaid Community Mental Health Services | ($9,486,857) | ($11,942,682) | ($21,429,539) |
| Reform Medicaid Transportation | ($10,079,444) | ($12,780,458) | ($22,859,902) |
| Prior Authorization for Hospital Inpatient Psychiatric Days | ($5,407,217) | ($6,919,191) | ($12,326,408) |
| Administrative Cost to Implement Prior Authorization Review | $62,500 | $187,500 | $250,000 |
| Competitive Bidding/Mandatory Assignment for HMO Contracts | ($10,800,000) | ($13,848,744) | ($24,648,744) |
| Dispensing Policy for Maintenance Drugs as 60 or 90 Days | ($1,126,800) | ($1,442,897) | ($2,569,697) |
| Expand Medicaid Estate Recovery | ($3,500,000) | $3,500,000 | $0 |
| Home Health Care Reforms | ($5,898,375) | ($7,506,032) | ($13,404,407) |
| Limit Outpatient Hospital Rate of Increases for Inflation | ($6,000,000) | ($7,704,139) | ($13,704,139) |
| Nursing Home Care Reimbursement Reforms | ($7,500,000) | ($9,464,488) | ($16,964,488) |
| Reform Medicaid Prescribed Drugs Program | ($9,000,000) | ($11,524,743) | ($20,524,743) |
| Provider Enrollment Reforms | ($4,800,000) | ($6,163,204) | ($10,963,204) |
| County Billing for HMO Inpatient Hospital Days | ($18,500,000) | $0 | ($18,500,000) |
| Refinance Intermediate Care Facilities for Developmentally Disabled Services | | ($34,283,340) | ($34,283,340) |
| ***Total Fiscal Year 1996-1997*** | ***($94,036,193)*** | ***($115,892,418)*** | ***($209,928,611)*** |
| | | | |
| **Fiscal Year 1997-1998** | | | |
| Efficiency Adjustment for Expenses | ($27,000) | $0 | ($27,000) |
| Fund Shift - Mental Health Utilization Management | ($62,500) | $62,500 | $0 |
| Enhance Third Party Liability Functions | ($4,184,000) | ($5,316,000) | ($9,500,000) |
| Credentialing of Community Mental Health Providers | ($2,217,000) | ($2,783,000) | ($5,000,000) |
| Competitively Bid Selected Medicaid Services | ($1,739,631) | ($2,182,875) | ($3,922,506) |
| Implement Disease Management Program for AIDS | ($390,830) | ($490,410) | ($881,240) |
| Implement Disease Management Program for Asthma | ($590,471) | ($740,919) | ($1,331,390) |
| Implement Disease Management Program for Diabetes | ($533,952) | ($669,998) | ($1,203,950) |
| Implement Disease Management Program for Hemophilia | ($332,837) | ($417,643) | ($750,480) |
| Expand Fraud and Abuse Recoupments | ($22,497,956) | ($28,789,871) | ($51,287,827) |
| Contract with Provider Service Networks/Local Governments | ($1,500,000) | ($1,833,333) | ($3,333,333) |
| Implement Variable Dispensing Fee for Prescriptions | ($2,730,294) | ($3,443,772) | ($6,174,066) |
| Expand Nursing Home Diversion Waiver | ($5,588,658) | ($6,806,138) | ($12,394,796) |
| ***Total Fiscal Year 1997-1998*** | ***($42,395,129)*** | ***($53,411,459)*** | ***($95,806,588)*** |
| | | | |
| **Fiscal Year 1998-1999** | | | |
| Intensified Third Party Liability Initiative | ($5,500,000) | ($6,946,255) | ($12,446,255) |
| Eliminate Adult Cardiac Transplant Program | ($711,452) | ($893,083) | ($1,604,535) |
| Recalculation of Drug Rebate Revenues | ($5,000,000) | ($6,314,777) | ($11,314,777) |
| Additional Fraud and Abuse Recoupments | ($3,000,000) | $3,000,000 | $0 |
| Expanded Fraud and Abuse Recoupments in Prescribed Medicine | ($4,022,772) | ($5,091,771) | ($9,114,543) |
| Additional Savings from Disease Management Initiatives | ($10,911,012) | ($13,780,122) | ($24,691,134) |
| Implement New Disease Management Program for Heart Disease, Cancer, Sickle Cell, and Renal Disease | ($6,500,000) | ($8,223,853) | ($14,723,853) |
| Modify Methodology for Payments for Medicare Crossover Claims | ($28,284,126) | ($35,356,070) | ($63,640,196) |
| ***Total Fiscal Year 1998-1999*** | ***($63,929,362)*** | ***($73,605,931)*** | ***($137,535,293)*** |
| | | | |
| **Fiscal Year 1999-2000** | | | |
| Enroll Pregnant Women in Managed Care | ($7,939,110) | ($10,294,951) | ($18,234,061) |
| Fraud and Abuse Initiatives/Prescribed Drugs | ($15,000,000) | ($19,498,620) | ($34,498,620) |
| Provider Profiling and Medicaid Utilization Review | ($18,000,000) | ($22,733,198) | ($40,733,198) |
| HMO Pharmacy Rebates | ($9,000,000) | $9,000,000 | $0 |
| Reduce Nursing Home for Diversion Waiver | ($5,000,000) | ($6,314,777) | ($11,314,777) |
| Emergency Services for Undocumented Non-citizens | ($3,967,354) | $3,967,354 | $0 |
| ***Total Fiscal Year 1999-2000*** | ***($58,906,464)*** | ***($45,874,192)*** | ***($104,780,656)*** |
| | | | |

| Issue | General Revenue | Trust Funds | Total All Funds |
|---|---|---|---|
| | | | |
| **Fiscal Year 2000-2001** | | | |
| Ingredient Cost Reimbursement Adjustment | ($10,470,851) | ($13,656,142) | ($24,126,993) |
| Drug Benefit Management | ($17,789,900) | ($23,210,100) | ($41,000,000) |
| Pharmacy Network Controls | ($9,800,000) | ($12,785,849) | ($22,585,849) |
| Secure Prescription Pads | ($7,810,200) | ($10,189,800) | ($18,000,000) |
| Generic Drug Rebates | ($1,300,000) | ($1,696,082) | ($2,996,082) |
| Monthly Limit on Recipient Drugs - 4 brand | ($30,373,000) | ($39,627,000) | ($70,000,000) |
| HMO Drug Rebates - Reverse Policy | $9,000,000 | ($9,000,000) | $0 |
| Adjust HMO Rates | ($5,000,000) | ($6,523,393) | ($11,523,393) |
| Drug Therapy Limits | ($4,339,000) | ($5,661,000) | ($10,000,000) |
| Cytogam Limits | ($7,593,250) | ($9,906,750) | ($17,500,000) |
| Voluntary Preferred Drug List and Education Program | ($10,847,500) | ($14,152,500) | ($25,000,000) |
| Improve Case Management of MediPass Recipients | ($20,000,000) | ($26,093,570) | ($46,093,570) |
| Improve Disease Management Efficiencies | ($10,000,000) | ($13,046,785) | ($23,046,785) |
| Reduce Nursing Home for Diversion Waiver | ($12,000,000) | ($15,656,142) | ($27,656,142) |
| Reduce Regular Disproportionate Share Program | | ($20,189,671) | ($20,189,671) |
| ***Total Fiscal Year 2000-2001*** | ***($138,323,701)*** | ***($221,394,784)*** | ***($359,718,485)*** |
| | | | |
| **Fiscal Year 2001-2002** | | | |
| Preferred Drug List/Drug Benefits Management Initiatives/Supplemental Rebates | ($104,536,094) | ($101,800,759) | ($206,336,853) |
| Brand Name Drug Patent Expirations | ($6,335,000) | ($8,211,498) | ($14,546,498) |
| Competitive Bid Independent Laboratory Services | ($364,318) | ($484,766) | ($849,084) |
| Competitive Bid Private Duty Nursing | ($1,510,077) | ($1,957,730) | ($3,467,807) |
| Competitive Bid Durable Medical Equipment | ($520,635) | ($785,853) | ($1,306,488) |
| Competitive Bid Non-Emergency Transportation | ($277,900) | ($362,784) | ($640,684) |
| Eliminate Administrative Cost Component in HMO Rates (10/01/01) | ($1,644,165) | ($2,184,617) | ($3,828,782) |
| Limit Reimbursement for Medicare Crossover Claims Hospital Outpatient | ($25,786,590) | ($33,424,867) | ($59,211,457) |
| Set HMO Rates on Net Cost of Drugs | ($13,963,013) | ($18,552,773) | ($32,515,786) |
| Prior Authorization - Mental Health Services | ($3,710,515) | ($6,267,166) | ($9,977,681) |
| Prior Authorization/Concurrent Review Non-Emergency Hospital Admissions | ($7,006,063) | ($8,740,484) | ($15,746,547) |
| Autoimmune Center | ($150,000) | ($842,537) | ($992,537) |
| Cut Institutional Rates by 6% restore 4/1/02 | ($38,137,199) | ($50,006,028) | ($88,143,227) |
| Restrict Rate Increases for Changes in Ownership | ($6,763,073) | ($8,766,371) | ($15,529,444) |
| Eliminate Nursing Home Intermediate II Level of Care | ($5,849,943) | ($4,143,481) | ($9,993,424) |
| Children's Clinic Network/Reduce Emergency Room Use | ($644,540) | ($835,460) | ($1,480,000) |
| Increase Managed Care Enrollment to 50% HMO / 50% MediPass | ($2,936,168) | ($3,805,894) | ($6,742,062) |
| Fund Shift - Teaching Hospital DSH Program | ($5,888,862) | $5,888,862 | $0 |
| Limit Medicaid Reimbursement for Nursing Home Medicare Crossover Claims | ($1,763,917) | ($2,286,409) | ($4,050,326) |
| ***Total Fiscal Year 2001-2002*** | **($227,788,072)** | **($247,570,615)** | **($475,358,687)** |
| | | | |
| **Fiscal Year 2001-2002 Special Session** | | | |
| Implement Pharmacy Dispensing Fee Incentives | ($1,722,003) | ($2,230,265) | ($3,952,268) |
| Expanded Fraud and Abuse Recoupment | ($6,250,000) | ($3,611,009) | ($9,861,009) |
| Reduce Pharmaceutical Expense Assistance Program | | ($22,500,000) | ($22,500,000) |
| Eliminate Nursing Home Up or Out Program | ($1,450,000) | ($1,450,000) | ($2,900,000) |
| Reduce Non-Essential Services Under the AIDS Waiver | ($2,177,500) | ($2,822,500) | ($5,000,000) |
| Mail Order Diabetic Supplies | ($957,227) | ($1,240,769) | ($2,197,996) |
| Brand Name Drug Patent Expirations | ($2,600,000) | ($3,370,149) | ($5,970,149) |
| ***Total Fiscal Year 2001-2002 Special Session*** | ***($15,156,730)*** | ***($37,224,692)*** | ***($52,381,422)*** |
| | | | |
| **Fiscal Year 2002-2003** | | | |
| Restructure MEDS AD | ($23,897,504) | ($40,190,646) | ($64,088,150) |
| Eliminate Pharmacy Dispensing Fee Increase for Institutionalized Recipients | ($713,492) | ($924,838) | ($1,638,330) |
| Eliminate Adult Dental, Vision and Hearing Services | ($5,590,242) | ($25,243,854) | ($30,834,096) |
| Restore Adult Dental, Vision and Hearing Services/ Non-recurring Funds | $7,045,965 | $10,345,476 | $17,391,441 |
| Implement Pharmacy Dispensing Fee Incentives | ($1,722,003) | ($2,230,265) | ($3,952,268) |
| Ticket to Work Program | ($3,156,481) | ($4,573,298) | ($7,729,779) |
| Expanded Fraud and Abuse Recoupment | ($6,250,000) | ($3,914,656) | ($10,164,656) |
| Enhance PDL/MAC Pharmaceutical Pricing | ($8,254,356) | ($3,680,910) | ($11,935,266) |
| Reduce Diverted Pharmaceuticals | ($2,805,939) | ($6,050,109) | ($8,856,048) |

| Issue | General Revenue | Trust Funds | Total All Funds |
|---|---|---|---|
| Increase Managed Care Enrollment to 55% HMO / 45% MediPass | ($1,462,378) | ($2,089,671) | ($3,552,049) |
| Capitate Mental Health Payments in Area 1 | ($316,846) | ($449,038) | ($765,884) |
| Choice Counseling | ($1,348,042) | ($1,348,042) | ($2,696,084) |
| Geriatric Falls Demonstration Program | | ($503,156) | ($503,156) |
| ***Total Fiscal Year 2002-2003*** | ***($48,471,318)*** | ***($80,853,007)*** | ***($129,324,325)*** |
| | | | |
| **Fiscal Year 2003-2004** | | | |
| Delay Hospital Rate Increases to October 1, 2003 | ($5,851,777) | ($8,408,404) | ($14,260,181) |
| Restocking of Nursing Home Pharmaceuticals | ($4,710,961) | ($9,399,178) | ($14,110,139) |
| Expansion of State MAC Pharmacy Pricing | ($4,674,315) | ($7,076,200) | ($11,750,515) |
| Pharmacy Recipient Lock-in Program | ($277,894) | ($519,505) | ($797,399) |
| Eliminate Payments for Circumcision | ($971,395) | ($1,393,824) | ($2,365,219) |
| Capitate Payment for Behavioral Health Services | ($1,444,849) | ($2,072,310) | ($3,517,159) |
| Increase Managed Care Enrollment to 60% Managed Care, 40% MediPass | ($3,983,667) | ($7,706,858) | ($11,690,525) |
| Transportation 10% Reduction | ($4,510,076) | ($6,500,002) | ($11,010,078) |
| Restructure Value Added Programs | ($6,586,880) | ($9,447,395) | ($16,034,275) |
| Utilization Management of Therapies | ($4,393,739) | ($6,301,828) | ($10,695,567) |
| Coinsurance for Prescribed Drugs | ($11,010,213) | ($15,791,670) | ($26,801,883) |
| Fund-shift Hospital Upper Payment Limit | ($29,141,917) | $29,141,917 | $0 |
| Increase Third Party Liability Collections | ($5,799,605) | $5,799,605 | $0 |
| Increase Rebates on Generic Drugs | ($229,813) | $229,813 | $0 |
| Copayments for Non-Emergency Use of Emergency Room | ($9,988,731) | ($14,346,434) | ($24,335,165) |
| Delay Nursing Home Staffing Increase to May of 2003 | ($7,998,941) | ($11,472,678) | ($19,471,619) |
| Cap Nursing Home Beds/Expand Nursing Home Diversion | ($14,648,306) | ($21,009,694) | ($35,658,000) |
| Reduce HMO Rates by 1% | ($5,884,042) | ($8,539,289) | ($14,423,331) |
| Adult Dental Vision and Hearing - Non-recurring | ($6,975,180) | ($10,127,552) | ($17,102,732) |
| Nursing Home Pharmacy Dispensing Fee - Non-recurring | ($713,492) | ($924,838) | ($1,638,330) |
| Home Health Care Provider Fee Increase - Non-recurring | ($1,308,718) | ($1,696,376) | ($3,005,094) |
| Subacute Pediatric Transitional Care - Non-recurring | ($778,619) | ($1,103,467) | ($1,882,086) |
| Lung Cancer Screening Pilot - Non-recurring | ($750,000) | ($994,186) | ($1,744,186) |
| Nursing Home Rate Reduction - Liability Insurance - Non-recurring | ($11,139,221) | ($15,786,621) | ($26,925,842) |
| HIV AIDS Waiver - Non-recurring | ($2,700,000) | ($3,826,468) | ($6,526,468) |
| Geriatric Falls Demonstration Program - Non-recurring | ($1,206,000) | ($1,206,000) | ($2,412,000) |
| ***Total Fiscal Year 2003-2004*** | ***($147,678,351)*** | ***($130,479,442)*** | ***($278,157,793)*** |
| | | | |
| **Fiscal Year 2004-2005** | | | |
| Establish Physician Lock-in Program for Recipients | ($379,918) | ($544,457) | ($924,375) |
| Reduce Nursing Home Reimbursement Rate Increase | ($27,409,218) | ($39,279,876) | ($66,689,094) |
| Delay Nursing Home Staffing Increase | ($29,431,392) | ($42,665,209) | ($72,096,601) |
| Reduce Hospital Inpatient and Outpatient Reimbursement Rate Increase | ($34,427,415) | ($49,337,585) | ($83,765,000) |
| Pharmacy Reimbursement Rate Ingredient Cost Adjustment | ($10,579,140) | ($15,160,860) | ($25,740,000) |
| Behavioral Health Drug Management Program | ($13,900,000) | ($19,919,951) | ($33,819,951) |
| Pharmaceutical Dosing Limits | ($3,218,313) | ($4,612,132) | ($7,830,445) |
| Expand State MAC Pricing of Pharmaceuticals | ($10,275,000) | ($14,325,000) | ($24,600,000) |
| Eliminate Nursing Home Intermediate Care Facility Bed Hold Days | ($5,969,186) | ($8,554,382) | ($14,523,568) |
| Freeze Intermediate Care Facility Reimbursement Rates | ($1,967,868) | ($2,820,132) | ($4,788,000) |
| Managed Care Enrollment on Effective Date of Medicaid Enrollment | ($1,102,919) | ($1,580,582) | ($2,683,501) |
| Increase Pharmaceutical Supplemental Rebate Minimum | ($6,051,153) | $6,051,153 | $0 |
| Prior-authorize Off-label Use of Prescribed Drugs | ($2,877,016) | ($4,253,984) | ($7,131,000) |
| Limit Selected Prescribed Drugs to One Dose Per Day | ($2,466,000) | ($3,534,000) | ($6,000,000) |
| Limit Erectile Dysfunction Drugs to One Dose Per Month | ($1,604,544) | ($2,299,456) | ($3,904,000) |
| Utilization Review of Neonatal Intensive Care Unit Services | ($500,598) | ($782,366) | ($1,282,964) |
| Eliminate Lifesaver RX Program Due to Medicare Part D | ($4,852,265) | ($24,553,845) | ($29,406,110) |
| Impact to Hospice Rates Due to Nursing Home Rate Reduction | ($2,939,624) | ($4,212,746) | ($7,152,370) |
| Eliminate Pharmaceutical Value Added Projects | ($35,000,000) | ($50,158,151) | ($85,158,151) |
| Expand Nursing Home Diversion Waiver | ($5,862,674) | ($8,401,740) | ($14,264,414) |
| Establish Hospitalist Program | ($7,880,263) | ($11,231,642) | ($19,111,905) |
| Establish Home and Community Based Waiver Prior Authorization/Utilization Review Program | ($721,287) | ($6,490,732) | ($7,212,019) |
| Utilization Management of Private Duty Nursing | ($3,370,215) | ($4,894,785) | ($8,265,000) |
| Consolidate Home and Community Based Waiver Services | ($721,287) | ($6,136,681) | ($6,857,968) |
| Nursing Home Transition Initiative | ($7,557,950) | ($10,831,222) | ($18,389,172) |
| Provider Network Management | ($5,750,000) | ($8,240,268) | ($13,990,268) |
| ***Total Fiscal Year 2004-2005*** | ***($226,815,245)*** | ***($338,770,631)*** | ***($565,585,876)*** |

| Issue | General Revenue | Trust Funds | Total All Funds |
|---|---|---|---|
| | | | |
| **Fiscal Year 2005-2006** | | | |
| 100-Day Supply of Maintenance Medications | ($1,991,779) | ($2,853,221) | ($4,845,000) |
| Savings From Wireless Hand Held Database | ($1,644,400) | ($2,355,600) | ($4,000,000) |
| Home and Community Based Waiver Consolidation and Utilization | ($2,220,784) | ($3,181,269) | ($5,402,053) |
| Delay Nursing Home Staffing Increase | ($27,870,730) | ($39,924,770) | ($67,795,500) |
| Prescribed Drug Pool Purchasing | ($1,174,284) | ($1,862,854) | ($3,037,138) |
| Freeze Intermediate Care Facility Reimbursement Rates | ($2,038,450) | ($2,920,076) | ($4,958,526) |
| Adjust HMO Rates for Children Under One Using Two Infant Groupings | ($30,545,512) | ($44,454,488) | ($75,000,000) |
| Impact to Hospice Rates Due to Nursing Home Rate Reduction | ($3,433,746) | ($5,098,834) | ($8,532,580) |
| Recipient Age Related Prior Authorizations for Certain Prescribed Medicine | ($371,177) | ($866,080) | ($1,237,257) |
| Revise Medicaid Preferred Drug List | ($90,000,000) | ($201,970,803) | ($291,970,803) |
| Limit Hospital Inpatient and Outpatient Reimbursement Rate Increases | ($48,165,743) | ($69,168,682) | ($117,334,425) |
| Limit Nursing Home Reimbursement Rate Increase | ($54,305,018) | ($77,791,839) | ($132,096,857) |
| Limit HMO Rate Increase | ($51,970,408) | ($75,153,861) | ($127,124,269) |
| Eliminate Non-Institutionalized Eligible Recipients From MEDS AD | ($64,368,718) | ($20,330,839) | ($84,699,557) |
| Expand Nursing Home Diversion Waiver | ($9,503,409) | ($13,613,616) | ($23,117,025) |
| ***Total Fiscal Year 2005-2006*** | ***($389,604,158)*** | ***($561,546,832)*** | ***($951,150,990)*** |
| | | | |
| **Fiscal Year 2006-2007** | | | |
| Savings From Nursing Home Staffing Ratio of 2.9 Average Instead of 2.9 Minimum | ($17,456,222) | ($24,882,420) | ($42,338,642) |
| Expansion of State MAC Pharmacy Pricing | ($2,515,640) | ($3,584,360) | ($6,100,000) |
| Increase Managed Care Enrollment to 65% Managed Care, 35% MediPass | ($1,583,952) | ($2,257,794) | ($3,841,746) |
| Expand Nursing Home Diversion Waiver | ($579,403) | ($838,102) | ($1,417,505) |
| PACE Expansion | ($41,333) | ($58,893) | ($100,226) |
| ***Total Fiscal Year 2006-2007*** | ***($22,176,550)*** | ***($31,621,569)*** | ***($53,798,119)*** |
| | | | |
| **Fiscal Year 2007-2008** | | | |
| Eliminate Surplus Budget for Pharmaceutical Expense Assistance Program | ($1,428,712) | $0 | ($1,428,712) |
| Rebates for Dialysis Drugs | ($775,620) | $775,620 | $0 |
| ***Total Fiscal Year 2007-2008*** | ***($2,204,332)*** | ***$775,620*** | ***($1,428,712)*** |
| | | | |
| **Fiscal Year 2007-2008 Special Session "C"** | | | |
| Expand Prior Authorization of Inpatient Hospital to Include Length of Stay for Labor and Delivery Services | ($1,662,217) | ($2,195,331) | ($3,857,548) |
| Hospital Inpatient Rate Reduction | ($18,369,077) | ($24,588,554) | ($42,957,631) |
| Hospital Outpatient Rate Reduction | ($4,927,913) | ($6,585,819) | ($11,513,732) |
| Nursing Home Rate Reduction | ($16,198,032) | ($21,393,131) | ($37,591,163) |
| Reduce Prescribed Drug Costs | ($7,211,311) | ($9,587,710) | ($16,799,021) |
| Nursing Home Diversion Disenrollment Penalty | ($626,313) | ($827,187) | ($1,453,500) |
| Limit Payment of Hospital Claims for Non US Citizens/Legal Residents for Federally Required Emergency Services | ($14,087,252) | ($18,605,373) | ($32,692,625) |
| Medicaid Cost Sharing Obligation for Qualified Medicare Beneficiaries | ($57,383,011) | ($75,787,123) | ($133,170,134) |
| Funding for Services for Individuals 65 and Over in Institutions for Mental Disease | ($5,170,800) | ($6,829,200) | ($12,000,000) |
| Reduce Nursing Home Expenditure Projection | ($47,658,696) | ($62,884,653) | ($110,543,349) |
| Impact to Hospice Rates from Adjusting Nursing Home Rates | ($1,312,914) | ($1,734,436) | ($3,047,350) |
| Nursing Home Diversion Expansion | ($1,269,003) | ($1,676,003) | ($2,945,006) |
| Increase Managed Care Enrollment | ($201,063) | ($268,261) | ($469,324) |
| ***Total Fiscal Year 2007-2008*** | ***($176,077,602)*** | ***($232,962,781)*** | ***($409,040,383)*** |
| | | | |
| ***Grand Total*** | ***($1,653,563,207)*** | ***($2,170,432,733)*** | ***($3,823,995,940)*** |

Data Source: General Appropriation Acts