The Impact of Medicaid Cuts on Rural Communities

Working Paper No. 82
WORKING PAPER SERIES
North Carolina Rural Health Research and Policy Analysis Center
Cecil G. Sheps Center for Health Services Research
The University of North Carolina at Chapel Hill

725 Martin Luther King Jr. Blvd., CB #7590, Chapel Hill, N.C. 27599-7590
phone: 919/966-5541 fax: 919/966-5764

www.shepscenter.unc.edu/research_programs/rural_program

The Impact of Medicaid Cuts on Rural Communities

Pam Silberman, JD, DrPH, Matt Rudolf, BS, Laura Brogan, BS, Stephanie Poley, BS,
Rebecca Slifkin, PhD, Charity Moore, PhD

North Carolina Rural Health Research and Policy Analysis Center

Cecil G. Sheps Center for Health Services Research
The University of North Carolina at Chapel Hill

August, 2005

This study was funded under a cooperative agreement with the federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services, Grant Number U1CRH00027-04-02

Executive Summary

States have experienced multiple years of budget shortfalls, caused by lower-than-expected revenues coupled with increased budgetary needs. Over the last four years, efforts have been made in many states to cut Medicaid costs by either cutting or freezing provider payments, cutting eligibility or service coverage, reducing pharmacy benefits, adding recipient cost-sharing, or changing the program structure. Generally, because of Medicaid requirements, programmatic changes must be implemented consistently across the state; however, there are specific concerns for rural communities associated with Medicaid policy changes. Because a higher proportion of rural populations live in poverty and are elderly, they are more vulnerable to eligibility restrictions. Changes in reimbursement or benefits could create additional barriers to accessing care, because rural Medicaid beneficiaries already face greater transportation barriers and provider shortages. Finally, some rural providers, such as pharmacists, are more dependent on Medicaid reimbursement than their urban counterparts.

This study assesses the perception of state Medicaid staff and individuals from State Offices of Rural Health (SORH) and Rural Health Associations (RHA) regarding the impact on rural areas of state Medicaid policy changes that occurred between 2002 and 2004. We conducted telephone interviews with respondents from 45 states, including someone from a SORH or a RHA in 39 states, and 67 respondents in 28 Medicaid offices. We also obtained county level Medicaid enrollment data from 21 states, to analyze changes in enrollment growth across counties, based on their level of rurality. Baseline data from 2001 were compared to those from 2003, the most recent year for which data was consistently available across the states.

We find that there was little uniformity in state Medicaid changes over the past three years, as programs were both cut and in some cases, expanded. In a few states, specific groups of eligibles were eliminated, but generally, changes were more modest—often some groups of eligibles were restricted while at the same time, coverage was expanded to other groups. In some instances, cuts that occurred in one year were subsequently rescinded. Almost every state froze or cut provider payments at some point during the study period, but increased payments in other years. In addition, it was often difficult to tease out the impact of programmatic changes from the concurrent downturn in the economy that resulted in more individuals becoming eligible for Medicaid.

There has been little focus on the rural impact of these changes by Medicaid officials or representatives of SORH or RHAs. The few rural-specific concerns that were raised were based on anecdotal information rather than data analyses. Our interviews suggest that Medicaid staff do not typically consider whether policy changes have a differential rural impact, as most are made on a statewide basis. However, a few Medicaid officials noted specific policy changes that could have differential impact in rural communities, usually highlighting changes that had a more significant impact on the elderly because of the high concentration of elderly residents living in many rural communities. For example, some Medicaid officials noted that some changes which have made it more difficult for people to qualify for nursing home level care could have a differential rural impact. Also, reductions

in outreach programs were thought to pose a particular threat to rural communities because these efforts are so frequently rural-centered. Conversely, some Medicaid officials noted that enrollment simplification, such as on-line or mail-in applications, could have a differentially positive impact on rural communities because they address transportation problems.

Although few of the rural respondents from SORH and RHA were familiar with all of the Medicaid policy changes in their state, they were more likely than Medicaid officials to identify the potential rural impact of the Medicaid changes. For example, some respondents felt that eligibility restrictions which made it more difficult for people to qualify for Medicaid would have a differential rural impact because rural residents are more likely to live in poverty. Others suggested that cuts or restrictions in the medically needy program would have a greater impact on the elderly, and would therefore have a differential rural impact. A few also noted that restrictions in coverage of prescription drugs (either through expanded formularies or increasing the number of drugs subject to prior approval) could have a differential rural impact because these restrictions would have a greater impact on the elderly. SORH and RHA representatives also felt that any changes which discourage providers from participating in Medicaid, or that increase travel distance for rural recipients are a particular problem for rural communities.

Analysis of county-level Medicaid enrollment data did not reveal any consistent trends in enrollment growth or contraction across states after adjusting for changes in population, poverty, and unemployment. Enrollment growth was significantly greater in rural communities in three states. However, the remaining states for which we had data did not experience a differential growth by geographic area. It is important, though, not to rely too heavily on these statistical analyses when examining potential impacts of specific policy changes on geographic areas of states. These data represent total Medicaid enrollment and do not identify trends associated with many of the states' eligibility policy changes which target specific Medicaid subpopulations (for example, elderly or disabled, children and/or families). We were unable to obtain enrollment data by specific Medicaid eligibility groups at the county level in most states, thus we could not determine whether there were differential geographic effects following a state-level policy change for a particular eligibility group. Further, many states avoided making specific eligibility cuts in the early years of the recession, relying instead on short-term budget fixes to address the shortfalls. However, some states were forced to make more significant cuts in eligibility in later years that are not reflected in these data.

Medicaid is a critical program in both urban and rural areas, but it is particularly important in rural areas because of high levels of poverty and less access to employer-sponsored insurance. Despite the importance of this program to rural communities, our study suggests that few people are specifically concerned with the unique challenges Medicaid changes may pose to rural communities. This study presents insight to the potential rural impact of Medicaid policy changes, especially those that could adversely affect the ability of rural residents to access services or that might potentially affect the overall rural health infrastructure.

Introduction

States have experienced multiple years of budget shortfalls, caused by lower-than-expected revenues coupled with increased budgetary needs. Rising Medicaid expenditures are often considered a major contributor to the states' budget woes. The program is financed by federal, state, and in some states, local funds, with the federal government paying between 50-77% of program costs. Despite the large contribution of the federal government, Medicaid is the second largest expenditure in state budgets after education. In 2004, it constituted 16.5% of state general fund spending, or nearly 22% of total expenditures including federal funds. Between 2004 and 2005, Medicaid expenditures increased 12%, far faster than state general revenues, and 18 states anticipated Medicaid budget shortfalls in 2004.[1]

Medicaid is one of the largest health insurance programs in the country, covering more people and having a larger budget than Medicare in 2004.[2] In addition to being a major source of health insurance for many low-income families, children, older adults, and people with disabilities, Medicaid is also a critical payer to safety net providers, including Federally Qualified Health Centers, Rural Health Clinics, health departments, hospitals, nursing homes, and pharmacists.

Over the last four years, efforts have been made in many states to cut Medicaid costs by either cutting or freezing provider payments, cutting eligibility or service coverage, reducing pharmacy benefits, adding recipient cost-sharing, or changing the program structure.[3] Generally, any programmatic changes would have to be implemented consistently across the state, because Medicaid requires the statewide operation of the program. [4] Nonetheless, Medicaid policy changes can have differential impacts on different parts of the state, depending on the demographics and provider supply in different communities.

This study builds on an earlier policy paper that explored potential areas of concern for rural communities raised by Medicaid policy changes.[5] In that paper we hypothesized that:

- Medicaid cut-backs that reduced or restricted eligibility could have a disproportionate impact on rural communities because rural residents are more likely to live in poverty and therefore be covered by Medicaid than are urban residents (14.7% versus 11.2%, respectively, in 2002).[6] [7] [8]
- Eligibility changes that affect the elderly may also have a disproportionate impact on rural communities, as there are proportionately more rural elderly receiving Medicaid (10.1%) than urban elderly (8.2%).[9]
- Medicaid changes in enrollment procedures that lead to more frequent recertifications or in-person applications could create greater transportation barriers for rural residents.

- Efforts to control rising pharmacy costs could create unique access barriers in rural communities, as rural pharmacists are more reliant on Medicaid reimbursement than urban pharmacists.[10]
- Cuts in Medicaid provider payments, coupled with rising liability premiums, technology, and workforce costs, may make it harder for providers to maintain their practices. While this is a potential problem in any community, it is a particularly acute issue for health professional shortage areas (HPSAs) where the loss of a few providers could have a major effect on the health care infrastructure. Not only could access to care be compromised, but there could also be spillover effects on the local economy, as health care is one of the major employers in many rural communities.

In this study, we collected data about state Medicaid policy changes that occurred between 2002 and 2004, and then assessed the perception of state Medicaid staff and individuals from State Offices of Rural Health and Rural Health Associations regarding whether these recent programmatic changes had a differential impact on rural beneficiaries and providers. We also obtained county level Medicaid enrollment data, when available, for the years 2001-2003 to determine if there was differential growth or cuts in the numbers of Medicaid eligibles across counties based on level of rurality.

Methodology

Telephone interviews: We created a database of state Medicaid policy changes that occurred between 2002 and 2004, relying largely on the published work of Vernon Smith and his colleagues,[11 12] and the Health Policy Tracking Service, then a service of the National Conference of State Legislatures.[13 14 15] Our database covered Medicaid policy changes in six areas: eligibility, outreach and enrollment, covered services, provider reimbursement, cost sharing, and delivery systems. To update this information, and to assess the perceived impact of Medicaid policy changes on rural communities, we conducted semi-structured telephone interviews with respondents from State Offices of Rural Health (SORH), Rural Health Associations (RHAs) and Medicaid agencies. Respondents from SORH and RHA were asked whether they had knowledge of Medicaid changes in eligibility, outreach or enrollment, services, providers' willingness to participate in Medicaid, and whether there were any changes in the ability of Medicaid recipients to access health care services. These respondents were also asked whether they perceived that the changes had a differential impact in rural communities. Medicaid staff were asked more extensive questions. In addition to the topics listed above, the Medicaid officials were asked about changes in recipient cost-sharing, health care delivery system, and provider reimbursement. We also asked the Medicaid respondents to review and correct our list of Medicaid policy changes.

In total, we spoke with respondents from 45 states (Table 1). We interviewed someone from a SORH or RHA in 39 states, talking with 34 respondents from 30 SORH and 14 respondents from 14 RHAs. We also interviewed 67 respondents in 28 Medicaid offices. All respondents were mailed a copy of their interviews to verify or correct the information we had obtained.

Table 1
Interviews Conducted and Enrollment Data Availability, by State

States*	State Office of Rural Health	Rural Health Association	Medicaid Officials	Medicaid Enrollment Data
Alabama		√	√	
Alaska	√			
Arizona	√		√	
Arkansas	√			
California		√	√	√
Colorado		√		
Connecticut	√			
Delaware		√	√	√
Florida	√	√	√	
Georgia	√		√	√
Hawaii		√	√	
Idaho		√	√	√
Illinois	√	√		
Indiana	√	√	√	
Iowa			√	
Kansas	√		√	√
Kentucky				√
Louisiana	√			
Maine	√			
Maryland	√	√		
Massachusetts			√	√
Michigan	√			
Minnesota	√		√	√
Missouri			√	
Montana			√	
Nebraska		√	√	√
Nevada			√	
New Hampshire	√			
New Jersey			√	√
New Mexico	√	√		√
New York	√		√	√
North Carolina	√		√	√
North Dakota	√		√	
Ohio	√	√		
Oklahoma	√		√	√
Oregon	√			√
Pennsylvania	√		√	√
Rhode Island	√			
South Carolina		√	√	
South Dakota	√			√
Texas	√		√	√
Utah	√		√	√
Vermont	√			
Virginia				√
Washington	√		√	√
West Virginia			√	
Wyoming	√			

** We could not get a response from any individuals in Mississippi, Tennessee, Virginia, or Wisconsin.*

Secondary data analysis: We obtained county level Medicaid enrollment data from state Medicaid agency websites when available. In states without posted data, we asked Medicaid respondents to supply enrollment numbers for 2001 and 2003 when possible. We were able to collect county level Medicaid enrollment data from 21 states (Table 1). We chose 2001 as a baseline, because this year was before most states started making extensive cuts. For our assessment of enrollment changes over time, baseline data were compared to those from 2003, the most recent year for which data was consistently available across the states. County level data on other temporal changes known to affect Medicaid enrollment (total population, number of persons unemployed, and number of persons in poverty) were obtained from Claritas (2003 Pop-Facts [unit-of-geography] demographic file; Claritas Inc; 2003). There is a slight error in our calculations because we only had access to county demographic data for 2000 and 2003. Urban/rural status is defined using the Office of Management and Budget's Core Based Statistical Areas (CBSA). We consider Metropolitan counties to be urban; Micropolitan counties and those counties not in a CBSA are considered rural.

We calculated the percentage point change in the percent of the population enrolled in Medicaid in each county, to assess whether Medicaid policies had a differential effect on rural eligibles.[i] We use this definition of change in enrollment as it controls for changes in the population that occurred over the same time period.

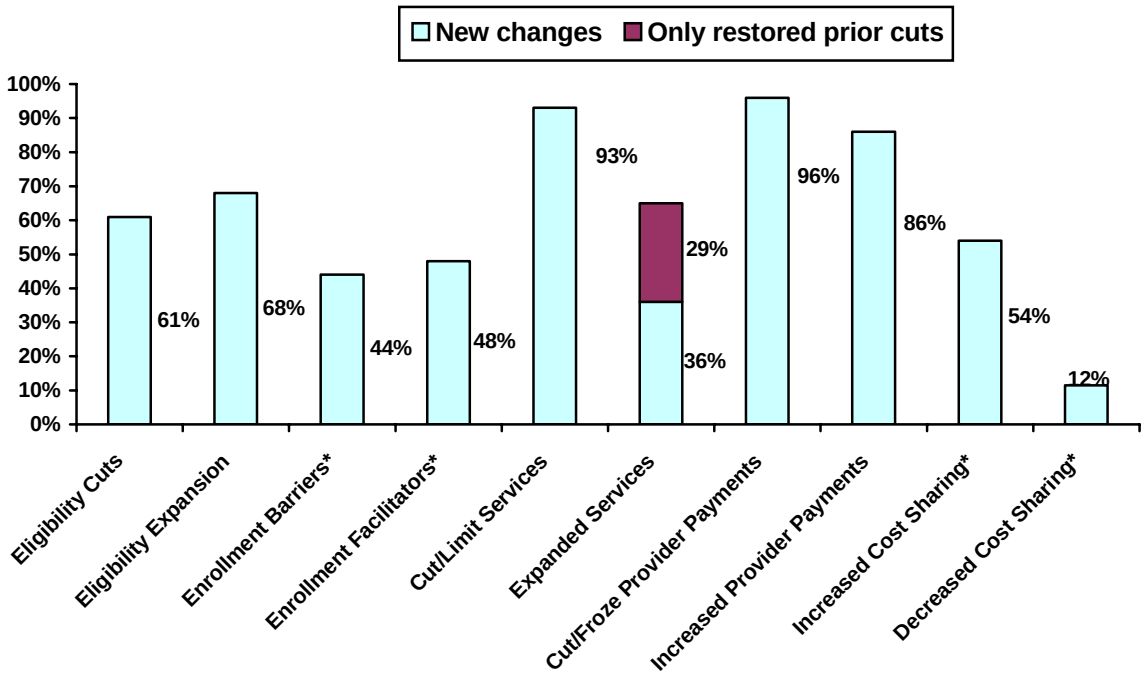
Analysis of variance was used to compare change in enrollment, unemployment, and poverty between urban and rural counties. We used analysis of covariance (ANCOVA) to test if urban-rural differences in percent enrollment were consistent for all states for which we have data, adjusted for change in percentage of persons in poverty and unemployed. A significant interaction was detected between urban-rural status and state, indicating that the urban-rural differences were not consistent across states. As a result, all analysis were stratified by state and controlled for changes in poverty and unemployment. All hypothesis testing was two-sided and conducted at α=0.05. Analyses were conducted using SAS version 9 (Cary, NC).

Findings from Interviews with State Medicaid and Rural Respondents

We found that state Medicaid agencies were both expanding and cutting their programs during the 2002-2004 time period (Figure 1). Of the 28 state Medicaid agencies with which we completed interviews, a majority had cut or eliminated covered services (93%), cut or frozen provider payments (96%), cut or restricted eligibility (61%) and/or increased the cost sharing (54%), although some of the cuts in covered services or eligibility were later restored by the state. At the same time, a majority of respondents also reported increased eligibility (68%), increased provider reimbursement or inflationary increases (86%), and expanded services or restoration of prior cuts (68%).

[i] For example, if there are 20 persons enrolled in 2001 with a population of 100 people in a county, then 20% are enrolled. If 30 persons are enrolled in 2003 with a population of 120, then 25% are enrolled, with a 5 percentage points increase in enrollment between 2001 and 2003.

Figure 1: Medicaid Program Changes, 2002-2004
(n=28 states, except where noted)



** Respondents in 27 states responded to the enrollment questions, and respondents in 26 states responded to the cost sharing questions.*

Eligibility Changes

Program changes

Over the three-year time period (2002-2004), changes in eligibility were made in 25 of the 28 states studied. In 11 states, both cuts and expansions in different eligibility categories occurred.[16] Six states had only cuts in eligibility,[17] and eight expanded their programs or liberalized eligibility policies.[18]

Among the 17 states with eligibility cuts, some eliminated entire eligibility categories, while others tightened eligibility requirements. Five states also reduced transitional Medicaid benefits from 24-12 months,[19] and one state eliminated coverage of 19 and 20 year-olds.[20] Five states eliminated all or part of their medically needy programs, or made the program more restrictive.[21] States also reduced or tightened income eligibility limits for pregnant women or teens (four states),[22] imposed stricter income or resource eligibility criteria for some groups of adults or families (seven states),[23] tightened transfer of assets or estate recovery provisions (three states),[24] or required a community spouse to contribute more of his or her income and assets to the institutionalized spouse in determining Medicaid eligibility (two states).[25] In some states, respondents noted that the reported impact of these changes was negligible, and in three states, some of the eligibility changes

were postponed or rescinded due to court injunction or a ruling from the Centers for Medicaid and Medicare Services (CMS) that the proposed cut would violate federal law.[26]

At the same time that states were cutting or restricting Medicaid eligibility for some populations, they were expanding the programs for others. For example, between 2002 and 2004, ten states expanded Medicaid to cover women with breast and cervical cancer,[27] eight states expanded Medicaid to cover the working disabled,[28] three states implemented a pharmacy waiver,[29] and two states implemented a family planning waiver.[30] Medicaid income limits for the aged, blind and disabled were also expanded in three states,[31] and two states made small changes to liberalize their nursing home eligibility policies.[32] Finally, three states took steps to restore prior cuts, although one is waiting for a CMS waiver to be approved.[33]

Many of the Medicaid respondents with whom we talked were uncertain of the exact number of people affected by changes in Medicaid eligibility policies, unless the state either created or eliminated a Medicaid eligibility category. For example, respondents in four states mentioned that their programs grew overall because of program expansions such as coverage of the working disabled, Medicaid expansion to low-income adults or a family planning waiver, while four others noted that enrollment was cut as a result of programmatic changes, including restrictions or cuts in the medically needy program, cuts in eligibility for 19-20 year olds, or cuts in the income eligibility guidelines. Respondents in five states thought their changes did not have much of an impact on program enrollment. Because of program growth due to the downturn in the economy during the time period studied, it was difficult for many state respondents to assess the impact of their programmatic changes. Respondents in five states specifically mentioned that changes in enrollment were largely due to changes in the economy rather than specific policy changes.

Respondents' estimate of rural impact of eligibility changes

We asked Medicaid officials if the eligibility changes were likely to have a differential impact in rural or urban areas. Most respondents thought that either the impact would be the same across geographic areas (52%) or that they did not have enough information to know what impact the changes would have (36%). Only respondents from five of the states thought there might be a differential geographic impact, and two of these reported that urban residents fared worse because more people were losing jobs in urban areas. Three respondents felt that rural areas would be more adversely affected by some of the policy changes: state policies that made it more difficult for people to qualify for nursing home care could have a differential impact on rural communities because of the higher concentration of elderly living there; the tightening of transfer of assets rules could have a differential impact on rural residents who own farms and transfer land or equipment; and the general concern that rural residents were, on average, poorer, and less likely to have employer-sponsored insurance, so that any cuts in their Medicaid or state-funded program would have a differential impact on rural residents.

Perceptions of respondents from State Offices of Rural Health and Rural Health Associations regarding the differential impact of eligibility changes on rural residents

differed from those of Medicaid official in most states. We were able to interview both a Medicaid official and at least one respondent from a SORH or RHA in 21 states. The rural respondents were aware of all or most of the policy changes in 12 of these states, and there was agreement on the perceived rural impact on eligibility changes in only five states. In general, rural respondents were more likely to report that eligibility changes were worse for rural residents or that their impact was unknown, while Medicaid officials were more likely to report that there was no differential impact.

Not all respondents from the State Offices of Rural Health or Rural Health Associations were aware of changes in eligibility, or felt that changes in eligibility would have a differential rural impact. Among those who did, a few saw the changes as more beneficial to rural residents, but most felt rural residents were disadvantaged. One respondent reported that a Family Planning expansion benefited rural areas more because more Medicaid beneficiaries live in rural areas than in urban areas, while another respondent thought that eligibility expansions for children affected rural and urban residents equally, and another rural respondent noted that the expansion of SCHIP to include pregnant women was not as effective in rural areas because of the shortage of providers who accept Medicaid in rural parts of the state. Respondents in seven states thought that rural areas fared worse as a result of eligibility cuts, often citing the disproportionate impact that increased income requirements and asset tests have on rural areas with higher poverty rates, and the higher percentage of medically needy beneficiaries who live in rural areas. Respondents from 16 states reported that there were no eligibility changes, or that the eligibility changes made during this time period affected very few people, and respondents from 12 states were unsure as to the impact that eligibility changes had on rural areas.

Enrollment Procedures

Program Changes

Respondents from 27 of the 28 Medicaid agencies provided information about changes in enrollment procedures in their state. In 67% of the states (18), changes were made to outreach and enrollment process; in six states the changes made it harder to apply,[34] in six states changes were made to facilitate the enrollment process,[35] and six did both types of changes.[36] Five states cut outreach workers or reduced outreach activities.[37] Four states eliminated or reduced continuous eligibility for children,[38] and four states otherwise changed their enrollment or recertification requirements.[39] These changes created enrollment barriers for some individuals because of the need for more frequent applications, recertifications, less time to return needed forms, or more extensive verifications; although some states reported trying to mitigate the impact of the changes through more extensive outreach or education to applicants and recipients.

While some Medicaid agencies made changes that made it more difficult to enroll, others were trying to streamline and automate the enrollment process. For example, changes to facilitate enrollment were made in 12 states—by either creating on-line applications, reducing or streamlining verification, linking eligibility to the National School Lunch Program, extending presumptive eligibility to children, or simplifying the application

forms.[40] Two state agencies increased their outreach activities or outstationed workers during this time period.[41] One state that had previously cut continuous eligibility later restored it,[42] and another expanded continuous eligibility for children.[43] Three state agencies were consolidating their eligibility offices or creating call centers, although respondents were uncertain at the time of the study of the effect these changes would have on filing applications or determining eligibility.[44]

Respondents' estimate of rural impact of enrollment procedure changes

As with the eligibility changes, most of the Medicaid officials thought that the changes in their state's enrollment procedures would not have a differential impact across geographic areas (nine respondents) or were unclear about the potential impact (four respondents). However, respondents in five state agencies—those that expanded outreach or created online or phone applications—thought that their changes would be more beneficial to rural residents because they would reduce time and travel costs needed to file an application. One respondent from a state that reduced outreach workers thought the change might have more of an adverse impact in rural areas.

Rural respondents were generally less aware of the specifics of the changes in enrollment procedures than they were of eligibility changes. As a general rule, the respondents from the SORH and RHA were more familiar with ongoing outreach or simplification efforts, and less knowledgeable about other changes in enrollment procedures such as changes in the certification time periods or continuous eligibility. Rural respondents in 12 states thought the outreach and simplification efforts made it easier for Medicaid recipients to enroll during the study period, despite any other changes to the enrollment procedures. Seven of these respondents thought the outreach effort was equally beneficial in both urban and rural areas, but respondents in five states noted that the outreach or simplification efforts had a differentially positive impact on rural residents. Rural respondents in three states thought that enrollment changes would have a differentially negative impact on rural areas, because the changes would require more frequent applications or recertifications, decreased outreach, or closed local offices that exacerbated existing transportation problems. Respondents from seven states noted that changes such as the elimination of presumptive eligibility, the institution of enrollment premiums, or enrollment staff cuts negatively affected both rural and urban enrollees. In four states, respondents felt that some changes made enrollment easier for rural applicants, while others made it harder. For example, one respondent reported that their state had streamlined the application process, but also closed many local offices, and another reported that presumptive eligibility was eliminated but outreach increased. Finally, rural respondents from eight states were uncertain about the impact of changes in enrollment procedures and respondents from another eight states reported that there were no changes to enrollment made.

Of interest, in states where a Medicaid official was also interviewed, there was very little congruence between the assessment of the impact of enrollment changes from state Medicaid officials and respondents from the SORH or RHA. In general, state Medicaid officials were more likely to report that the impact of enrollment changes were the same across geographic areas of the state or were uncertain of their impact, whereas rural

respondents were more likely to note specific ways in which the enrollment changes would either differentially benefit or hurt rural areas.

Covered Services

Medicaid officials in all but two of the 28 states we studied noted cuts or restrictions in covered services. A majority of respondents (20) noted that their program had expanded the list of drugs that required prior approval, created or expanded the classes of medications in their preferred drug list (PDL).[45] The preferred drug list (PDL) operates as a non-exclusive formulary. Medicaid recipients may obtain any of the drugs on the PDL, but if they wish to obtain medications that are not on the PDL, they must seek prior approval or file an appeal. Historically, Medicaid agencies have operated a more open formulary, with few drugs subject to prior approval. Expanding the class of medications on the PDL was considered a service restriction because it narrows the types of medications that can be prescribed to those on the PDL without prior approval. Six states also began requiring generic substitution when medically appropriate,[46] and one state implemented a four-brand limit per month.[47]

Almost half of the states (13) eliminated or restricted adult dental services,[48] and seven states eliminated or limited coverage for vision services for adults.[49] States made other cuts to services, including adult hearing (4 states),[50] therapy services (4 states),[51] chiropractic (4 states),[52] circumcisions (4 states),[53] personal care services (3 states),[54] and child dental services (typically, orthodontia-3 states).[55]

Expansions were less common, but they did occur during this time of budget constraints. Nine states restored some or all of their prior cuts in covered services;[56] in eight of these states these were the only programmatic "expansions." Some provision of behavioral health services was expanded in four states,[57] home and community based services were expanded in three states,[58] and two states expanded case management services.[59] Other program expansions included covering services such as transplants, independent physical and occupational therapists, and speech/language pathologists, tobacco cessation, bariatric surgery, and access to dental clinics at academic dental clinics for managed care enrollees.[60]

We also asked about changes in covered services that might have occurred at the local level. Respondents in eight states reported changes in how they delivered Medicaid transportation services; the most common changes were to try to get recipients to use the least expensive form of transportation, change the transportation fee structure, or move to a broker or regional coordination system.[61]

A majority of the Medicaid respondents indicated that they were not monitoring trends in utilization that might result from cuts or that the cuts were too new to discern changes in utilization. Respondents in six states reported that they were monitoring utilization trends, but had not seen any changes as a result of the changes in covered services, but in three of these states, the state restored most of the cuts so the cuts may not have been in place long enough to have detected spillover effects. State officials in one state reported that use of

emergency dental services rose when the state limited adult dental coverage to emergency services only. As a result, some of the adult dental cuts were restored. Only five respondents thought that the changes in covered services had differential effects in either rural or urban areas. Three thought that the changes in transportation policy (e.g., raising rates to providers or improving the transportation system) would be more helpful for rural residents, although one respondent noted that the move to a regional broker system adversely affected Native Americans on the reservations. Respondents in two states thought that their service expansion to cover Medicaid services for people in assisted living helped people in urban areas more, because assisted living facilities were more prevalent in urban communities.

Rural respondents knew about all or most of the changes in covered services in eight of the 21 states from which we had interviewed both Medicaid and rural health respondents. Few of the rural respondents had any idea of how these changes affected rural residents, although respondents in three states did note that the changes to the prescription drug coverage (through expanded formularies or the addition of drugs subject to prior approval), might have a differential rural impact because the restrictions would adversely affect the elderly, and rural communities have a higher proportion of elderly Medicaid recipients than urban communities.

Provider Reimbursement

It was difficult to tease out changes in provider reimbursement over the three year time period (2002-2004), as some of the changes were hard to categorize. Changes to reimbursement methodology could result in real increases in reimbursement for some providers, but decreased revenues for others. For example, in some states, there were increases in reimbursement for some procedure codes, but decreases or freezes for others. Seventeen states froze provider reimbursement in one year, but then gave increases in subsequent years.

The most common cuts were in the reimbursement for medications (21 of 28 states), which either decreased payments to pharmacists and/or encouraged pharmacists to dispense generic medications.[62] In 21 states, physician/practitioner reimbursement rates were reduced or frozen,[63] although in one of these states the proposed physician payment change was enjoined through court action. In total, some type of freeze or reduction in provider payments occurred during the three year study period in every state studied except Arizona, which runs its program almost exclusively through capitation arrangements. At the same time, respondents from almost every state (24) reported increasing some provider payments through inflationary adjustments or *real* increases in reimbursement.[64]

Impact of provider reimbursement cuts on provider participation

Respondents in seven state Medicaid agencies reported that some participating physicians had either dropped out of the program, or had begun to limit the number of Medicaid patients they were willing to serve as a result of inadequate reimbursement, among other factors. In three states, Medicaid officials cited the low Medicaid reimbursement coupled

with the rising malpractice costs as contributing factors. In another state, the low reimbursement coupled with problems with the fiscal intermediary led some providers to withdraw from the program. We specifically asked Medicaid officials whether increased malpractice premiums were having spillover effects on their providers' willingness to participate in Medicaid, but with the exception of the three states noted above, none of the respondents felt their state was experiencing attrition in the Medicaid program as a result of increasing malpractice premium costs. Respondents in three states reported that the freeze or cuts in physician payment had led some providers to explore converting to FQHC or RHC status in order to maintain cost-based reimbursement.

Medicaid officials in several states reported dissatisfaction among pharmacists with the decrease in the reimbursement for prescription drugs. Respondents from five states reported that rural pharmacists were most unhappy with the changes; however, a decline among participating pharmacists was actually reported in only one state. Although pharmacists were generally not happy with the reductions in reimbursement for ingredient costs, several respondents noted that Medicaid was still a better payer than other third party reimbursement.

Medicaid officials also reported dental access barriers in 12 states, although this was not attributed specifically to changes in provider reimbursement during the study period. In general, these respondents noted that there was an overall dental shortage, and that this provider shortage was exacerbated in rural communities. While it was more common to hear about dental shortages, respondents from five states did report increasing dentist participation, most often the result of an intentional decision to increase reimbursement rates to dentists in order to encourage participation. In most of these states, however, the increased dental participation in Medicaid did not resolve underlying rural provider shortages. In three states with increased dental fees there was no resulting increase in dentist participation.

Rural respondents' assessment of impact of provider cuts

The rural respondents were generally more knowledgeable about changes in provider participation in Medicaid than in other areas of programmatic changes. Respondents from 12 states noted that providers were leaving the Medicaid program and/or closing their practices to new Medicaid patients. Six of these respondents cited low reimbursement rates as a major reason for the reduction in provider participation, and respondents in six states (three that had also mentioned low reimbursement) noted that increase in the professional liability premiums was one of the underlying causes. In most of the 12 states, the problem was occurring in both rural and urban areas. Rural respondents in only three of the states thought that the problem was more acute in rural areas, while respondents in three other states thought the problem was more acute in urban areas. Respondents from three states felt that although provider participation had not changed during the study period, the dearth of providers in some rural areas made it more difficult for Medicaid recipients to access services. In contrast, in two states, respondents noted that rural providers were actually more likely to take Medicaid, so the access problems were more acute in urban communities. As with the Medicaid officials, rural respondents in seven

states noted an increased interest among some providers in converting to FQHC or RHC status in order to obtain cost-based reimbursement.

When specifically considering access to dental care, rural respondents in 10 states noted an increase in dental participation during the study period, largely a result of increased reimbursement. We only heard of a decrease in dental participation in four states. However, despite the fact that reports of increased participation were common, rural respondents in 27 states still noted dental access problems. Many indicated that while the problem existed statewide, it was more acute in rural areas.

In total, rural respondents in 20 states noted particular rural access barriers, even though these problems were not always directly related to changes in Medicaid policies. Sometimes these concerns were provider specific (e.g., dentists or specialists), but others noted a more widespread provider shortage. Rural respondents felt that any changes that discouraged providers from participating in Medicaid exacerbated existing problems. In addition, transportation barriers made it difficult for many rural residents to access services because there are proportionately fewer providers in rural communities and/or transportation problems accessing providers.

Cost Sharing

Respondents in 14 of the 26 states that responded to these questions reported some increases in the costs that Medicaid recipients were required to pay. In four states, the copayments for a variety of services were increased.[65] Six other states limited their increased copayments to medications.[66] In three states, a copayment was imposed for the non-emergency use of the emergency room.[67] Six states also imposed premiums for the working disabled, for their expansion populations or for the second six months of transitional benefits.[68] Four states lowered or limited their cost sharing during this time, including lowering the copayment for generic drugs, creating a monthly cap on overall copayments, and reducing the premium for the working disabled.[69] There were no changes in the cost sharing for the other states we interviewed.

Medicaid respondents generally thought the increase or change in cost sharing would have little impact on recipients, because federal law prohibited providers from refusing treatment or services because of a patient's inability to make the copayment. Because of this provision, some of these respondents did recognize that the increase in copayments was effectively a decrease in provider reimbursement. Only two respondents thought the increase in cost sharing was a problem. One state that increased its premium for the working disabled experienced a decline in enrollment after the premium increase. The premium was later reduced to encourage participation. Respondents in another state noted that the increase premiums for children caused some problems to low-income families. One respondent thought the increase in the cost sharing might be more detrimental to urban Medicaid recipients, because he thought that rural providers may be more willing to absorb the loss when recipients could not make their copayment.

Changes in Program Design

Medicaid officials in some states were exploring ways to reduce program costs or improve quality of care through changes to their Medicaid delivery system. For example, ten states had or were in the process of developing or expanding disease management protocols and/or enhanced case management systems in their primary care case management program.[70] Respondents in two of these states thought the enhanced case management would be especially helpful in rural areas, by helping link rural recipients to needed services. Six states expanded their fully capitated Medicaid managed care programs into other parts of the state; this expansion included rural communities in three of the states.[71] While some states were successful in expanding their fully capitated Medicaid managed care programs, three other states lost Managed Care Organization (MCO) participation.[72] When one state cut capitation rates, all of the MCOs pulled out, forcing the state to transition the urban areas into the partially capitated program that was already in operation in rural areas. Respondents in this state thought that the move to partial capitation resulted in increased provider participation, because providers in the urban areas had previously resisted participating in the fully capitated managed care plan.

Results of Enrollment Data Analysis

On average, county-level Medicaid enrollment increased over the time period studied in the 21 states for which we had secondary data (Table 2). There were significant differences across counties when grouped according to metropolitan and non-metropolitan, with greater enrollment gains seen in the more urban counties. However, during this same time period, population increases were also larger in more urban areas, and the actual difference in the percentage of the population enrolled between 2001 and 2003 did not significantly differ across the two county groups. Because Medicaid enrollment levels are influenced by economic conditions, we also adjusted for changes in unemployment and poverty across counties. Although both poverty and unemployment became significantly worse over time in the most rural counties, the absolute changes were small relative to change in total population, and poverty and unemployment change were not significant in predicting change in enrollment in the multivariable analysis.

Table 2.
Descriptive Statistics of Change in Medicaid Enrollment, and Associated County Demographic Characteristics.

	Metropolitan counties n=537 Mean (SD)	Non-Metropolitan counties n=1020 Mean (SD)	ANOVA p-value
Average percent change in county-level enrollment ([2003 enroll-2001 enroll]/2001 enroll)	25.7 (19.8)	17.5 (20.3)	<0.0001
Average percent change in population ([2003 pop – 2001 pop]/ 2001 Pop)	4.3 (3.8)	1.0 (3.1)	<0.0001
Percent of population enrolled in 2001	11.3 (6.1)	14.2 (7.6)	
Percent of population enrolled in 2003	13.7 (8.0)	16.4 (9.1)	
Difference in percent of population enrolled 2003-2001	2.3 (2.7)	2.2 (2.8)	0.3399
Unemployment Rate 2000	5.3 (2.1)	5.9 (3.0)	
Unemployment Rate 2003	5.3 (2.1)	5.9 (3.0)	
Difference in unemployment rate 2003-2000	-0.037 (0.07)	0.0075 (0.15)	<0.0001
Percent of families in poverty 2000	6.6 (4.1)	11.0 (6.1)	
Percent of families in poverty 2003	6.6 (4.1)	11.2 (6.1)	
Difference in percent of families in poverty, 2003-2000	0.041 (0.23)	0.19 (0.60)	<0.0001

There were considerable differences across states in the levels of enrollment change between 2001 and 2003 (Table 3), as well as inconsistency of urban-rural differences. Because of this, and because of differences across states in programmatic changes that might affect enrollment, we conducted an analysis stratified by state (Table 4).

Table 3
State Level Enrollment Change

State	No. of Counties	Number Enrolled 2001	Population 2000*	Number Enrolled 2003	Est Population 2003*	% Enroll 2001	% Enroll 2003	Relative Change	Difference in % Enrollment (2003-2001)
CA	58	5,214,221	33,871,648	6,363,172	35,526,692	15.4%	17.9%	22.0%	2.5%
DE	3	141,115	783,600	162,761	815,222	18.0%	20.0%	15.3%	2.0%
GA	159	1,437,430	8,186,453	2,216,180	8,681,578	17.6%	25.5%	54.2%	8.0%
ID	44	88,257	1,293,953	121,069	1,356,506	6.8%	8.9%	37.2%	2.1%
KS	105	205,321	2,688,418	233,245	2,724,736	7.6%	8.6%	13.6%	0.9%
KY	120	607,316	4,041,769	653,845	4,109,331	15.0%	15.9%	7.7%	0.9%
MA	13	982,768	6,349,097	976,371	6,451,860	15.5%	15.1%	-0.7%	-0.3%
MN	87	480,304	4,919,479	566,719	5,051,203	9.8%	11.2%	18.0%	1.5%
NC	100	906,359	8,049,313	1,039,488	8,408,414	11.3%	12.4%	14.7%	1.1%
NE	93	192,789	1,711,263	204,284	1,734,956	11.3%	11.8%	6.0%	0.5%
NJ	21	756,801	8,414,350	917,156	8,648,219	9.0%	10.6%	21.2%	1.6%
NM	33	357,319	1,819,046	418,369	1,867,337	19.6%	22.4%	17.1%	2.8%
NY	58	2,869,943	18,976,457	3,755,091	19,214,548	15.1%	19.5%	30.8%	4.4%
OK	77	439,632	3,450,654	509,984	3,508,062	12.7%	14.5%	16.0%	1.8%
OR	36	365,163	3,421,399	398,268	3,555,010	10.7%	11.2%	9.1%	0.5%
PA	67	1,452,882	12,281,054	1,567,438	12,352,083	11.8%	12.7%	7.9%	0.9%
SD	66	76,504	754,844	90,065	763,030	10.1%	11.8%	17.7%	1.7%
TX	254	1,842,413	20,851,820	2,474,075	22,086,674	8.8%	11.2%	34.3%	2.4%
UT	29	252,040	2,233,169	310,779	2,343,691	11.3%	13.3%	23.3%	2.0%
VA	95	261,714	4,720,321	301,685	4,966,447	5.5%	6.1%	15.3%	0.5%
WA	39	775,400	5,894,121	850,716	6,126,602	13.2%	13.9%	9.7%	0.7%

*Population counts came from CLARITAS

As can be seen in Table 4, there are very few states where the adjusted change in enrollment rates differs significantly between metropolitan and non-metropolitan counties. In the states where such differences do occur, the non-metropolitan counties have greater gains in enrollment.

Table 4.
Percentage Point Change in the County Mean Percent of Population Enrolled in Medicaid, 2001 to 2003, Adjusted for Poverty and Unemployment Change.

State	Metropolitan counties Least square mean	Non-Metropolitan counties Least square mean	p-value adjusted for poverty and unemployment change
California	2.1	2.7	0.1510
Georgia*	8.5	9.8	0.0003
Idaho	2.0	2.7	0.1595
Kansas	0.68	0.83	0.4253
Kentucky	0.92	0.98	0.6800
Massachusetts	-0.34	0.80	0.2429
Minnesota*	1.4	1.8	0.0088
Nebraska	0.54	0.21	0.2203
New Mexico	2.8	1.9	0.1465
New York	3.0	3.5	0.0794
North Carolina	1.1	1.0	0.4621
Oklahoma	1.7	1.8	0.6427
Oregon	0.64	0.18	0.2258
Pennsylvania	1.0	1.1	0.7159
South Dakota	1.3	1.6	0.5756
Texas	1.7	2.1	0.0611
Utah	2.1	2.9	0.0986**
Virginia*	0.56	0.83	0.0131
Washington	0.86	1.1	0.6858

**UT: Urban rural variable was significant without adjusting for poverty change and unemployment change (p=0.0068), but after adjusting for poverty change, which was positively associated with change in enrollment, differences were not significant.

Note: Delaware and New Jersey are not shown because they have no non-metropolitan counties.

Discussion

There has been little uniformity in state Medicaid changes over the past three years, as states were both cutting and in some cases, expanding their Medicaid programs. A few states eliminated specific groups of eligibles, but generally, states made more modest changes—often restricting some groups of eligibles while at the same time expanding coverage to other groups. In some instances, eligibility or service cuts that occurred in one year were rescinded in subsequent years. Almost every state froze or cut provider payments at some point during the study period, but in other years, they increased payments. In addition, it was often difficult to tease out the impact of programmatic changes from the concurrent changes in the economy. Medicaid programs were growing because of the downturn in the economy at the same time that states were making it more difficult for people to apply for, and/or become eligible for, Medicaid.

There has been little formal data analysis of the rural impact of these changes by Medicaid officials or representatives of State Offices of Rural Health or Rural Health Associations, and the few rural-specific concerns that were raised were largely based on anecdotal information rather than data analyses. Medicaid staff do not often consider whether policy changes have a differential rural impact, as most of the policy changes are made on a

statewide basis. Because the impact of changes by geographic area is rarely assessed, most of the Medicaid respondents assumed that the changes would be the same across the state. However, a few Medicaid officials noted specific policy changes that could have differential impact in rural communities, usually highlighting changes that had a more significant impact on the elderly, as there is a higher concentration of elderly living in many rural communities. For example, some Medicaid officials noted that changes that made it more difficult for people to qualify for nursing home level care and/or changes in the transfer of assets policies could have a differential rural impact. Conversely, some of the Medicaid officials noted that enrollment simplification, such as on-line or mail-in applications, could have a differentially positive impact on rural communities because it helped reduce transportation barriers.

Few rural respondents from SORH and RHA, who presumably have a closer connection to the rural health infrastructure, were familiar with all the specific Medicaid policy changes made at the state level. Even if not knowledgeable about the exact specifics of each policy change, rural respondents were more likely than Medicaid officials to identify potential rural effects of the Medicaid changes. For example, some rural respondents noted any eligibility restrictions that made it more difficult for people to qualify for Medicaid would have a differential rural impact, as more rural residents live in poverty. Some thought that cuts or restrictions in the medically needy program would have a larger impact on the elderly, again more significantly affecting rural residents. As with Medicaid officials, rural respondents noted that increased outreach or simplification helped people throughout the state, but several argued that this would differentially benefit rural residents because it would reduce transportation barriers (or conversely, if the state cut outreach or required more frequent recertification, that this would have a differentially adverse effect on rural communities for the same reason). A few of the rural respondents also noted that restrictions in coverage of prescription drugs (either through expanded formularies or increasing the number of drugs subject to prior approval) could have a differential rural impact because these restrictions would have a greater impact on the elderly. Rural respondents were most likely to identify rural access issues, stemming from either specific Medicaid policy changes or the overall lack of providers in rural communities. They noted that any changes that discouraged providers from participating in Medicaid, or which made rural recipients have to travel farther to obtain health services, was a particular problem for rural communities.

We were able to analyze differences in county-level Medicaid enrollment between 2001 and 2003 in 21 states. We did not see any consistent trends in enrollment growth or contraction across states after adjusting for changes in the county population, poverty and changes in unemployment during that time period, and in most states there was no differential growth by geographic area. However, it is important not to rely too heavily on these statistical analyses when examining potential effects of specific policy changes on geographic areas of the state. The data available for this study include total Medicaid enrollment, whereas many of the eligibility policy changes affected a specific Medicaid subpopulation (for example, elderly or disabled, children and/or families). We were unable to obtain enrollment data by specific Medicaid eligibility groups at the county level in most states, and thus could not determine whether there was a geographic impact of a

state-level policy change on a particular eligibility group. Further, the impact of policy changes may be more obvious in the future. Many states avoided making specific eligibility cuts in the early years of the recession, relying instead on short-term budget fixes to address the shortfalls. However, some states were forced to make more significant cuts in eligibility in later years—which would not be reflected in the data presented here. Additionally, many of the state-level policy changes affected services or payment to providers, not specifically groups of eligibles. These enrollment data do not capture changes in access to providers or availability of services.

Medicaid is important across all geographic areas of states, but it is particularly important in rural areas because of high levels of poverty and less access to employer-sponsored insurance. Despite the importance of this program to rural communities, our study suggests that few people are specifically examining the unique challenges Medicaid program changes may pose in rural communities. Because Medicaid is a critical source of health coverage for millions of rural people, and helps them access needed health services, it is important to examine the potential rural impact of specific Medicaid policy changes, especially those that could adversely affect the ability of rural residents to access services or that effect the overall rural health infrastructure.

---

[1] National Governors Association and National Association of State Budget Offices. The Fiscal Survey of States. 2004 Dec.

[2] Kaiser Family Foundation. Key Medicare and Medicaid Statistics. July 26, 2005. http://www.kff.org/medicaid/upload/Key%20Medicare%20and%20Medicaid%20Statistics.pdf (Accessed August 5, 2005)

[3] Smith, V., Ramesh R., Gifford, K., Ellis E., and Wachino, V. States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004. Kaiser Commission on Medicaid and the Uninsured. 2003 Sept.

[4] 42 USC § 1396a(a)(1). 42 CFR § 431.50.

[5] Silberman, P., Rudolf, M., D'Alpe, C., Randolph, R., Slifkin, R. The Impact of The Medicaid Budgetary Crisis in Rural Communities. Chapel Hill, NC: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. Working Paper #77. 2003 Aug.

[6] Data & Publications. 2003 Jul. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrg.gov/data_public.htm.

[7] Area Resource File (ARF). 2002 Feb. US Department of Health and Human Services. Washington DC: National Center for Health Workforce Analysis, Bureau of Health Professions, Health Resources and Services Administration.

[8] Census 2000 Summary File 3 – United States. US Department of Commerce. US Census Bureau; 2002.

[9] Data & Publications. 2003 Jul. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrg.gov/data_public.htm.

[10] Fraher, E., Slifkin, R., Smith, L., Randolph, R., Rudolf, M., and Holmes, G. How might the Medicare Prescription Drug Improvement and Moderization Act of 2003 affect the financial viability of rural pharmacies? An analysis of pre-implementation prescription volume and payment sources in rural and urban areas." *Journal of Rural Health*, 21(2):114-121.

[11] Smith, V., Gifford, K., Ramesh, R., and Wachino, V. Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003. Kaiser Commission on Medicaid and the Uninsured, 2003 Jan.

[12] Smith, V., Ramesh R., Gifford, K., Ellis E., and Wachino, V. States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004. Unpublished data. Kaiser Commission on Medicaid and the Uninsured. 2003 Sept.

[13] Health Policy Tracking Service. State Actions Affecting Health Care. January 27, 2003; February 10, 24, 2003; March 10, 24, 2003; April 7,21, 2003; May 5, 2003.
[14] Health Policy Tracking Service. Medicaid and Indigent Care. Snapshots. January 17, 2003; February 3, 17, 2003; March 3, 17, 2003; April 14, 28, 2003.
[15] Health Policy Tracking Service. Provider Reimbursement Year End Report (2002). December 31, 2002. Medicaid: Access to Health Services. Year End Report (2002). December 31, 2002. Medicaid: Services Covered. Year End Report (2002). December 31, 2002. Medicaid: Benefits and Services. Issue Brief. April 1, 2003; July 1, 2003. Medicaid: Eligibility. Issue Brief. April 1, 2003, July 1, 2003. Medicaid: Provider Reimbursement. Issue Brief. July 1, 2003.
[16] States that both cut and expanded different eligibility groups: AZ, FL, KS, MA, MO, NC, ND, NV, SC, TX, WA.
[17] States that only had cuts—not expansions—in eligibility: GA, ID, MN, NE, NJ, OK.
[18] States that expanded their Medicaid programs to cover additional eligibility categories or liberalized eligibility rules: AL, DE, HI, IN, NY, PA, UT, WV.
[19] States that reduced transitional Medicaid benefits from 24-12 months: AZ, KS, MO, NC, NE.
[20] State that eliminated coverage of 19 and 20 year-olds: NE.
[21] States that eliminated all or part of their medically needy programs, or made the program more restrictive: FL, GA, MO, OK, TX. Oklahoma eliminated the medically needy program. Florida eliminated coverage of all services for the medically needy except prescription drugs, and Georgia eliminated the medically needy program for nursing home residents with incomes above 300% of the SSI payment level. Missouri made their medically needy program more restrictive by requiring Medicaid recipients to that medical bills had been paid, rather than just incurred.
[22] States that reduced or tightened income eligibility limits for pregnant women or teens: FL, GA, NC, TX.
[23] States that imposed stricter income or resource eligibility criteria for some groups of adults or families: MO, MN, NE, ND, NV, SC, TX.
[24] States that tightened transfer of assets or estate recovery provisions: ID, KS, NC.
[25] States that required the community spouse to contribute more of his or her income and assets to the institutionalized spouse in determining Medicaid eligibility: ND, WA.
[26] Some of the eligibility changes were postponed or rescinded due to court injunction or a ruling from the Centers for Medicaid and Medicare Services (CMS) that the proposed cut would violate federal law in the following states: NC, TX, NE.
[27] States that expanded Medicaid to cover women with breast and cervical cancer: AL, DE, MA, MO, ND, NV, NY, PA, WA, WV.
[28] States that expanded Medicaid to cover the working disabled: AZ, KS, MO, ND, NV, NY, WA, WV.
[29] States that implemented a pharmacy waiver: FL, HI, SC.
[30] States that implemented a family planning waiver: NY, WA.
[31] States that expanded the Medicaid income limits for the aged, blind and disabled: AZ, MO, UT.
[32] States that made small changes to liberalize their nursing home eligibility policies: IN, NC.
[33] States took steps to restore prior cuts: NC, MA, TX.
[34] States that made changes to enrollment that made it harder for applicants to apply: GA, IN, MA, NE, SC, WA.
[35] States that made changes to their outreach or enrollment process that made it easier to apply: HI, KS, NY, PA, UT, WV.
[36] States that made some changes to their enrollment processes that made it more difficult to apply, and other changes that facilitated the enrollment process: AZ, CA, FL, ID, MO, MN.
[37] States that cut outreach workers or reduced outreach activities: CA, FL, GA, ID, MO.
[38] States that eliminated or reduced continuous eligibility for children: AZ, IN, MN, WA.
[39] States that otherwise changed their enrollment or recertification requirements: MA, NE, SC, WA.
[40] States that made changes to facilitate enrollment, by either creating on-line applications, reducing or streamlining verification, linking eligibility to the National School Lunch Program, or simplifying the application forms: AZ, CA, FL, HI, ID, KS, MN, MO, NY, PA, UT, WV. Idaho actually implemented their mail in application in CY 2001, but the respondent thought that these enrollment changes had more of a beneficial impact than some of the other enrollment changes made later (2002-04).

[41] Two state agencies increased their outreach activities or outstationed workers during this time period: UT, NY. New York entered into a Memorandum of Understanding with family planning providers to enable them to enroll eligible participants.
[42] One state that had previously cut continuous eligibility later restored it: AZ.
[43] One state expanded continuous eligibility for children: CA.
[44] Three state agencies were consolidating their eligibility offices or creating call centers: FL, KS, TX.
[45] States that expanded the list of drugs that required prior approval, created or expanded the classes of medications in their preferred drug list (PDL): AL, CA, GA, HI, IA, ID, IN, KS, MA, MO, ND, NE, NV, NY, OK, PA, SC, TX, WA, WV.
[46] States that began requiring generic substitution when medically appropriate: KS, MA, NJ, NY, UT, WA.
[47] Alabama implemented a four-brand limit per month.
[48] States that eliminated or restricted adult dental services: AZ, CA, FL, HI, IA, ID, IN, MA, MT, ND, OK, UT, WA.
[49] States that eliminated or limited coverage for vision services for adults: FL, KS, MA, MT, ND, TX, UT.
[50] States that cut or limited adult hearing: FL, KS, TX, UT.
[51] States that cut or limited therapy services: FL, GA, ND, UT.
[52] States that cut or limited chiropractic services: ND, NE, TX, UT.
[53] States that eliminated coverage for circumcisions: AZ, FL, NC, UT.
[54] States that cut or limited personal care services: NJ, NV, WA.
[55] States that restricted child dental services, generally orthodontia: FL, GA, NE.
[56] Nine states restored some or all of their prior cuts in covered services: FL, IA, ID, KS, MA, MT, ND, OK, UT.
[57] States that expanded coverage of behavioral health services: MN, MO, WA, WV.
[58] States that expanded coverage of home and community based services: HI, NV, WV.
[59] States that expanded case management services: FL, WA.
[60] States that made other miscellaneous expansions to covered services include: transplants (FL), independent physical and occupational therapists, and speech/language pathologists (DE), tobacco cessation (PA), bariatric surgery (WV), and access to dental clinics at academic dental clinics for managed care enrollees (NY).
[61] States that changed their Medicaid transportation system; the most common changes reported included systems to get recipients to use the least expensive form of transportation, changes in the transportation fee structure, or move to a broker or regional coordination system: FL, HI, KS, MN, ND, NV, NY, WA.
[62] States that changed their reimbursements for medications (e.g., larger deductions off the average wholesale prices or changes to the state's maximum allowable costs), which decreased payments to pharmacies or encouraged pharmacists to dispense generics: CA, DE, FL, GA, IA, ID, IN, KS, MN, MO, MA, MT, NC, ND, NJ, NV, NY, OK, TX, UT, WA.
[63] States that limited inflationary increases, froze or reduced physician/practitioner reimbursement rates: CA, FL, IA, IN, KS, MA, MN, MO, MT, NC, ND, NE, NJ, NV, NY, OK, SC, TX, UT, WA, WV.
[64] States that reported increasing some provider payments through inflationary adjustments or *real* increases in reimbursement sometime during the study period: AZ, CA, DE, FL, GA, HI, IA, ID, MA, MN, MO, MT, NC, ND, NE, NV, NY, OK, PA, SC, TX, UT, WA, WV.
[65] States that increased the copayments for a variety of covered services: AZ, MN, ND, SC.
[66] States that only increased copays to medications: IA, IN, MA, MT, NE, UT.
[67] States that imposed a copayment for the non-emergency use of the emergency room: FL, MA, ND.
[68] States that imposed premiums for the working disabled, for their expansion populations or for the second six months of transitional benefits: MA, MN, IA, UT, WA, WV.
[69] Massachusetts lowered the copayment for generic drugs, Minnesota and Montana included a monthly cap on overall copayments, and Utah reduced the premium for the working disabled.
[70] States that had or were in the process of developing or expanding disease management protocols and/or enhanced case management systems in their primary care case management program: AL, GA, IA, MT, MO, NJ, NC, PA, SC, WA.
[71] States that expanded their fully capitated Medicaid managed care programs into other parts of the state: KS, ND, NV, PA, TX, WV. This expansion included rural communities in three of the states: KS, ND, WV.
[72] States that lost Managed Care Organization (MCO) participation: OK, HI, IA. Oklahoma ended its fully capitated managed care program during the study period.