

Trends in Medicaid Cost Control in the States

By Trudi Matthews

Medicaid stands out as the program hit hardest by the economic downturn and rising health care costs. Governors, legislative leaders and Medicaid officials around the country see the program's current cost trajectory as unsustainable in both the short-term and the long-term. Yet, states have faced similar situations before. As in previous eras of runaway cost growth, state leaders are marvelously adept at developing coping mechanisms. Emerging trends in state responses to the Medicaid crisis may indicate the future direction of Medicaid policy.

As newly elected officials took office and state legislatures met in early 2003, state officials faced one of the gravest economic situations in recent memory. The faltering economy and plummeting state revenues caused many states to cut services, dip further into reserves and continue hiring freezes and layoffs.

Adding to budgetary woes was the tremendous growth in health care spending. The Centers for Medicare and Medicaid Services reported that health care costs overall grew by 8.7 percent in 2001 from the previous year, and that Medicaid spending grew 10.8 percent, caused, among other things, by an 8.5 percent rise in enrollment.¹ This growth far outpaced the economy, which grew only 2.6 percent. Worse still, the projections for 2003 and beyond paint a gloomy picture. Final figures for Medicaid cost growth in 2002 are expected to be around 13 percent.² Congressional Budget Office projections place Medicaid cost growth at around 9 percent per year for the remainder of the decade.³

In this midst of this bleak picture, Medicaid stands out as the program hit hardest by the economic downturn and rising health care costs. Governors, legislative leaders and Medicaid officials around the country see the program's current cost trajectory as unsustainable in both the short-term and the long-term.⁴ Threatened by the runaway trains of rapid health care inflation and stagnant state budgets, Medicaid unfortunately has few brakes able to slow its growth, outside of throwing people off the rolls and simply paying less for the same services. Looking ahead, the aging population — coupled with consumer insistence on unrestrained choice of providers and treatments — spells disaster for cost-containment efforts in the future.

Yet, states have faced similar situations before. As in previous eras of runaway cost growth, state leaders are marvelously adept at developing coping mechanisms, especially with regard to Medicaid. There are already emerging trends in state responses to the Medicaid crisis that may indicate the future direction of Medicaid policy.

Medicaid's Past

Medicaid is an incredibly complex program due to its mix of beneficiaries, joint funding and differing features from state to state. The program has also evolved considerably over time. Understanding its past can help explain some of the unique challenges Medicaid faces currently and into the future.

Medicaid covers many of the nation's poor and most vulnerable citizens, including women and children, the disabled and the elderly. Because Medicaid is funded and controlled by both the federal government and the states, state policy-makers face a complex political landscape that makes cost containment more difficult than it is for the private sector. Federal requirements limit the scope of state action concerning eligibility, cost-sharing and other program features. In addition, Medicaid enrollees often have more complex health care needs than the general public and therefore are more expensive to treat.

Title XIX of the Social Security Act established Medicaid in 1965. A kind of afterthought during legislative discussions of Medicare, Medicaid was designed as a means-tested program to serve certain low-income groups, or "categories," of people receiving cash assistance from the government — primarily women and children on welfare. Medicaid also provided supplemental coverage for low-income disabled and elderly individuals receiving Social Security assistance.⁵ When Medicare was enacted, it was designed to provide only hospital and physician services coverage for seniors. In a curious accident of history, long-term care, prescription drugs and a host of other services for the low-income elderly were placed within Medicaid, not Medicare. The decision to bifurcate coverage for the low-income elderly and disabled between the two programs seems odd to observers today. However, at the time, few health insurance plans provided comprehensive coverage for items such as prescription drugs. But this decision has greatly affected the prospects for uncontrolled cost growth within Medicaid.

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Medicaid was designed as a program jointly funded and controlled by both the federal government and the states. Each state administers its Medicaid program within federal guidelines and receives federal matching funds of 50 to 80 percent of the program's cost. The federal government mandates that states cover certain categories of individuals and certain services. Mandated services include inpatient and outpatient hospital, physician care, lab and x-ray and long-term care services, among others. States can also opt to cover additional populations and services and receive federal matching funds for these benefits. Among the optional benefits states frequently cover are prescription drugs, hearing aids, dental care and vision care.⁶

These features mean that Medicaid is very different from other health insurance programs, and these differences have important implications for cost containment. First, Medicaid is not just one program; it is actually 56 different programs, each one very different depending on the state or territory administering it. Each state must cover certain categories of individuals who fall within certain income guidelines, but the vast majority of states have taken advantage of federal matching funds to extend coverage beyond the minimum guidelines. Almost half of Medicaid spending is on coverage for services or populations that are optional under federal law.⁷

Second, states spend most of their Medicaid money on providing health care to the elderly, blind and disabled populations, rather than on women and children. While families and children make up more than 70 percent of Medicaid's enrollees, they account for less than 30 percent of spending. The elderly and disabled populations, meanwhile, make up a little more than 25 percent of enrollees but account for more than 70 percent of Medicaid's program costs.⁸ This is true despite the fact that many of the low-income elderly and disabled are "dually eligible," receiving coverage through both Medicare and Medicaid. This small dual eligible population alone is responsible for 35 percent of Medicaid spending.⁹ Trends in elderly and disabled enrollment combined with Medicaid's role in providing coverage to these populations mean that Medicaid cost growth will continue to outstrip overall economic growth rates significantly, even if the economy rebounds.¹⁰

Finally, joint control of the Medicaid program means it has neither the uniformity one might expect from a federally sponsored program nor the complete flexibility state leaders would like in order to fit each state's needs. States must follow broad federal guidelines, but there is substantial program variation across

states. States are required to submit state plans to the U.S. Department of Health and Human Services for approval. If they wish to deviate from federal rules governing the program, they must file a waiver and receive federal approval, a process that traditionally has been both politically and administratively complex and time-consuming.

Medicaid now represents more than 20 percent of state spending, second only to education in state budgets.¹¹ To harried state leaders responsible for balancing the budget, Medicaid's joint control and financing can seem like a Faustian bargain. States must surrender substantial control over how they spend a large portion of their budgets in return for sizeable funds from the federal government. Joint funding also makes cutting Medicaid's budget more difficult. If state leaders cut one dollar from their Medicaid budget, they stand to lose anywhere from \$1 to \$3.31 of federal matching funds.¹²

From Welfare to Waivers

Although historically the neglected stepsister compared to Medicare, Medicaid is now the largest health insurer in the nation, surpassing Medicare in both enrollment and spending. This shift in status occurred in the 1990s due to the proliferation of waivers, welfare reform and the creation of the Children's Health Insurance Program.

Beginning in the 1980s and accelerating greatly in the 1990s, states sought waivers from federal requirements in order to experiment with different benefits and program designs. States used waivers to implement a number of changes, including Medicaid managed care, increased use of home and community-based services for the elderly and disabled, and coverage expansions for optional income groups and populations. Managed care offered the promise of cost control while also improving the quality of care by providing regular preventative care for every client, better coordination of care, and resulting in fewer emergency room visits and unnecessary hospitalizations. Managed care also promised to end the reputation of second-class care that plagued Medicaid by folding clients in with managed-care plans' privately insured members. Concentrating mostly on women and children and enrollees in urban areas, states established a wide range of managed-care arrangements. By the end of the 1990s, Medicaid managed-care programs had expanded to cover more than 56 percent of Medicaid enrollees.¹³ Despite widespread use of managed care for populations of women and children enrolled, Medicaid for the elderly and disabled remained largely a fee-for-service program. States sought to control long-term care costs through waiv-

ers aimed at beefing up home and community-based care options for the elderly and disabled.

Another sea change in Medicaid occurred in 1996 with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act, otherwise known as welfare reform. Prior to welfare reform's passage, all families receiving welfare payments were automatically enrolled in Medicaid. The new law, with its emphasis on moving individuals from welfare to work, "delinked" Medicaid and Temporary Assistance for Needy Families enrollment. The goal of the new system was to transform Medicaid and its institutional culture from a welfare program to a truer form of health insurance for the working poor.

A year after welfare reform, Congress passed another federal law that heralded a new era of state experimentation with health care. The State Children's Health Insurance Program passed in 1997, giving states the option to expand their Medicaid programs or establish new programs to provide coverage for uninsured children. Like Medicaid, states and the federal government jointly funded this new program. The new law's structure gave states timelines and financial incentives for establishing their programs and enrolling eligible children quickly. Fueled by record budget surpluses, states stepped up to the plate and reconfigured their medical assistance programs for families and children. A new esprit de corps emerged as state officials used enhanced federal funding to design new and innovative programs focused on reaching uninsured kids through advertising, outreach and enrollment assistance. The success of state efforts was evident in the drop in the number of uninsured by the end of decade, attributable largely to state coverage expansions.¹⁴

While analysts may argue about the degree to which Medicaid has been transformed from a welfare program to a health insurance program in the intervening years, reforms throughout the 1990s undoubtedly affected Medicaid enrollment and spending. From 1996 to 1998, enrollment dropped dramatically due to welfare reform changes, before going up again with the implementation of the SCHIP program. Furthermore, implementation of managed care and lower enrollments meant that Medicaid cost growth was just 3.6 percent per year from 1995 to 1998 — an extra boon to state budgets during already prosperous economic times.¹⁵

Medicaid's Present

After many years of very low cost growth, the trend in health care costs shifted, and states began to experience higher than expected costs in Medicaid. Costs

actually began increasing again in 1999, but few observers recognized it as a potential problem due to strong economic growth at the time.¹⁶

It is helpful to remember that today's cost growth is not out of line with historic trends in Medicaid or health care overall.¹⁷ The tremendous decline in state revenues due to the recession is mostly to blame for the severity of the current crisis.¹⁸ Added to this is a perception problem. Uncharacteristically low health care inflation during the late 1990s, combined with bulging state coffers, fostered optimism about Medicaid. These unusual circumstances made the sudden shift in the fortunes of health care and state budgets in 2001 that much more difficult for state officials to grasp and effectively counter.

Medicaid is affected by the larger world of health care spending growth, but also has unique features that cause it to differ from overall health care expenditures. Like the private sector, one of the most significant sources of Medicaid cost growth is the retreat from managed care as a cost-containment tool.¹⁹ Providers across the board are pushing back on rates that managed-care plans pay. Hospital spending now accounts for around 50 percent of health care cost increases.²⁰ Medical inflation and per capita use of services have increased significantly since 1998, signaling the end of managed care's containment of both prices and use of health care services.²¹

In addition, prescription drug costs are another significant contributor to Medicaid cost growth. Prescription drug costs have been the fastest-growing portion of the health care dollar, growing at double-digit rates since 1995.²² An aging populace, the prevalence of chronic diseases that require drug treatment, the boom in new drugs entering the marketplace, and the move toward outpatient drug treatment over expensive and invasive surgical treatments have fueled this growth. Because it covers drug costs for the poor elderly and disabled, who are intensive users of prescription drugs, Medicaid has been especially hard hit by prescription drug cost growth.

Two sources of spending growth distinctive to Medicaid are growing enrollment and long-term care costs. With the economic downturn and growing unemployment, Medicaid enrollments increased by 8.6 percent in FY 2002 and are expected to grow by 7.7 percent in FY 2003.²³ Growing enrollment means states are serving larger numbers of people at higher prices, with less money in the bank.

Long-term care costs grew by a seemingly modest 5.2 percent in 2001.²⁴ However, because Medicaid covers nearly half the cost for nursing home care and a significant portion of home health care spending,

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long-term care costs are among the leading drivers of Medicaid spending.²⁵ Despite Medicaid's shift to managed care and home and community-based services in the 1990s, a large portion of Medicaid spending for the elderly and disabled — in particular long-term care services — has remained fundamentally unchanged over the years.

State Cost-Containment Strategies

In response to these pressures, most states have tried to cut back spending without changing eligibility. Going into the second half of FY 2003, however, the financial situation has caused states to look at steeper cuts to services and eligibility. A survey by the Kaiser Commission on Medicaid and the Uninsured found that states are using a number of strategies to contain Medicaid costs.

One of the most prevalent cost-containment strategies has been prescription drug controls. Forty-five states are taking steps to reduce prescription drug costs in one or more of the following ways: using prior authorization more intensively (12 states), using or expanding preferred drug lists (nine states), reducing payments (eight states), using supplemental rebates on drugs (five states), encouraging or mandating use of generics, (two states), setting limits on the number of prescriptions (five states), or increasing cost-sharing requirements (seven states).²⁶

According to the Kaiser Commission survey, in addition to drug controls, states have also frozen or reduced payments to providers (37 states), reduced or eliminated certain benefits such as dental care (25 states), reduced eligibility (27 states), and increased co-payments for enrollees (17 states). Another strategy is to control enrollment growth by eliminating outreach efforts, getting rid of continuous eligibility, and reinstating asset tests and other policies that were eliminated in order to sign up uninsured kids. States have also used other approaches, including disease management (11 states), increased fraud and abuse detection (six states), as well as increasing federal funds to Medicaid through the Upper Payment Limit or "Medicaid loophole" and Disproportionate Share Hospital strategies (31 states).²⁷

Medicaid's Future

Given the states' grave fiscal situation, further reductions of payments to providers as well as cuts in benefits and eligibility are inevitable. Some people fear that state budget problems will completely undo recent gains in coverage and increase the number of uninsured. These realities are causing policy-makers at both the state and federal levels to take a new

look at Medicaid and consider the program's future direction. At a recent CSG meeting on Medicaid, state leaders across the political spectrum said that states had all but exhausted their options to deal with the current crisis, both due to budgetary demands and federal oversight. The overwhelming consensus was that the federal government needs to change Medicaid.

Although officials from different parties see Medicaid's problems in different ways, generally, state leaders have asked the federal government to give states either greater funding, more flexibility or both. Some state leaders have called on Congress and the administration to increase the Federal Medical Assistance Percentage as a way to counter the effects of the recession. Many state leaders also support a Medicare prescription drug benefit, for the relief it would provide to seniors as well as to beleaguered state budgets. Other proposals have called on the federal government to assume control of financing care for the dual eligible population.

In the midst of these discussions, U.S. Department of Health and Human Services Secretary Tommy Thompson announced the administration's new proposal for the Medicaid program in January 2003. Building on the experience of the Health Insurance Flexibility and Accountability waivers, Secretary Thompson proposed an optional plan for states that would give them flexibility to redesign eligibility guidelines and benefits for optional groups without filing a waiver. If states participate in the plan, they would receive additional funds over the next three years with funding tapering off in the remaining seven years of the plan. States would still be required to continue services for mandatory populations in the same way as before.

Secretary Thompson provided broad outlines for the new plan and invited the nation's governors to provide input into the details. The administration must have congressional approval before the plan can be implemented. There are significant reservations about the nature of the administration's plan, especially its funding. Critics of the proposal say that it is a block grant and, if implemented, could place state budgets at risk if Congress cuts funds for Medicaid. Supporters of the plan say it will give states the flexibility they need both to save money and to continue coverage for low-income individuals and families in the most efficient manner.

Innovative State Strategies

As changes are debated at the federal level, state leaders are responding to the crisis, and their re-

sponses provide some indication of the future direction of Medicaid policy in the states. On the prescription drug front, several states, including Florida, Michigan and Oregon, are using preferred drug lists as a way to obtain additional rebates from drug makers and to assure that providers are prescribing the most cost-effective medications. State leaders are also exploring purchasing alliances between states. This option remains untested, but took a step forward recently when Gov. Jennifer Granholm of Michigan and Gov. Jim Douglas of Vermont announced they would participate in a joint-purchasing arrangement. Several other states have announced they would join this group. Five states have also used the new Pharmacy Plus waiver to provide prescription drug assistance to the elderly through Medicaid.²⁸

Another promising avenue is initiatives that interface with employer-sponsored insurance and that leverage funds from multiple sources to enhance coverage for low-income working families. Rhode Island passed legislation that requires commercial insurers to identify members who may also be enrolled in Medicaid. A number of states, including Rhode Island, Illinois, Massachusetts and Tennessee, are using waivers to provide financial assistance to individuals offered employer-sponsored insurance. States help pay the premiums and other cost-sharing requirements for employer-sponsored insurance at a much lower cost to the state than if individuals were enrolled in Medicaid. New Mexico's recent HIFA waiver goes a step further by creating a state-designed health insurance package that insurance agents will offer along with private insurance. It is financed through federal, state and employer funds for income-eligible individuals.²⁹ Another public/private model is community-based partnerships, like the Muskegon Community Health Project in Michigan, which uses funds from employers, individuals and Disproportionate Share Hospital payments to provide coverage for the uninsured.

States have also taken advantage of the increased flexibility available from the administration to redesign benefits and expand coverage to new populations without spending additional funds. Arizona, Maine, Oregon, Washington, Tennessee and Utah are among the states using this approach.³⁰ Arizona used its HIFA waiver to combine Medicaid and SCHIP funding to provide coverage to more adults. Utah funded a coverage expansion for primary care services to adults under 150 percent of the poverty level by limiting benefits for certain Medicaid eligibles, folding in a state-funded program, and implementing cost-sharing requirements. These new waivers have rein-

vigorated the debate over the tradeoff between deep and narrow coverage (e.g., traditional Medicaid benefits) versus shallow but broader coverage (e.g., SCHIP and employer-sponsored coverage). Medicaid benefits are now more extensive and more costly than most employer-sponsored insurance. Some state leaders believe states should extend coverage to more people by providing less extensive benefits, but this is a contentious issue with advocates for the poor.

Mirroring trends in the private sector, more states are also experimenting with disease management and chronic illness initiatives. Eleven states operated some form of disease management program in 2002, but the number is expected to rise to 21 in FY 2003.³¹ Care for chronic illness accounts for roughly 75 percent of health care spending, because chronically ill individuals are heavier users of health care services. Disease management targets services to those with chronic illnesses, such as diabetes, heart disease and other conditions. Florida, Virginia, Mississippi and other states have experienced some savings through disease management by ensuring that treatment adheres to accepted guidelines and that patients do not experience expensive, preventable complications.

In addition to disease management, states are experimenting with other approaches derived from the private sector. A few states have looked at the use of health care savings accounts within Medicaid, including Florida, Iowa and Vermont. Under these arrangements, states place a set amount of funds into an enrollee's "account" to purchase health care services. Then, beyond a certain amount, individuals are responsible for a portion of the costs. The idea is to help patients be more cost-conscious in their use of health care services.

Other states are borrowing cost-sharing approaches from the private sector and adapting them to Medicaid and SCHIP to control cost growth. As Medicaid and SCHIP have expanded to include individuals above 150 percent of the federal poverty level, some analysts argue that cost-sharing mechanisms, such as monthly premiums and per-visit co-payments, can promote appropriate use of services. Co-payments are generally used to encourage patients to use generics over brand-name drugs and to discourage use of the emergency room. Traditionally, cost sharing within Medicaid has been very limited in order to protect low-income individuals from financial risk.

Other consumer-directed approaches address controlling long-term care costs. Several states, including Arkansas, Florida and New Jersey, have operated "Cash and Counseling" demonstration projects. These programs provide a set amount of funds as

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well as guidance to elderly and disabled enrollees, who purchase and oversee the services they need to stay in their homes.

Finally, states are expanding the use of managed care and other means to coordinate care for special high-use populations. Rhode Island has focused on moving children eligible for Supplemental Security Income and children in foster care into managed care and has achieved significant savings.³¹ Other states are looking at administrative reorganization as a way to streamline services, not just in Medicaid, but across the board in social services.

Conclusion

As states look toward FY 2004, the outlook for economic growth remains bleak. Combined with continued cost growth in health care, this means that Medicaid is in for another bumpy ride. It remains to be seen what will come of the administration's proposal to restructure the Medicaid program and, if it is successful, how many states will opt into the new State Allotment Program.

The trend on the state side is a little more clear. Under pressure to balance budgets, states will have to continue to scale back benefits and eligibility to control growth. Yet, even while state leaders are cutting back, they are desperately looking for ways to leverage funds from a variety of sources to maintain coverage. The pressure to find innovative solutions to runaway cost growth is reshaping the face of Medicaid at the state level, pushing states to rethink benefit design and coordination with other payers and providers. These changes will certainly stay with Medicaid well beyond this economic downturn and provide a picture of what the program may look like many years from now.

Notes

¹ Katharine Levit, *et al.*, "Trends in U.S. Health Care Spending, 2001," *Health Affairs* 22, no. 1 (January/February 2003): 154-164.

² Vernon Smith, Kathy Gifford, *et al.*, *Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, January 2003).

³ Congressional Budget Office, "March 2002 Baseline: Medicaid and State Children's Health Insurance Program Fact Sheet" (Washington, D.C.: Congressional Budget Office, March 2002).

⁴ Author's conversations with state officials; see also Alan Weil's essay, "There's Something About Medicaid," *Health Affairs* 22, no. 1 (January/February 2003): 14; and State Coverage Initiatives, *State of the States: Bridging the Health Coverage Gap* (Washington, D.C.: AcademyHealth,

January 2003), available at <http://www.statecoverage.net/pdf/stateofstates2003.pdf>.

⁵ The Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Program at a Glance" (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, January 2001), available at <http://www.kff.org>.

⁶ The Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Program at a Glance".

⁷ The Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, August 1999).

⁸ The Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer*.

⁹ The Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for Low-Income Medicare Beneficiaries* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, January 2002).

¹⁰ Weil, "There's Something About Medicaid."

¹¹ National Association of State Budget Officers, "NASBO Analysis: Medicaid to Stress State Budgets Severely into Fiscal 2003" (Washington, D.C.: National Association of State Budget Officers, March 15, 2002), available at <http://www.nasbo.org/Publications/PDFs/medicaid2003.pdf>.

¹² The Kaiser Commission on Medicaid and the Uninsured, *The Role of Medicaid in State Budgets* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, October 2001).

¹³ Centers for Medicare and Medicaid Services, "National Summary of Medicaid Managed Care Programs and Enrollment, June 30, 2001" (Washington, D.C.: Center for Medicare and Medicaid Services, June 2001), available at <http://cms.hhs.gov/medicaid/managedcare/trends01.pdf>.

¹⁴ John Holahan, *Why Did the Number of Uninsured Fall in 1999?* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, January 2001).

¹⁵ John Holahan and Brian Bruen, *Acceleration of Medicaid Spending Reflects Mounting Pressures*, (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, May 2002).

¹⁶ Holahan and Bruen.

¹⁷ As a recent article by Drew Altman and Larry Levitt in the journal *Health Affairs* lamented, the health care system in the United States has a dismal record of controlling health care spending. During the mid- to late 1990s, the rapid expansion of managed care and the competitive insurance market helped to keep costs at their lowest levels of growth in decades. However, cost inflation has returned and the relatively simple economies that managed care used to keep costs down — building networks of providers willing to accept discounted rates and keeping people out of the hospital — are already in use. For more on this issue, see the January 23, 2002 Web exclusive available at http://www.healthaffairs.org/WebExclusives/Altman_Web_Excl_012302.htm.

¹⁸ Weil.

¹⁹ Holahan.

²⁰ Bradley Strunk, Paul Ginsburg and Jon R. Gabel, "Tracking Health Care Costs: Hospital Spending Spurs Double-Digit Increase in 2001," Data Bulletin No. 22, (Washington, D.C.: Center for Studying Health Systems Change, September 2002), available at <http://www>.

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²¹ Levit, *et al.*

²² Strunk, *et al.*

²³ Smith, Gifford, *et al.*

²⁴ Levit, *et al.*; Vernon Smith, Eileen Ellis, *et al.*, *Medicaid Spending Growth: Results from a 2002 Survey* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, September 2002).

²⁵ Smith, Ellis, *et al.*

²⁶ Smith, Ellis, *et al.*

²⁷ State Coverage Initiatives.

²⁸ State Coverage Initiatives.

²⁹ See the Centers for Medicare and Medicaid Services Web site for a complete list of current HIFA waivers at <http://www.cms.gov/medicaid/waivers/>.

³⁰ Smith, Ellis, *et al.*

³¹ State Coverage Initiatives.

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