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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

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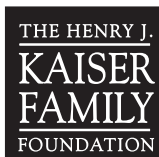
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As Tough Times Wane, States Act to Improve
Medicaid Coverage and Quality:

Results from a 50-State Medicaid Budget Survey for
State Fiscal Years 2007 and 2008

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October 2007



Acknowledgements

We thank the Medicaid directors and their staff in all 50 states and the District of Columbia, who took the time to complete the survey on which this study is based. Officials in every state provided information about their programs and their plans for the future, participated in structured interviews and responded to our follow-up questions. Without their help the study could not be done and we truly appreciate their assistance.

We offer special thanks to our colleagues at Health Management Associates. Dennis Roberts developed and managed the data base work, as usual, was excellent and invaluable. Danielle Chesher and Donna Mass assisted with data entry, and we thank them for their excellent work.

Finally, we thank the Kaiser Commission on Medicaid and the Uninsured and the Kaiser Family Foundation. We especially appreciate the personal interest and support of the Executive Director of the Commission, Diane Rowland, and Deputy Director Barbara Lyons.

Executive Summary

As states finalized Medicaid policy decisions fiscal year 2008, an improved fiscal environment coupled with modest Medicaid spending and enrollment growth allowed states to focus on program restorations, improvements and expansions for long-term care that have not been possible for the last several years. States are placing a priority on measuring and improving quality of Medicaid-financed health care, often through enhancements in managed care or disease management. More broadly, almost all states report that they are moving forward with initiatives to address the increasing number of uninsured and Medicaid is a key building block and critical component of financing for these strategies. Despite a more positive fiscal environment, states reported on-going pressures to control Medicaid spending growth.

The Medicaid program, which provides health care and long-term care support services to 58 million individuals, has been faced with some enormous challenges over the last few years. A severe economic downturn beginning in 2001 put Medicaid at the center of budget debates at the state and federal levels of government. Medicaid spending and enrollment growth peaked at the same time state revenues plummeted in 2002 forcing states to implement an array of measures to control Medicaid spending growth. As this period of fiscal stress abated, two major pieces of federal legislation with significant implications for Medicaid were implemented. The Medicare Modernization Act (MMA) was implemented in January 2006, causing over 6 million low-income seniors and individuals with disabilities who previously received their drug coverage through Medicaid to transition to Medicare Part D plans. The Deficit Reduction Act (DRA) enacted in February 2006 presented states with new Medicaid requirements as well as some new options.

For the seventh consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy initiatives. This report presents findings for state fiscal years 2007 and 2008.

Medicaid spending continued to grow slowly in state fiscal year (FY) 2007 after reaching an all-time low in 2006, and state revenues remained strong in most states. Total Medicaid spending growth hit a record low of just 1.3 percent for FY 2006 and states reported that total Medicaid spending growth continued at a higher but relatively slow pace of 2.9 percent in FY 2007. Lower Medicaid spending growth occurred at the same time revenue growth in most states was strong in 2006 and remained strong, though somewhat lower into 2007. This picture is dramatically different from the depth of the economic downturn in 2002 when Medicaid spending growth hit a high of 12.7 percent at the same time state revenues plummeted hitting a low of -10.6 percent. Moving into FY 2008, state legislatures authorized total Medicaid spending growth that averaged 6.3 percent as state revenue growth was projected to be still relatively strong but somewhat less robust than it was in 2007.

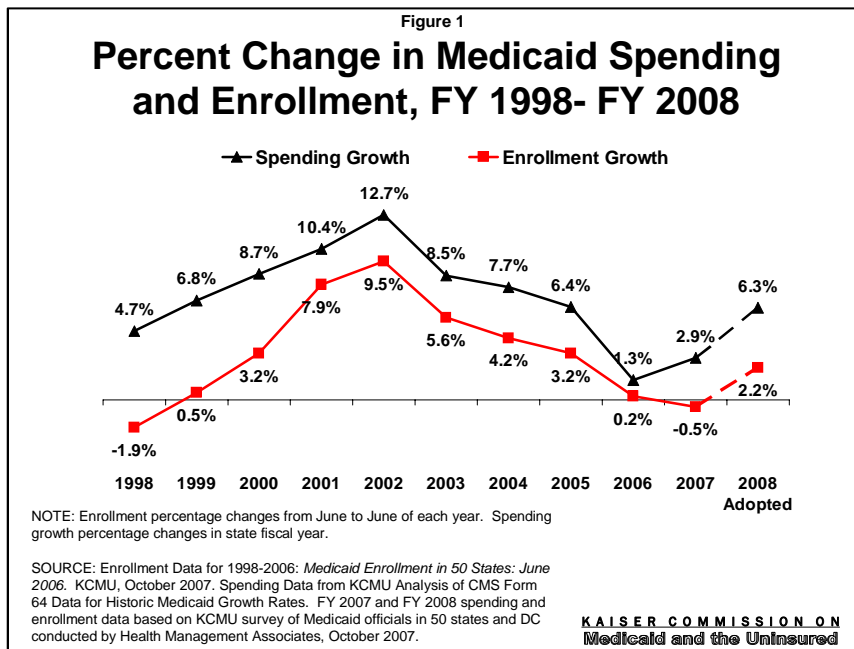
For state policy makers, the state general fund share of Medicaid is a key factor. For the last few years, the state share of Medicaid spending has increased more rapidly than total Medicaid spending as the federal matching rate (the Federal Medical Assistance Percentage, or FMAP) had declined for over half of states. The FMAP is recalculated annually based on average personal

income for each state. Declines in the FMAP placed pressure on states to allocate additional state general revenues to maintain current programs. State general fund spending for Medicaid increased on average by 3.0 percent in 2006 by 3.2 percent in 2007. State legislatures appropriated an increase in state general funding for Medicaid that averaged 7.8 percent for 2008. For each of these years, the growth in state funding was greater than for total Medicaid spending.

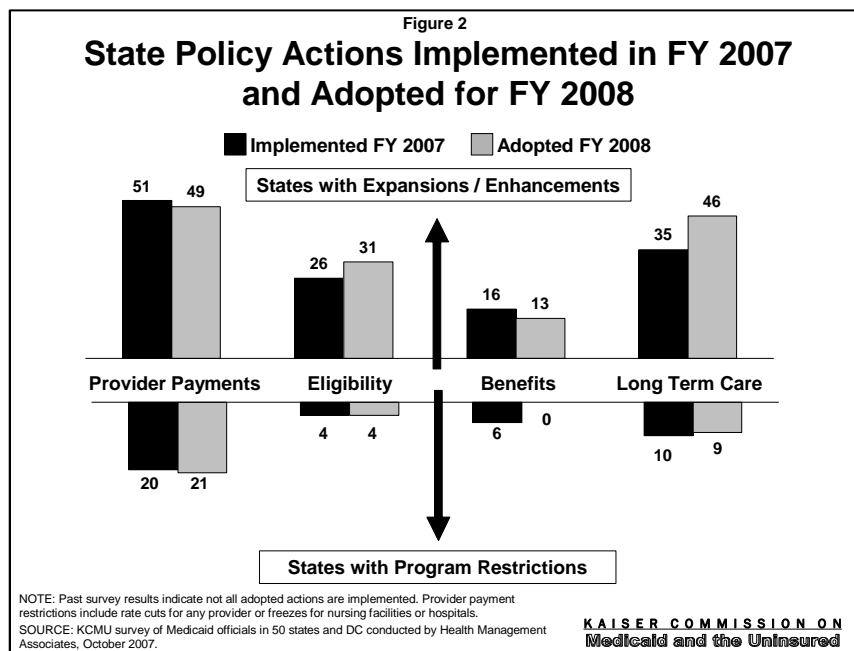
Slow enrollment growth and the transition of prescription drug costs for duals from Medicaid to Medicare Part D were the two primary factors contributing to lower Medicaid spending growth.

States attributed the slowdown in Medicaid spending growth to two primary factors: low enrollment growth and the impact of Medicare Part D. First, Medicaid enrollment growth was low in 2006, and in 2007, enrollment actually decreased. The decline in enrollment was relatively small, about one-half of one percent, but it was the first decline since 1998. Many states cited the implementation of the new citizenship and identity requirements as a factor contributing to this decline. Medicaid enrollment growth is also tied to the economy. During an economic downturn more people are likely to be unemployed, move into poverty, lose employer sponsored health coverage and subsequently become eligible for the program and the reverse is true when the economy is strong. At the depth of the economic downturn in 2002, Medicaid enrollment grew by 9.5 percent. From that point through 2007, growth each year has been less than the previous year. States projected Medicaid enrollment to increase about 2.2 percent in 2008 as states implement recently adopted program expansions.

Second, the implementation of Medicare Part D shifted responsibility for prescription drugs for individuals on Medicaid also enrolled in Medicare (the “duals”) from Medicaid to Medicare in January 2006. States are still obligated to pay a maintenance-of-effort payment each month (known as the Clawback) based on the number of duals and the cost of their drugs, but these payments are now counted as a source of financing for Medicare and not as Medicaid spending (even though most states appropriate these payments as part of their Medicaid budgets). The cumulative effect of state cost containment efforts also contributed to lower Medicaid spending growth (Figure 1).



More states than in any of the last seven years removed restrictions or adopted policies to improve or expand their Medicaid programs in FY 2007 and FY 2008. Most notably, every state implemented some type of provider rate increase in 2007 and 49 states planned to increase rates for at least one provider group in 2008. During the economic downturn, cutting or freezing provider rates was a primary mechanism states used to control Medicaid spending growth. States indicated that improving Medicaid provider payment rates is necessary to maintain access to services and important for state strategies that use Medicaid to expand coverage to more of the uninsured. More than half of all states in 2007 and in 2008 made positive eligibility changes such as increasing the income limit for eligibility, expanding eligibility for a new group such as foster children or persons with disabilities who were working, or by streamlining and simplifying the application or renewal processes. A few states restored or added new benefits. Compared to previous years, fewer states restricted provider payments, limited eligibility or cut benefits. For the first time since at least 2003, no state planned a cut in benefits for 2008 (Figure 2). States have largely kept in place and strengthened strategies to control costs, particularly strategies to control prescription drug spending that had been implemented in earlier years.



Nearly three out of four states said that the new citizenship and identity documentation requirements have contributed to slowing enrollment growth and 45 states say the requirements have increased administrative costs. As part of the DRA, states were required to obtain documentation to prove citizenship and identity for individuals applying for renewing Medicaid coverage starting July 1, 2006. This was not a change in eligibility requirements for the program, but it did represent a major change in state enrollment practices. Prior to the DRA, 47 states allowed applicants to self-declare their citizenship status. Thirty-seven states specifically identified the new citizenship and identity documentation requirements as contributing to slower enrollment growth or actual drops in the number enrolled; 36 states said that this was one of the most significant factors impacting Medicaid enrollment. On the administrative front, states have had to train eligibility workers, make changes to their enrollment processes, set up systems to do data matching of vital records, or roll back some eligibility simplifications that had been in place (such as reinstating the face-to-face interview). States reported that the new requirements had caused

delays in processing new applications and renewals, and that in most cases these delays were for individuals otherwise eligible for the program.

Few states have taken advantage of new options to change benefits or impose new cost sharing requirements that were granted as part of the DRA. To date, eight states have used or reported plans to use the new DRA options related to home care. Kentucky, West Virginia and Idaho moved quickly to take advantage of the new flexibility to do a comprehensive review of their Medicaid benefits. Five other states are using this new flexibility in a much more targeted way. In FY 2007, Virginia converted its existing disease management program from a voluntary “opt-in” program to a voluntary “opt-out” DRA benchmark program and Washington implemented a chronic care management pilot program under DRA authority. In FY 2008, Kansas is adding personal assistance services for participants in the state’s Ticket-to-Work Medicaid buy-in program. Also in FY 2008, South Carolina will implement a voluntary one-county pilot “Health Savings Account” plan using the State Employee Health plan as the benchmark plan and Wisconsin is planning to offer a modified benefit package adapted from Wisconsin’s largest commercial, low-cost health care plan to the BadgerCare Expansion population. Kentucky was the only state to use DRA authority to impose higher than nominal cost sharing amounts and to make co-payments enforceable (meaning that providers or pharmacies could deny services for individuals who could not pay their co-payment at the point of service).

States continue to expand home and community-based care services (HCBS) to balance their long-term care delivery systems and some states are using new long-term care (LTC) options provided under the DRA. States continue to expand home and community-based long-term care services. In FY 2007, 35 states expanded LTC services while in FY 2008 a total of 46 states planned to do so. The most commonly reported LTC expansion in both years was expanding existing HCBS waivers or adopting new ones. States also continued to add Programs for All-Inclusive Care for the Elderly (PACE). The DRA presented states with a number of options intended to give states increased flexibility to deliver long-term care services and supports. Thirty-one states are using the DRA “Money Follows the Person” initiative which encourages states to reduce reliance on institutional care by transitioning individuals from institutions to the community to support HCBS efforts. Nearly half (24) states had plans to implement a Long Term Care Partnership Program in 2008 to help increase the use of private long-term care insurance. Thus far, there has been limited take-up of new DRA state options around cash and counseling or the HCBS state plan options, although states continue to pursue these strategies using waivers. As states expand community-based services, nearly 2007 and eight states in 2008 implemented cost controls for institutional providers including policies designed to reduce the number of institutional beds.

States are increasingly focusing on Medicaid quality improvement and initiatives to get better value from public Medicaid expenditures. Many states have made quality improvement a priority. The development of HEDIS® and CAHPS® by the National Committee on Quality Assurance (NCQA) provided nationally accepted quality measures. In 2008, 44 states will be using HEDIS® and/or CAHPS® performance data from managed care organizations to measure and provide incentives for improved performance. An increasing number of states are also requiring their health plans to be accredited by a national organization such as NCQA or implementing Medicaid pay-for-performance (P4P) reimbursement policies to reward and encourage quality care. By 2008,

a total of 27 states will have pay-for-performance programs for managed care. A few states have reimbursement systems that reward performance for hospitals, physicians and nursing homes.

States are committed to program integrity, but many report that they are frustrated and concerned about the administrative burdens imposed by federal oversight activities. Program integrity remains a high priority for state Medicaid officials. In 2007 and 2008, states implemented an array of strategies such as increasing state oversight, creating new organizational units to provide centralized control and coordination, or hiring new contractors aimed at enhancing program integrity. Concerns at the federal level about Medicaid spending, payment policies and program integrity have prompted more intense federal oversight of state Medicaid programs. State officials recognized and agreed with the role of the federal agencies in ensuring fiscal and programmatic integrity in Medicaid. However, they also expressed strong concerns about the administrative burden imposed on states by the new level of federal audits, reviews and other federal efforts to examine the program. State officials also mentioned frustration at new federal interpretations of long-standing, previously approved Medicaid policies which in some cases have had the effect of shifting federal Medicaid costs to the states.

To address a growing number of uninsured individuals, 42 states are moving forward with or developing plans to expand health insurance coverage and almost all rely extensively on Medicaid to support and finance these plans. Despite a year dominated by program enhancements, Medicaid directors said that rising program costs remains a top concern; however, the singular urgency of this issue has significantly abated as state revenues rebounded in recent years. The latest census figures show that in 2006 there were 47 million uninsured Americans, an increase of 2.2 million from 2005. Forty-two states reported that they have efforts underway to expand coverage to the increasing number of uninsured. Almost all of these states are looking to Medicaid as a vehicle to help finance new coverage efforts. Many strategies include Medicaid or SCHIP expansions and promotion of private health insurance coverage. The outlook for state revenue growth as well as the outcome of the reauthorization of SCHIP and federal support for these expansions will determine how far states can go in expanding coverage. As state efforts continue, Medicaid is likely to stay at the forefront of the policy debate as the larger discussions around health care reform on issues of coverage, costs, quality and long-term care continue to play out at both the state and national level into the 2008 election cycle.

Methodology

For the seventh consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy initiatives. The survey also asked Medicaid officials about the impact of Medicare Part D and the ACA on their programs. The KCMU/HMA survey on which this report is based was conducted in July and August 2007 to document the policy actions states had implemented in the previous year, state FY 2007, and new policy initiatives that they had adopted, or expected to implement, in state FY 2008, which for most states had begun on July 1, 2007. The data in this report were based on survey responses and interviews with Medicaid directors and staff for all 50 states and the District of Columbia. Where possible, the results from previous surveys are referenced to provide trends, context and perspective for the results of this survey.

For FY 2007 and 2008, average rates of growth for Medicaid spending and enrollment were calculated as weighted averages across all states using Medicaid expenditures from the National Association of State Budget Officers (NASBO), State Expenditure Report, October 2006, and state enrollment data reported by state officials to HMA for the Kaiser Commission on Medicaid and the Uninsured for the month of June 2006.

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