kaiser commission on medicaid and the uninsured

Low Medicaid Spending Growth Amid Rebounding State Revenues

Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007

Executive Summary

Prepared by
Vernon Smith, Ph.D., Kathleen Gifford, Eileen Ellis and Amy Wiles
Health Management Associates

Robin Rudowitz, Molly O'Malley and Caryn Marks
Kaiser Commission on Medicaid and the Uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

October 2006

kaiser commission medicaid and the uninsured

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 bi-partisan group of national leaders and experts in health care and public policy.

kaiser commission on medicaid and the uninsured

Low Medicaid Spending Growth Amid Rebounding State Revenues

Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007

Executive Summary

Prepared by
Vernon Smith, Ph.D., Kathleen Gifford, Eileen Ellis and Amy Wiles
Health Management Associates

Robin Rudowitz, Molly O'Malley and Caryn Marks
Kaiser Commission on Medicaid and the Uninsured

October 2006

THE HENRY J. KAISER FAMILY FOUNDATION

Acknowledgements

The authors 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. They provided information about their programs and their plans for the future, 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. His work, as usual, was excellent and invaluable. Danielle Chesher assisted with data entry, and we thank her for her 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

FY 2006 represented an important turning point for Medicaid as spending growth slowed and state revenues continued to recover. Medicaid, administered and financed jointly by states and the federal government, provides health coverage and long-term care assistance to over 41 million people in low-income families and nearly 14 million elderly people and persons with disabilities.[1] Following a period of severe fiscal stress from 2001 through 2004, where state revenues plummeted and Medicaid spending and enrollment growth peaked, revenue growth started to rebound in FY 2005. In FY 2006 state revenue growth exceeded Medicaid cost growth for the first time since the late 1990's.

An improved fiscal picture eased the imperative to implement major cost containment measures and allowed for some program investments. However, states continue to approach Medicaid policy changes from very different fiscal and policy perspectives. For example, some states like Michigan are experiencing actual drops in state revenue, while states like Idaho are experiencing strong revenue growth. Some states like Tennessee and Missouri enacted major eligibility restrictions, whereas Massachusetts and Illinois are moving forward with major health care expansions building on a strong base of Medicaid coverage.

In addition to changes in state fiscal situations, two major pieces of federal legislation had significant implications for Medicaid. First, the passage of the Medicare Modernization Act resulted in the transition of over 6 million low-income seniors and individuals with disabilities (duals) from Medicaid drug coverage to newly created Medicare Part D plans on January 1, 2006. Second, the President signed the Deficit Reduction Act (DRA) of 2005 in February of 2006. This legislation included a number of new requirements for state Medicaid programs (related to new documentation requirements for citizens applying for Medicaid and new asset transfer rules) as well as new flexibility for states to offer alternative Medicaid benefit packages and to impose cost sharing.

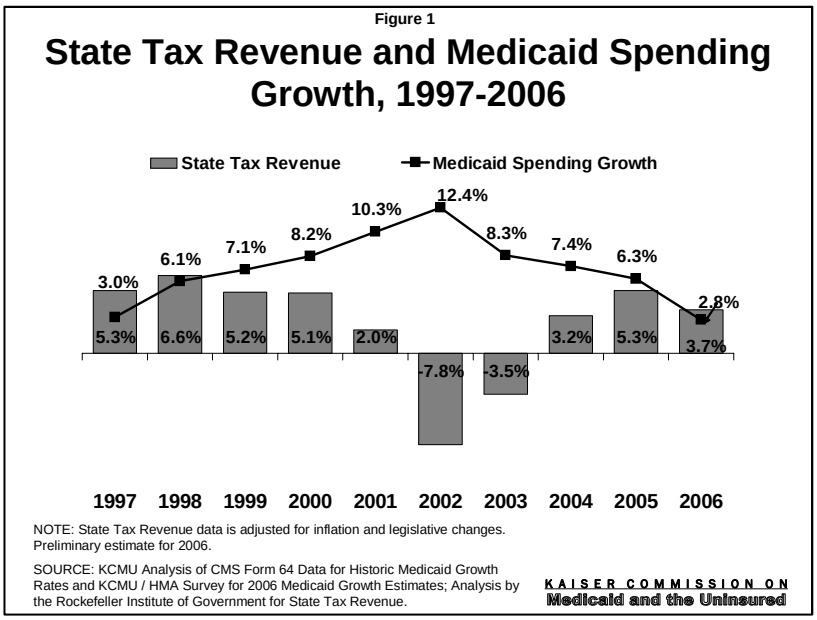
This report presents findings from a survey (of Medicaid officials from all 50 states and the District of Columbia) about changes in Medicaid spending, enrollment and policies for state fiscal years 2006 and 2007, conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates. Key survey findings include the following:

Medicaid spending slowed to near record lows as state revenues continued to rebound. Across all states, total Medicaid spending increased in state fiscal year 2006 by just 2.8 percent on average – the lowest rate of growth in Medicaid since 1996 growth of 2.7 percent. FY 2006 also marked the first year since 1998 that state revenues grew at a rate faster than total Medicaid spending. A dramatic slowing in program enrollment growth to just 1.6 percent, the lowest rate since 1999, was a major factor contributing to lower spending growth. Slower enrollment was mostly attributable to the improving economy resulting in fewer individuals becoming eligible for the program. The shift of prescription drug spending for the dual eligibles from Medicaid to Medicare was another factor contributing to declining Medicaid spending growth. States are now obligated to finance a portion of this Medicare coverage through a payment referred to as the "clawback" to the federal government. Most states continue to count the clawback payments as state Medicaid spending, but since these payments are not matched with federal funds, they are not included in calculations of

[1] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2003 MSIS data.

federal Medicaid spending. Without accounting for state clawback payments, total Medicaid spending would have been even lower (about 1.7 percent) (Figure 1).

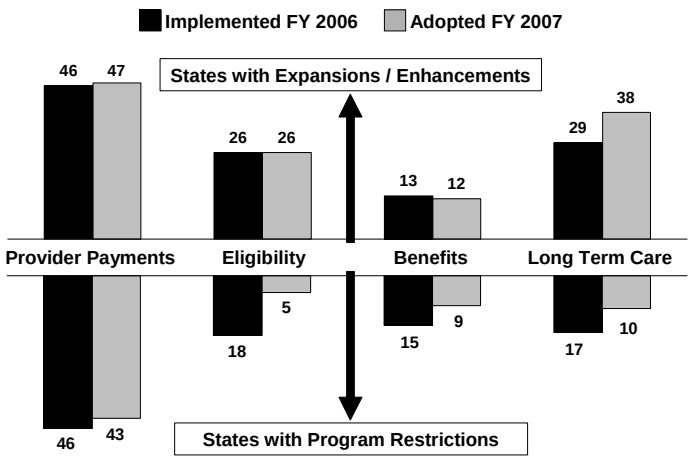
Figure 1



States continue to focus on measures that control costs, but improving fiscal conditions allowed for more program investments than in previous years. Throughout the economic downturn, the most prevalent cost containment action taken by states was to freeze or reduce provider payment rates. While many states continued to freeze provider rates in efforts to control costs, more states implemented in FY 2006, or plan to implement in FY 2007, provider rate increases. As economic conditions improved, states felt pressure to increase rates that had been cut or frozen over the last several years. Some states continue to implement mostly targeted benefit cuts, while the number of states moving forward with benefit restorations has increased relative to previous years. For FY 2006, several states including Tennessee, Missouri, Florida and Mississippi implemented policies that significantly restricted Medicaid enrollment. However, looking forward to FY 2007, only five states have plans to restrict eligibility, while 26 states have plans to restore cuts from previous years, expand to new populations, or make positive changes to Medicaid application and enrollment procedures (Figure 2).

Figure 2

State Policy Actions Implemented in FY 2006 and Adopted for FY 2007



NOTE: Past survey results indicate not all adopted actions are implemented.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2006.

KAISER COMMISSION ON Medicaid and the Uninsured

Many states expect the new citizen documentation requirements included in the DRA to increase administrative costs and to negatively affect enrollment. One of the mandatory provisions in the DRA effective July 1, 2006 requires all individuals applying for or renewing their Medicaid coverage to provide documentation of their identity and citizenship status. This is not a change in Medicaid citizenship requirements, but a major change from current state enrollment practices where 47 states allow applicants to self-declare citizenship status. Over half of the Medicaid directors expected these requirements to have a negative impact on Medicaid enrollment while others remained uncertain. All but three states (three of the four states that already had documentation requirements in place) indicated that the new requirements would increase state administrative costs.

Few states planned to use new flexibility allowed under the DRA to change benefits or impose cost sharing in FY 2007, but others are considering these options. Three states, Kentucky, West Virginia and Idaho had plans approved to change benefits. Kentucky also used new cost sharing options. Kentucky and Rhode Island plan to make copayments enforceable, using another DRA option that would allow providers and pharmacists to deny services if beneficiaries cannot pay copayment amounts. State officials indicated that they will continue to evaluate these options, which suggests there may be more activity in the future. The DRA included changes that some states had been pursuing through the use of Medicaid 1115 Waiver authority. After the passage of the DRA, state plans to implement 1115 Waivers slowed from FY 2005. A few states like Florida and Vermont are still moving ahead with new Medicaid reform plans using waiver authority, but nine states indicated that they were re-thinking their plans because of the new DRA authority.

A growing number of states are moving forward to expand community based long-term care services, with nearly three-quarters planning to implement expansions in FY 2007. Increasingly, states are focusing their efforts on significant changes to their Medicaid long-term care delivery systems, and the clear focus is on enhancing home and community-based programs. In FY 2006, over half of the states enhanced home and community based services (HCBS), usually by adopting new or expanding existing waivers or adding services. In FY 2007, a total of 38 states plan to

adopt expansions of HCBS, including 13 states that plan to implement or expand a PACE program. The DRA includes new provisions that give states flexibility in delivering long-term care services in addition to new mandatory changes to the asset transfers rules that affect qualifying for Medicaid nursing home services. Most states expected the fiscal impact of the asset transfer provisions to be insignificant, but reported that these provisions could have negative implications for beneficiaries seeking nursing home care. Almost half of all states reported plans to implement a long-term care partnership policy to encourage the purchase of private long-term care insurance (22 states), apply for a "Money Follows the Person" demonstration grant to increase the use of community versus institutional services (18 states), or take advantage of the cash and counseling option that allows for self-direction of personal assistance services (16 states).

States were more focused on expanding disease management, quality initiatives and program integrity efforts, which are more likely to have longer-term program benefits rather than immediate savings. States continue to develop and expand their disease management initiatives focusing on high cost cases, recognizing data that shows that a small fraction of enrollees (4 percent) account for about half of all Medicaid spending. Similar to efforts in Medicare and the private sector, Medicaid programs have adopted policies designed to improve quality of health care. By FY 2007, more than two-thirds of all states will have quality initiatives in place, most classified as "pay for performance." Many of these initiatives use bonuses or penalties for performance that meets or falls short of specific quality criteria or there are automatic managed care enrollment formulas that reward higher performing plans with more enrollees. Seventeen states in FY 2006 and 21 in FY 2007 adopted policies to improve program integrity through the use of new technologies, data mining, additional staff, and better procedures to improve coordination across agencies. New program integrity efforts will emerge as CMS implements plans for the Medicaid Integrity Program that was established in the DRA. States also continue to take actions to expand their use of managed care by expanding service areas, adding eligibility groups, such as the elderly and persons with disabilities, and making enrollment into managed care mandatory.

While states and beneficiaries have overcome some of the early Medicare Part D implementation issues, state officials identified several on-going concerns. On January 1, 2006, Medicaid drug coverage ended for over six million duals (those eligible for both Medicare and Medicaid) whose coverage was transferred to new Medicare "Part D" prescription drug plans. Duals faced numerous problems accessing needed drugs during this transition and many states stepped in to provide temporary coverage programs.[2] CMS established a Medicare demonstration program to repay states for the costs of their temporary programs; however, at the time of the survey, many states had not received any reimbursement from this program. States expressed immediate and on-going concerns related to Part D including the impact on duals, (such as access to non-formulary drugs and the impact of potentially new copayment requirements), the clawback (with officials in 15 states stating that the FY 2007 clawback obligation is more costly to their states compared to the amount they would have spent in the absence of Part D), other fiscal issues (including the impact on supplemental rebates), administrative issues (especially ongoing data exchange issues), and FY 2007 contracting concerns.

[2] *See* Vernon Smith, Kathleen Gifford, Sandy Kramer and Linda Elam, *The Transition of Dual Eligibles to Medicare Part D Prescription Drug Coverage: State Actions During Implementation, Results from a 50-State Snapshot*, Kaiser Commission on Medicaid and the Uninsured, February 2006, Publication No. 7467.

While the direction of Medicaid may be determined by the outcome of state gubernatorial elections in many states, on-going fiscal pressures, as well as the changing balance in the federal-state partnership for Medicaid, will continue to be major factors affecting the program in the future. Despite dramatic slowing of Medicaid spending and enrollment growth, pressure to control Medicaid spending growth remains strong. Requirements to balance state budgets each year, rising health care costs, increasing numbers of Americans without health insurance and the aging population (contributing to more elderly and more persons with disabilities) all continue to impose demands on Medicaid. States may be facing additional strains around Medicaid financing as formula driven changes continue to push down federal match rates and as the Center for Medicare and Medicaid Services (CMS) continues to scrutinize state financing practices regarding what expenditures qualify for federal matching dollars. Many states expressed frustration that the "rules of the road" around these fiscal issues are murky, changing, and inconsistently applied, which makes budgeting for Medicaid extremely difficult. Even with these challenges, a rebounding economy has made it possible to move beyond measures to produce immediate cost savings and focus more on improving the quality and integrity of the program. Looking forward, some states plan to continue to evaluate new options made available in the DRA and a number of states look to expand health coverage to new populations. Major reform efforts in states like Massachusetts or Illinois are building on a strong Medicaid base of coverage and financing.

Methodology

For the sixth 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 DRA on their programs. The KCMU/HMA survey on which this report is based was conducted in July and August 2006 to document the policy actions states had implemented in the previous year, state FY 2006, and new policy initiatives that they had adopted, or expected to implement, in state FY 2007, which for most states had begun on July 1, 2006. 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 2006 and 2007, average rates of growth for Medicaid spending and enrollment were calculated as weighted averages across all states using Medicaid expenditures reported in: National Association of State Budget Officers (NASBO), *State Expenditure Report*, October 2005, and state enrollment data reported by state officials to HMA for the Kaiser Commission on Medicaid and the Uninsured for the month of June 2005.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

Additional copies of this report (#7569) are available
on the Kaiser Family Foundation's website at www.kff.org.