kaiser commission on MEDICAID FACTS
medicaid and the uninsured
THE HENRY J. KAISER FAMILY FOUNDATION

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STATE FISCAL CONDITIONS AND MEDICAID

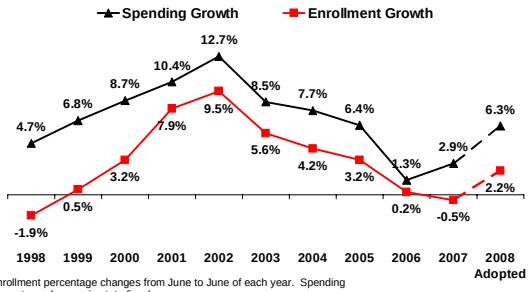
Medicaid spending and enrollment growth reached an all-time low in state fiscal year 2006 and continued to grow slowly in FY 2007. The Medicaid program provides health coverage and long term care support services to 44 million people in low-income families and nearly 14 million elderly and disabled people. Compared to the 2001-2004 period of economic downturn where state revenues plummeted and states were forced to aggressively curtail Medicaid spending growth, in FY 2006 and FY 2007, state revenues were strong, and states were able to focus less on cost containment activities and more on program enhancements including eligibility expansions and quality initiatives. In 2006 and 2007 states were also enacting two major pieces of federal legislation, the Medicare Modernization Act (MMA) and the Deficit Reduction Act (DRA), both of which affected spending and enrollment growth.

Medicaid Spending and Enrollment Growth Slowing

Medicaid spending growth hit a record low of 1.3% in FY 2006 and for the first time in nearly a decade, enrollment growth declined in FY 2007 to -.5%. This picture is dramatically different than the 12.7% spending and 9.5% enrollment growth at the height of the economic downturn in 2002. According to estimates reported by state Medicaid officials, states expect both enrollment and spending growth to increase in FY 2008 (Figure 1).

Figure 1

Percent Change in Medicaid Spending and Enrollment, FY 1998- FY 2008



NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentage changes in state fiscal year.

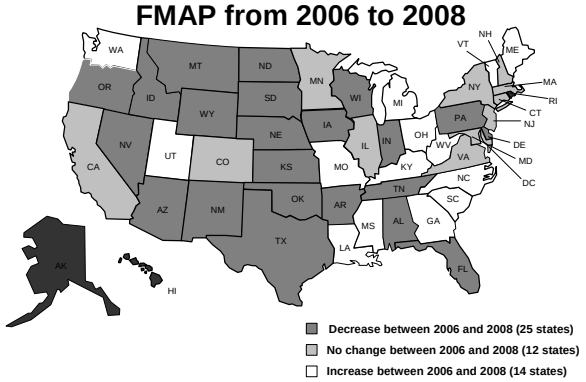
SOURCE: Enrollment Data for 1998-2006: *Medicaid Enrollment in 50 States: June 2006.* KCMU, October 2007. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2007 and FY 2008 spending and enrollment data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007.

States attribute the decline in spending to slowed enrollment growth and the impact of Medicare Part D which transitioned prescription drug costs for beneficiaries eligible for both Medicaid and Medicare (duals) from Medicaid to Medicare. While 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, these payments are now counted as a source of financing for Medicare and are not subject to the federal match or counted as Medicaid spending. States reported that the effect of cost containment efforts enacted in prior years also contributed to the slowdown in spending growth.

Financing for Medicaid is shared by the federal government and states and is based on the federal Medicaid matching rate (FMAP) which relies on states relative per capita income. Recently, the state share of spending has increased more rapidly as the federal match rate continually declines for many states (Figure 2). These declines in the FMAP place pressure on states to allocate additional state funds in order to maintain current program levels. Total Medicaid spending in FY 2007 and projected spending for FY 2008 was 2.9% and 6.3% respectively, while the state share increased by 3.2% and 7.8%.

Figure 2

Half of the States Experienced a Reduced FMAP from 2006 to 2008

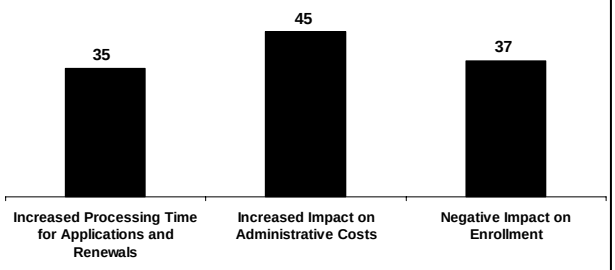


SOURCE: http://aspe.os.dhhs.gov/health/fmap.htm

The decline in enrollment growth in FY 2006 and 2007 is attributed to the new citizenship and identity documentation requirements set forth in the DRA, as well as an improving economy and lower unemployment rates. At the beginning of FY 2007, as part of the DRA, states were required to obtain documentation to prove citizenship and identity for individuals applying for or renewing Medicaid coverage. While this change did not affect eligibility requirements, it has caused administrative delays in processing applications and renewals resulting in postponement and denial of coverage often for individuals otherwise eligible for the program (Figure 3).

Figure 3

States Reporting Impacts of Citizenship Documentation



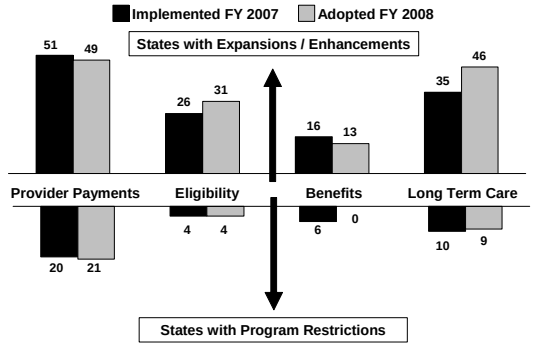
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007.

Program Expansions and Enhancements

More states than ever before implemented or plan to implement program expansions. In FY 2007, all states increased provider payments, and for the first time since at least 2003, no states plan a reduction in benefits in FY 2008. Program expansions such as increasing income eligibility limits or streamlining application processes, as well as increasing provider payment rates, all serve to increase access to services and to expand coverage to more of the uninsured. States are also balancing their long-term care delivery system by continuing to focus on and expand home and community-based long-term care services (Figure 4). Cost containment measures enacted in early years have largely been kept in place, particularly strategies that control prescription drug spending.

Figure 4

State Policy Actions Implemented in FY 2007 and Adopted for FY 2008



NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007.

Additionally, states are increasingly focusing on Medicaid quality improvements and initiatives to get better value from public Medicaid expenditures. Almost all states (44) will be using the nationally accepted quality measures, HEDIS® and CAHPS®, by 2008, in order to measure and provide incentives for improved performance of managed care organizations. Other quality measures being adopted by states include pay-for-performance reimbursement policies and public reporting of managed care organizations.

DRA Options

Few states have taken advantage of the flexibility to change benefits or impose cost sharing as a result of the DRA. Early adopters including Kentucky, West Virginia and Idaho implemented complete redesigns of their Medicaid benefit packages and only five other states are using this flexibility in a more targeted way by focusing on disease management programs, adding personal assistance services and developing high deductible health plans. However, many states are using new long-term care options provided under the DRA including implementation of "Money Follows the Person" initiatives and Long Term Care Partnership Programs which increase the role of private long-term care insurance (Figure 5).

Figure 5

States Using DRA Options for FY 2007 and FY 2008

DRA Options	# of States
New Options	
Benefits	8
Cost Sharing	1
New LTC Options	
LTC Partnership Program	29
Self-Directed Personal Assistance Services	8
HCBS for Residential Treatment Facilities for Children	10
HCBS State Option	6
Medicaid Buy-In for Disabled Children	2
Grants and Demonstration Programs	
Medicaid Transformation Grants	26
Money Follows the Person	31
Health Opportunity Accounts	1

Outlook

In 2006, the Census bureau reported that the number of uninsured grew to 47 million Americans, a 2.2 million increase from 2005. States have recognized this problem by developing reform plans in an effort to expand coverage to the uninsured. Medicaid plays a large role in many of the reform proposals both as a vehicle for financing and as a building block for coverage.

The outlook for state revenue growth as well as the outcome of the SCHIP reauthorization debate will determine how much reform will occur at the state level. As states look to expand coverage to the uninsured and sustain their Medicaid program, controlling program costs, improving quality and balancing long-term care services will undoubtedly remain top priorities.

For additional information see the report entitled: As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey. State Fiscal Years 2007 and 2008, October 2007 at http://www.kff.org/medicaid/7569.cfm.

For additional copies of this publication (#7580-02), please visit www.kff.org/kcmu.

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.