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Current Issues in Medicaid: A Mid - FY 2008 Update

Based on a Discussion with Medicaid Directors

Prepared by

Vernon K. Smith and Barbara Coulter Edwards
Health Management Associates

and

Jennifer Tolbert
The Kaiser Commission on Medicaid and the Uninsured

January 2008

THE HENRY J. KAISER FAMILY FOUNDATION

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

James R. Tallon
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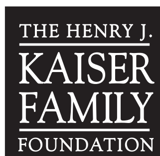

ACKNOWLEDGEMENTS

We thank Medicaid directors who serve on the Executive Committee of the National Association of State Medicaid Directors who took the time to participate in a discussion of current issues in Medicaid, and who offered feedback on an earlier version of this report. Especially, we thank Medicaid officials from Alabama, California, Connecticut, Minnesota, Nevada, New Jersey, Oklahoma, Rhode Island, and Washington. We also thank staff of the National Association of State Medicaid Directors who participated in the discussion.

INTRODUCTION

The purpose of this report is to provide a brief mid-fiscal year 2008 update on current issues in Medicaid, from the perspective of state Medicaid directors who administer the program. This report augments the most recent Medicaid budget survey report,[1] which focused on Medicaid spending, enrollment and policy trends at the beginning of state fiscal year 2008, [2] based on survey responses and interviews with Medicaid directors in all 50 states and the District of Columbia in July and August 2007.

As indicated in the annual Medicaid budget survey report, at the beginning of state fiscal year 2008 Medicaid directors had described a generally improving state fiscal situation, with increases in state revenues that had allowed Governors and state legislatures to restore many of the cuts and restrictions that had been adopted during the economic downturn, as well as to adopt positive changes in Medicaid, including modest increases in provider payment rates and expansions in benefits and eligibility. Notably absent from state policy decisions for 2007 and 2008 were cuts in Medicaid provider payment rates, program benefits and eligibility levels. Instead, there was a clear focus on improving coverage and the quality of care provided under the program.

However, just a few months into state fiscal year 2008, in the fall of 2007, signs began to emerge across the states that the economic climate was changing. The outlook was no longer as generally positive as had been the case early in the state fiscal year. For example, a special session of the legislature was convened in September in Florida due to softening state revenues. By November, Medicaid budget shortfalls for state fiscal year 2008 were identified as issues in Ohio and Kentucky, and news reports from a number of other states suggested that state economies might have reached a turning point as projected state revenues were coming in below previous projections.

It was in this context that the Medicaid directors gathered in November 2007 to discuss the issues currently facing Medicaid programs, how a changing economic and policy climate was affecting Medicaid, and how Medicaid programs were responding to the mid-year challenges.

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[1] Vernon Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, Molly O'Malley and Caryn Marks, *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*, Kaiser Commission on Medicaid and the Uninsured, October 2007. Available at: www.kff.org/Medicaid/7699.cfm

[2] State fiscal year 2008 began on July 1, 2007 in 46 states. The state fiscal year began on April 1 in New York, on September 1 in Texas, and on October 1 in Alabama, Michigan and the District of Columbia.

METHODOLOGY

This paper is based on discussions with Medicaid directors who serve on the Executive Committee of the National Association of State Medicaid Directors (NASMD). The Executive Committee is comprised of Medicaid directors elected by their peers to represent every geographic region of the country. As such, the Executive Committee is broadly representative of states, and its members are recognized nationally and in their states as leaders in Medicaid policy and administration.

These Medicaid directors gathered in Washington, DC at the invitation of the Kaiser Commission on Medicaid and the Uninsured to identify and discuss current program issues on the evening of November 11, 2007, the day prior to the NASMD annual meeting. The ten Medicaid directors on the Executive Committee were invited to participate in the discussion; seven were able to participate in the discussion in person. The remaining three members participated through follow-up telephone and in-person discussions. In this manner, input was obtained from all members of the NASMD Executive Committee, including Medicaid directors from the following states: Alabama, California, Connecticut, Michigan, Minnesota, Nevada, New Jersey, Oklahoma, Rhode Island and Washington. In addition, five staff members from the National Association of State Medicaid Directors (NASMD) also attended the discussion.

Directors were asked to identify and discuss the most important issues facing Medicaid in their states, and how the issues may have changed since the beginning of the fiscal year. They based comments on their personal experience and knowledge gained as administrators of the Medicaid program. At the beginning of the discussion it was acknowledged that their comments may not reflect the views of other officials within their states or in other states, and may not reflect positions of the National Association of State Medicaid Directors.

KEY ISSUES

Medicaid directors identified a number of key issues, concerns and priorities in mid fiscal year 2008. At the top of the list were the effects of an increase in fiscal stress across states, a number of federal – state issues, including those impacting Medicaid enrollment and access, and their current efforts to address the uninsured.

State Fiscal Stress

State Medicaid directors described an economic situation that in many states leveled off unexpectedly, or in some cases deteriorated, in the last half of calendar 2007. The result was that in a number of states, revenues early in fiscal year 2008 came in below projections and below levels on which state policy makers had based the state budget. Accordingly, as states approached the mid-point in fiscal year 2008, outlook for the immediate future was less optimistic than it had been at the beginning of the year.

At the beginning of state fiscal year 2008, Medicaid directors had described in the budget survey a strong sense that state economies were rebounding compared to recent years, based on recent rates of growth in state revenues. State budget decisions had been premised on this expectation of continued growth in revenues. In Medicaid, a stronger economy was reflected in projections for relatively slow growth (or even decreases) in program enrollment. State policy makers had a renewed interest in strategic improvements in Medicaid in a time of relative fiscal stability. This positive outlook was reflected in Governors' proposals and legislative decisions to enhance Medicaid coverage, eligibility and provider payments, and to adopt initiatives to improve and reward the provision of quality health care.

By mid-fiscal year 2008, Medicaid directors described a less optimistic picture of the economic conditions in several states. To be sure, some directors continued to describe positive economic news, but most reported that recent revenue projections indicated a likelihood that actual state revenues would be below previous estimates for the current fiscal year.[3]

State Medicaid officials noted that troubles in the housing market had been reported to be a primary contributor to the less optimistic outlook for state revenues. In addition, some states face what was described as an "unresolved structural deficit," where even a relatively healthy economic climate in the state would not translate into comparable strength in state revenues. The slower rate of growth in state revenues brought to the surface a state concern that the gap between the rate of growth in state revenues and Medicaid expenditures might widen, and that it may be more difficult for states to finance their share of program costs in the future.

The depth of concern about the state fiscal situation was reflected in descriptions of internal policy discussions occurring in some states about how state budget shortfalls might impact Medicaid. State officials suggested that targeted or even across-the-board Medicaid program cuts were a possibility before the end of calendar 2008. There was concern that there might be state workforce reductions, for example, that could impact Medicaid staff.

Another area of concern for Medicaid directors was the way state budgets are affected by the annual changes in each state's federal Medicaid matching rate (the Federal Medical Assistance Percentage, or FMAP). The FMAP formula is intended to be counter-cyclical by providing states with more federal funding during times of fiscal stress, but because of lags in the data, the changes in the matching rate usually are not responsive to changes in states' economic situations. In addition to the timeliness of annual changes in the federal matching rate, directors also expressed concern that the FMAP calculation does not account for the relative ability of states to finance Medicaid,

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[3] According to the National Association of State Budget Officers, "Overall, state finances peaked in fiscal 2006, remained very healthy in fiscal 2007, and will begin to slow significantly in fiscal 2008." Source: *2007 Fiscal Survey of the States*, National Association of State Budget Officers, December 2007. Available at: www.nasbo.org

or differences in the cost of living across states. A more responsive formula would improve Medicaid program stability at the state level.

Medicaid directors indicated that it would be more difficult to achieve significant Medicaid cost savings now than it had been during the last economic downturn. Medicaid cost control actions are rarely easy and almost always have impacts on program effectiveness. Many policy options that might otherwise be considered now were just used during the recession a few years ago and are no longer available. In 2003 and 2004, for example, virtually every state adopted prescription drug cost controls. Now, any savings states might realize from additional prescription drug cost controls would be considerably less. With the transfer of responsibility for prescription drugs to Medicare Part D for dual eligibles, the direct Medicaid cost exposure for prescription drugs was reduced by about half. However, states now pay a "clawback" payment to Medicare for prescription drugs for duals, and Medicaid can no longer manage these costs directly. In addition, there was a growing concern that if Medicaid restricted provider payment rates that it would impact beneficiary access to needed services.

Even with the less optimistic economic outlook, the directors expressed their strong commitment and a commitment of their state administrations to maintain current levels of coverage and the restorations of the payment rates and benefits that occurred in the last two years. Most states continue to look for ways to expand coverage for low-income uninsured individuals if at all possible, even while recognizing the need to restrain the growth in Medicaid spending in a time of state fiscal constraint. One director suggested that the issue of expanding coverage is such an imperative in states that all Governors have had to look at it.

State – Federal Issues

State Medicaid directors were unanimous is expressing concerns regarding current federal-state relationships, and the direction of recently proposed federal policy.

Medicaid directors agreed that recent federal regulatory changes are adverse to states and will negatively impact Medicaid programs, including proposed changes regarding Medicaid benefit design and Medicaid financing arrangements. They believed that the cumulative effect will be more negative to the program than has been publicly acknowledged by CMS. There was consensus that recent federal policy proposals could not be justified by instances of perceived abuse in specific states, and that the underlying motivation for CMS policy is believed to be a capping of federal financial participation. These federal policy changes will have a fiscal impact that will be especially difficult for states moving into a "down" economic cycle. Directors agreed that there needs to be closer attention paid to the amount of cost-shift to state budgets that would result from federal policy changes.

In addition, the directors noted that some recent federal policies actually work against efforts to manage care effectively, to integrate services for vulnerable populations, and to encourage broader coverage for low income uninsured populations. For example, among

currently proposed federal policies that would reduce the ability of states to meet critical needs of covered populations, Medicaid directors listed proposed restrictions on the use of Targeted Case Management, limits on administrative claiming in schools engaged in Medicaid outreach, limiting the scope of the Medicaid rehabilitation option, eliminating Medicaid funding for medical education, as well as new rigidity in managed care reimbursement policy, the new SCHIP guidance limiting eligibility to children with family incomes up to 250 percent of the federal poverty level and the application of this SCHIP policy to Medicaid.

Some directors suggested that, in addition to a clear motivation to reduce federal Medicaid spending, some current federal policy directions are the result of federal administration staff and even congressional staff not fully understanding and appreciating the realities of Medicaid program administration. They felt that some staff failed to understand the administrative complexities involved in implementing rule and policy changes and failed to provide states with the time needed to train staff, make programming changes, and notify beneficiaries of impending changes.

Directors generally agreed that the federal-state relationship now is badly strained and too often this has created real impediments to effective program operation at the state level. Directors expressed a fundamental concern that recent federal policy actions were announced without even cursory consultation with state directors, and that both the proposed policies and the process for promulgating them have undermined the federal-state partnership.

State directors singled out health information technology (HIT) as an example of state-federal relations moving in a positive direction. Directors described excitement for new HIT initiatives, supported in part by the Transformation Grants authorized by the Deficit Reduction Act (DRA) of 2005, to increase the effective use of health information technology at the state and program level. Directors noted that agreement to use community-wide quality standards and measurement, which has often been the focus of public/private collaborations, has proven a challenge at times for Medicaid, but it is a worthwhile goal to pursue.

In support of these efforts, NASMD has organized a collaborative of states interested in HIT initiatives such as electronic health records, electronic clinical support tools, interoperability among agencies, and public/private sector initiatives. The collaborative is led by Medicaid directors in Arizona and Alabama and is in the process of organizing a library of resource materials to share among the states. It was also noted that Medicaid has been well-represented nationally in efforts to collaborate with ERISA groups regarding standardization.

The Transformation Grants were praised by Medicaid directors as federal recognition of the importance of HIT for the future effectiveness of Medicaid, for federal willingness to participate in financing efforts in this area, and for enabling Medicaid to play a leadership role at the state level within public/private efforts to adopt system-wide reforms.

Medicaid Enrollment

On average across all states, total Medicaid enrollment dropped by -0.5 percent in fiscal year 2007, with enrollment increases for almost half of states, and enrollment decreases for just over half of states.[4]

While most of the ten Medicaid directors participating in the November discussion, indicated the Medicaid caseload in their states was showing a flat or continued downward-sloping caseload trend, several indicated that their current projections had been revised upward. Where the caseload was now increasing, the upward caseload trend was thought to be associated primarily with a more sluggish economy. In contrast, at the beginning of the fiscal year, Medicaid directors in their responses to the Medicaid budget survey had cited modest program expansions as the primary factor that would contribute to expected enrollment growth for fiscal year 2008.

Several states indicated that outreach initiatives were once again being implemented, with a particular focus on enrolling eligible children. For several years, outreach was limited or not conducted due to state budget constraints. One director indicated that the Governor had ordered aggressive outreach this year by all cabinet directors. Directors from states such as Connecticut, New Jersey, Minnesota and Oklahoma described a new commitment of funding to outreach.

On the other hand, one director reported that the state had definitely planned to do outreach, using county funds to help finance Medicaid-reimbursed outreach, but that the plan has been held up by CMS for two years. Another state reported that outreach funds had been authorized by the legislature for FY 2008, but that the rapid downturn in state revenues had forced curtailment of all discretionary spending. Deteriorating fiscal situations in states such as Alabama and Rhode Island, for example, had made outreach more difficult. In one state, the director indicated that outreach had been reduced on the premise that a successful outreach effort would worsen the state fiscal problem.

Medicaid directors generally agreed that the DRA requirement for documentation of identity and citizenship continues to contribute to lower Medicaid caseloads in 2008, as it did in 2007. Directors generally agreed that the primary impact of the documentation requirement has been on new applicants. States have experienced an increase in the backlog of pending applications, noting their administrative systems weren't fully prepared for this impact. Most states implemented electronic birth record matching for in-state records which partially addressed this problem. Directors indicated it is a challenge to obtain documentation for children born out of state. One director reported that local advocacy groups have organized to offer assistance to people who claimed citizenship but were denied coverage due to lack of documentation.

In some states, full implementation of citizenship documentation continues to be phased-in, reflecting the time required for systems changes and worker training. Several states have chosen to give current Medicaid enrollees additional time to document citizenship at

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[4]Smith, et al., *op. cit*., Kaiser Commission on Medicaid and the Uninsured, October 2007.

redetermination. However, states reported that even with additional time it is still difficult for many eligible citizens to obtain and provide the required documentation. Some states reported that they had created a centralized unit for review and assistance to assist particularly difficult documentation cases at redetermination.

Directors expressed particular concern about how the new documentation requirements would impact children. States with "state only" health coverage programs for persons who do not qualify for Medicaid (such as immigrant children) reported seeing an increase in applications for these programs as children applying for Medicaid have been asked for documentation. However, directors indicated that children turned away from Medicaid for lack of documentation are almost always U.S. citizens, which can in turn make them ineligible for the state-only programs and leave them without any coverage. One director indicated that their reports show that about half the children initially denied for lack of documentation later produced proof of citizenship, or they waited to reapply with documentation at the start of the school year. This experience underscored what was emphasized by the directors, which is that most of those impacted by the new documentation requirements are actually U.S. citizens.

Health Care Reform and Covering the Uninsured

Most Medicaid directors reported a strong interest on the part of their Governors in health care system reform, including strategies to reduce the number of individuals who do not have health insurance coverage. With the number of uninsured continuing to rise nationally, many states have proposed initiatives aimed at addressing the problem. The goal in some states is universal coverage, while in others the focus is on increasing coverage options for targeted populations. Many directors described current efforts proposed or underway to expand coverage through public and/or private sector reforms. These included some states that also reported a deteriorating economy and expected fiscal shortfalls. A number of states have chosen to focus more limited resources on expanding coverage for children. One director described a state commitment to guarantee enrollment in health coverage for "all newborns for the first four months of life."

Medicaid directors were unanimous is underscoring the importance of SCHIP reauthorization to state efforts to cover more uninsured working families. (Note: The discussion on which this report is based took place while the Congress and the President deliberated SCHIP reauthorization, but prior to the President signing a temporary reauthorization in December 2007 for funding through March 2009.) They expressed strong concern about their state's ability to maintain current enrollment levels for low income children if federal SCHIP funding was not authorized. The delay in reauthorization had made policy making difficult for state officials, due to the uncertainty about future funding for the program. Nationally, 21 states had been projected to exhaust their SCHIP allocation by the end of federal fiscal year 2008, with the first states exhausting funds beginning in March 2008 and with more states depleting funds each month thereafter.[5] Some states were concerned that proposed restrictions in funding

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[5] Congressional Research Service, Report for Congress: *FY 2008 SCHIP Allotments*, Updated October 25, 2007. Order code: RS22739.

availability for adults (parents and childless adults) will result in higher rates of uninsured individuals.

In particular, there was concern about the impact of a "Medicaid Director Letter" dated August 17, 2007 that imposed new requirements for states seeking to expand SCHIP coverage above 250 percent of the federal poverty level. Directors described situations in which state legislatures had authorized expansions of coverage to 300 percent of the poverty level, but due to the August 17 letter, state policy makers had scaled back their request to avoid challenging the newly announced conditions for federal approval.

Since Medicaid and SCHIP do not cover immigrants, several directors noted that the issue of providing health coverage for immigrant populations has been an important challenge in their consideration of state health reform strategies. Clearly, this is a controversial issue, especially regarding undocumented residents. However, all agreed that whether directly addressed or not, the care for uninsured immigrant populations has a cost impact that is borne by the state's health care system. In addition, as with any population group, lack of health care coverage contributes to poor health outcomes that have higher health and social systems costs "down the road." Some state officials described state or county-level programs for documented and undocumented uninsured immigrant children, noting that reform proposals under consideration in their state would attempt to address this issue directly. Directors expressed interest for research into the cost effectiveness of coverage for immigrant populations, especially newborns and children, and on the true impact of health coverage availability on patterns of immigration across states.

Improving Access

Issues of access have been perennial in Medicaid, due to generally lower rates of provider reimbursement in most states, occasional budget-driven rate cuts or freezes, and rate increases that occur at uncertain intervals when authorized by state legislatures. The discussion with Medicaid directors indicated that access remains a key issue across the states, and that several states have taken specific strategies to improve access for those with Medicaid coverage.

In an effort to improve access to services, directors described recent rate adjustments in their state Medicaid programs; however, many were uncertain that "reasonable" rate increases could overcome current access challenges, especially in certain specialty fields. States reported particular attention paid to pediatric rates. Medicaid directors in this discussion generally reported less concern over access to primary care for most populations, in part due, in the words of one director, to the "tremendous safety valve on access" provided by federally qualified health centers (FQHCs) in many states. Access to specialists, however, is often a concern, even in states with relatively higher payment policies. Medical specialists, including pediatric specialists, dentists, orthopedic specialists, psychiatrists and neurosurgeons were among those cited as most often a concern.

Some states noted that the problem of access was grounded in too few providers of specific types located in the state, and that commercially insured patients had access problems as well for certain specialties (e.g., psychiatrists, pediatric specialists in some states). Most however indicated that even when the issue was related to a shortage of specific specialties, problems of access were a greater concern for Medicaid enrollees.

Medicaid directors expressed particular concern over access to oral health and mental health services. In many states, few dental health providers participate in the Medicaid program and participation has not been improved by rate increases alone. One state reported that, despite rate adjustments, even the public university dental clinic would no longer serve Medicaid patients. While access to mental health services also suffers from a lack of providers, the issue is complicated by a lack of resources as well as the need to coordinate with other agencies to provide non-medical services.

The directors agreed that to make an impact on oral health access, other strategies might need to be used in addition to rate increases. Several non-reimbursement strategies were described. One director reported success in improving access to oral health services with a combination of improved rates and an on-staff dentist who helped providers have a "voice" in Medicaid dental policy. Another described progress in public ICF/MR facilities that set up dental suites to serve residents with developmental delays, as well as out-patients. Another reported Medicaid had begun allowing pediatricians to apply dental sealants for very young children, since some parents fail to seek out dental care until teeth are beyond repair.

Directors noted that states continue to struggle to find sufficient resources and service options to treat people with serious and persistent mental illness. Improving access for this population is difficult, since strategies include both medical and non-medical services. For example, many access-related issues arise due to lack of affordable housing, especially in states with expensive housing markets. One director reported challenges in responding to an Olmstead lawsuit (Americans with Disabilities Act-related) due to inadequate housing options. Another issue relates to Medicaid financing. One director indicated that progress had been achieved through an enhanced community-based mental health services option under a federal managed care waiver, but now that progress is threatened by new federal reimbursement policies. Moreover, proposed regulatory changes that would restrict the definition of what rehab services are eligible for federal Medicaid matching payments could limit Medicaid reimbursement for community-based mental health services, further exacerbating access problems for these services.

SUMMARY AND CONCLUSION

In the first half of state fiscal year 2008, the economic situation flattened or turned downward in a number of states. As states approached the mid-point of state fiscal year 2008, many were now projecting lower rates of growth in state revenues, higher Medicaid costs and caseloads, and potential state budget shortfalls. The changing projections had raised a flag of caution as states were preparing budgets for FY 2009. While the directors indicated the slowing economy had yet to force states to cut Medicaid

benefits or provider payment rates, it had caused some states to slow the implementation of positive policy directions adopted for state fiscal year 2008.

Adding to the challenge posed by the darkening economic picture was concern over the impact of federal policy initiatives designed to restrict the availability of federal funds for services and activities that have been eligible for federal matching funds under existing policy. In the view of Medicaid directors, these initiatives have the effect of shifting financing for necessary services from the federal government to the states. At a time when states may already find meeting program needs difficult, these federal policies will further add to the state fiscal burden.

Despite a tough economic and regulatory climate, Medicaid directors remain committed to improving the Medicaid program and to developing initiatives for the uninsured. The directors indicated that despite an array of ongoing challenges, there is a commitment across the states to move forward, and to improve access for the vulnerable populations served by the Medicaid program. The changing fiscal climate across states will certainly continue to test that commitment.

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

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