kaiser commission on medicaid and the uninsured

Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends

Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011

Executive Summary

Prepared by
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and

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Kaiser Family Foundation

September 2010

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.

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Medicaid staffs in virtually every state have seen administrative budgets trimmed and workloads increase as ongoing budget shortfalls have increasingly affected state governments. Especially in this year, we thank the public servants who administer the nation's Medicaid programs in all 50 states and the District of Columbia who completed the survey on which this study is based, provided information about their programs, participated in structured interviews and responded to our follow-up questions. Without the help of these Medicaid officials, this study could not be done. Given the challenges these staff are facing, we are truly grateful for their assistance.

We offer special thanks to Dennis Roberts at Health Management Associates who developed and managed the database. His work is always excellent and for several years has been invaluable to our work on this survey. David Fosdick and Jenna Walls from Health Management Associates assisted with data analysis, editing and writing the case studies and we thank them for their excellent work.

Executive Summary

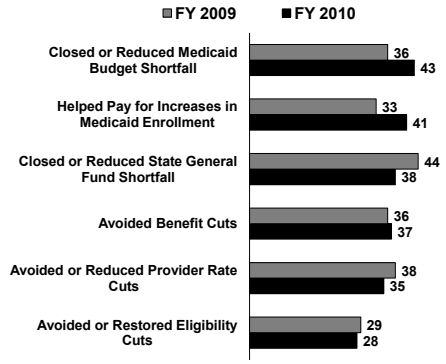
At the end of state fiscal year (FY) 2010 and heading into FY 2011, states were still in the midst of the worst economic downturn since the Great Depression with high unemployment, severely depressed revenues and increased demand for services, including Medicaid. While most states expect to see the impact of the recession last for the next few years, they are hoping that 2011 will be a turning point moving toward economic recovery. State economies were bolstered by federal fiscal relief from the American Recovery and Reinvestment Act of 2009 (ARRA) which provided a temporary increase in the federal Medicaid matching rate (known as the "Federal Medical Assistance Percentage," or "FMAP") from October 2008 through December 2010. Legislation to provide states with a scaled back extension of this fiscal relief through June 2011 was enacted in August 2010; however, this was after most states had adopted budgets for FY 2011. Even as states continue to grapple with historically difficult budget conditions, they are planning for the implementation of the Patient Protection and Affordable Care Act (ACA), major health reform legislation which envisions an expanded role for Medicaid and the states. While there are many health reform implementation challenges, states will benefit from a dramatic reduction in the number of uninsured and access to new federal funding associated with expanded Medicaid coverage as well as new funding for demonstrations to improve Medicaid delivery systems.

For the tenth 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 also includes background on the Medicaid program, as well as current issues facing the program. Findings are presented for FYs 2010 and 2011.

Fiscal relief funds in ARRA provided critical assistance to states in FYs 2009 and 2010; an extension of these funds through the end of FY 2011 was enacted but at a lower level than those originally approved in ARRA (ES-1). Pressure from the recession remained severe throughout FY 2010 and into FY 2011. The national unemployment rate remained high at 9.6 percent in August after reaching 9.9 percent in April of this year, up from 4.9 percent when the recession began in December 2007. States experienced the sharpest decline in revenues on record, had to close unprecedented budget shortfalls of an estimated $194 billion for FY 2010 and had to handle increased demand for public programs like Medicaid. Nearly all states have cut spending across state programs and for state employees. An estimated $87 billion in fiscal relief from ARRA, provided to states through an enhanced FMAP, helped to close budget shortfalls and to support Medicaid programs in FY 2009 and FY 2010. In August 2010, Congress extended a scaled back version of the Medicaid fiscal relief through June 2011, but because the FMAP extension occurred more than a month after the state fiscal year had begun for all but three states and the District of Columbia, states were forced months earlier to make tough budget decisions or assume the extension of relief in developing their FY 2011 budgets. A full

ES-1

How States Used ARRA Enhanced Medicaid Funding in FY 2009 and FY 2010



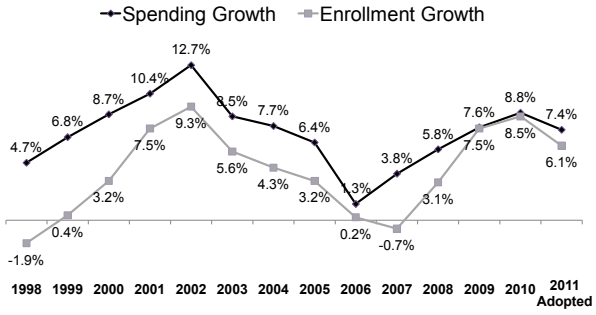
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2009 and 2010.

extension of the ARRA enhanced FMAP was estimated to cost $24 billion, however Congress passed a scaled back version with $16.1 billion in federal Medicaid funding. Given the late passage and phased down funding, many states will need to reexamine their FY 2011 budgets. For example, Virginia was able to reverse a provider rate cut and a benefit cut when ARRA funds were extended; however, other states that may have counted on a larger amount of federal fiscal relief may need to take additional actions to control costs.

As a result of the recession, Medicaid spending and enrollment growth significantly exceeded projections and continued to accelerate in FY 2010; in FY 2011, growth will remain high but is expected to taper somewhat (ES-2). Total Medicaid spending growth averaged 8.8 percent across all states in FY 2010, the highest rate of growth in eight years and well above original projections for FY 2010 of 6.3 percent growth. Medicaid Directors overwhelmingly attributed the growth to higher than expected increases in caseload due to the recession. Enrollment growth averaged 8.5 percent in FY 2010, significantly higher than the 6.6 percent growth projected at the start of FY 2010. States projected that Medicaid enrollment would grow at a still strong but somewhat slower rate for FY 2011 of 6.1 percent. For Medicaid spending in FY 2011, initial legislative appropriations authorized total spending growth that would average 7.4 percent above FY 2010 spending. As occurred in FY 2010, this initial rate of growth may understate actual spending increases for FY 2011, since Medicaid officials in over two-thirds of states believed that initial FY 2011 legislative appropriations could be insufficient. The federal government and states share in the financing of Medicaid.

ES-2

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2011

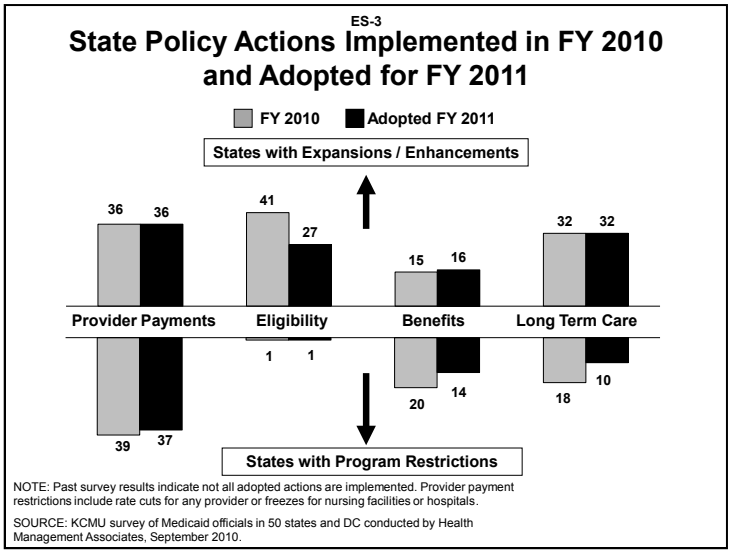


NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.
SOURCE: Enrollment Data for 1998-2009: *Medicaid Enrollment in 50 States*, KCMU. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2010 and FY 2011 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010.

The ARRA enhanced FMAP reduced the state costs for Medicaid. The ARRA enhanced FMAP reduced the state costs for Medicaid, resulting in an average decline in state general fund spending for Medicaid of 7.1 percent in FY 2010, following a drop of 10.9 percent in FY 2009, offset by larger increases in federal spending for the program. These drops represent the only declines in state spending for Medicaid in the program's history.

Even with the relief from ARRA, nearly every state implemented at least one new Medicaid policy to control spending in FYs 2010 and 2011 with more states turning to provider cuts (ES-3). In FY 2010, 48 states implemented at least one new policy to control cost and 46 states plan to do so in FY 2011 with some states reporting program reductions in multiple areas. While many states mentioned that ARRA helped to avoid or mitigate provider rate cuts, states still took action in this area. In FY 2010, 39 states implemented a provider rate cut or freeze compared to 33 states in FY 2009. In FY 2011, 37 states have planned provider rate restrictions. More than any other area, provider rates are linked to economic conditions. Under budget pressure, states turn to rate cuts to have an immediate budget impact and when conditions improve states are able to restore or enhance rates. States must balance the need to control costs with ensuring that provider rates are sufficient to maintain participation and access to services for enrollees. ACA funded the Medicaid and CHIP Payment and Access Commission that is

charged with preparing reports and recommendations to Congress on ways in which to improve access to care for enrollees.



In FY 2010, 20 states implemented benefit restrictions, the largest number in one year since the surveys began in 2001 and double the number from FY 2009. In addition to this record level of benefit restrictions in FY 2010, 14 states have planned benefit restrictions in FY 2011. These benefit restrictions include the elimination of covered benefits as well as the application of utilization controls or limits for existing benefits. For example, several states eliminated all or some adult dental services including Arizona, California, Hawaii and Massachusetts. A number of states also imposed limits on benefits such as imaging services, medical supplies or durable medical equipment, therapies or personal care services.

ARRA helped to protect Medicaid eligibility and even with tight budgets many states reported some eligibility expansions or enrollment simplifications. To be eligible for the enhanced federal matching funds in ARRA, states could not restrict their Medicaid eligibility standards, methodologies or procedures more than those in place on July 1, 2008.[1] The ACA maintained the ARRA maintenance of eligibility requirements for adults through 2014 and for children through 2019 as part of health reform. Despite severe budget circumstances, 41 states in FY 2010 and 27 states in FY 2011 implemented or have plans to expand or simplify eligibility processes. Many eligibility changes are expected to affect only a small number of beneficiaries, but a few states are implementing broader reforms and eligibility expansions such as Colorado and Wisconsin. Connecticut and the District of Columbia have already taken advantage of a new option in health reform to cover childless adults in advance of this requirement in 2014. Some of the efforts to streamline enrollment could help states qualify for performance bonus payments that were enacted as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA).

[1] In FY 2010 and FY 2011, New Mexico imposed a wait list on its State Coverage Initiative that counted as an eligibility restriction but was allowed under the MOE requirements.

While the majority of states continue to expand and improve options for community based long-term care, there are fewer states adopting these policies compared to previous years. States are continuing to expand home and community-based long-term care services (HCBS), but at a slightly slower pace than in previous years. Overall, 32 states took actions that expanded long-term care (LTC) services in FY 2010 (primarily expanding HCBS programs), and 32 states planned expansions for FY 2011. However, the number of states adopting new HCBS waivers or expanding existing waivers decreased to 23 in FY 2010 and 22 in FY 2011 compared to 27 in FY 2009 and 38 in FY 2008, suggesting that some states may be postponing additional balancing efforts due to difficult state fiscal conditions. In FY 2010, 18 states implemented utilization controls and other reductions on LTC services to contain costs and 10 states plan to do so in FY 2011. While states can restrict services in HCBS programs or the availability of other long-term care services, the ARRA maintenance of eligibility (MOE) requirements prohibit changes in eligibility. For example, states are prohibited from increasing stringency in institutional level of care determination processes or from reducing waiver capacity as of July 1, 2008. The ACA included a number of new long-term care options designed to increase community based long-term care. A few states are moving forward with new HBCS state plan options, and while there is not guidance from CMS, states seemed interested in the State Balancing Incentive Payment Program and the Community First Choice Option.

States continue to adopt policies to manage and coordinate care, to improve quality and to expand the use of health information technology. Thirteen states in FY 2010 and 20 states in FY 2011 implemented or plan to expand managed care by expanding service areas, adding eligibility groups, requiring enrollment into managed care or implementing managed long-term care initiatives. Sixteen states in FY 2010 and 13 states in FY 2011 are implementing new or expanded disease management programs. States are also moving forward with new medical home models as well as initiatives to care for those dually eligible for Medicare and Medicaid. The ACA includes a number of provisions related to improving care delivery in Medicaid such as a new Health Home option to provide enhanced funding for coordination of care activities for individuals with chronic care needs; the creation of the CMS Innovation Center to test payment and delivery models, the creation of the Federal Coordinated Health Care Office to coordinate policies for dual eligibles and several demonstration and grant programs. States also continue to expand the use of health information technology (HIT) activities to improve efficiency, costs, quality and patient safety. States have a major role in the adoption and meaningful use of electronic health records (EHRs) and health information exchanges (HIEs) aided by new federal funding that was included in ARRA. Nearly all states have received CMS approval for enhanced Medicaid funding (at a 90 percent match) to conduct planning for the EHR Incentive Program.

As states continue to grapple with historically difficult budget conditions, they must also plan for the implementation of the ACA which envisions new roles for Medicaid and for states. Under health reform, Medicaid will be expanded to cover nearly all individuals with incomes below 133 percent of poverty resulting in a large adult expansion in most states, particularly adults without dependent children who had historically been barred from coverage under the program. This expansion provides the foundation for new coverage under health reform. Not surprisingly, Medicaid officials are playing a lead role in preparing for health reform implementation, in many cases alongside insurance commissioners. Some of the key challenges that states will face in implementing reform include implementing the Medicaid expansion, transitioning to a new income eligibility methodology for Medicaid, setting up Health Insurance Exchanges and re-designing eligibility systems to coordinate with the Exchanges. These challenges are magnified by recent administrative cuts and state workforce reductions limiting states' capacity to focus on new responsibilities. Many states said that they need

timely regulations and guidance as well as financial support to help them move forward and meet tight implementation timelines.

Looking forward, states are hoping that the economy starts to improve as they plan to implement historic health reform legislation. Despite the tough economy, Medicaid directors reported that they were able to maintain the program's core mission and objectives and achieve some program improvements. In the near future, even if the economy begins to improve at the national level, the impact of the recession for states will persist for several years. Looking forward to FY 2012, the state share of Medicaid spending will increase dramatically (by as much as 25 percent or more) due to the expiration of the enhanced FMAP on June 30, 2011; while state revenues are almost certain to remain below pre-recession levels. In addition to the effects of the economic downturn, Medicaid directors see preparing for the implementation of health reform as a huge opportunity as well as the next major challenge. Health reform will dramatically reduce the number of uninsured and provide access to new federal funding associated with expanded Medicaid coverage, but it will not be easy to implement. In many states, new leadership and staff will take over the responsibilities of planning for and implementing health reform after the 2010 elections. Even in the face of daunting challenges, Medicaid remains the foundation of coverage for low-income Americans as well as a critical safety net in today's health care system, and the program is poised to fulfill an even larger role under health reform.

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