kaiser commission on MEDICAID FACTS

medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

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STATE FISCAL CONDITIONS AND MEDICAID

Heading into FY 2011, states were still suffering from the effects 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 several years, they are hoping that 2011 will be a turning point in the economic recovery.

State economies were bolstered by the enhanced federal Medicaid matching funds (FMAP) from the American Recovery and Reinvestment Act of 2009 (ARRA), which was effective October 2008 through December 2010, with a scaled back extension through June 2011 recently enacted by Congress. As states continue to grapple with historically difficult budget conditions, they are also 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.

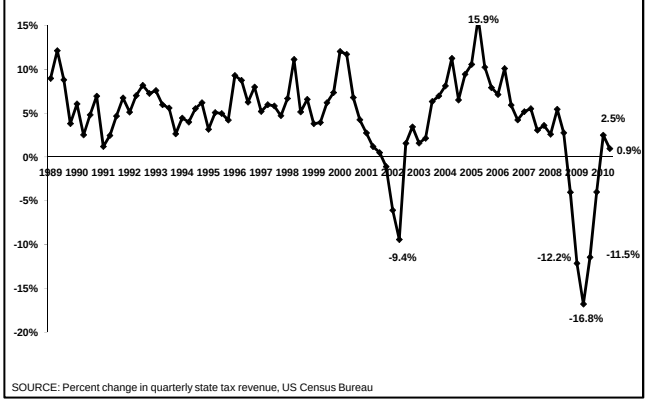
State Economic Conditions

The national unemployment rate has held at roughly 9.6% since the last peak of 9.9% in April 2010. The economy is estimated to have lost 95,000 jobs in the month of September.[1] Eleven states had unemployment rates at or above 10% in September. There are an estimated 14.8 million unemployed. The number of long-term unemployed (those jobless for 27 weeks or more) fell slightly to 6.1 million from a recent high of 6.8 million in May. Among those working, 9.5 million want to work full-time but have settled for part-time work.[2]

In 2009, states experienced the largest declines in quarterly tax revenues in decades. While tax revenue is starting to increase again for states, it is still far below pre-recession levels. After peaking at 2.5% growth in the first quarter of 2010, state revenue for the second quarter of 2010 grew by only .9% over the same period in 2009 (Figure 1).

Figure 1

State Tax Revenue, 1999 – 2010



SOURCE: Percent change in quarterly state tax revenue, US Census Bureau

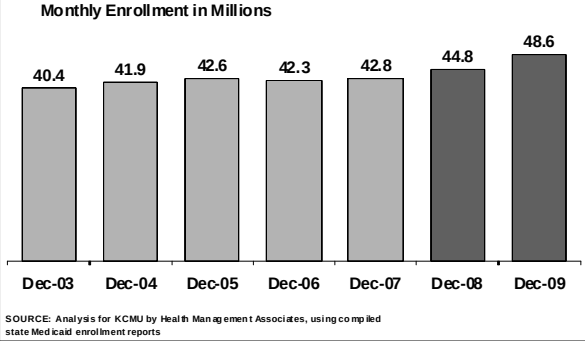
As a result, at least 46 states faced a budget shortfall at the start of fiscal year 2011, collectively totaling $121 billion. Looking forward to 2012, 23 states already estimate budget gaps of 10 percent or more.[3] Unlike the federal government, states are legally required to balance their budgets. Thus, forty-six states and DC are enacting cuts in all major program areas including health care, K-12 and higher education. At least 43 states and DC have also reduced state employee wages or instituted layoffs, furlough days, and hiring freezes.[4]

Medicaid and the Economy

During economic downturns such as the current one, unemployment rises, incomes decline, and individuals lose employer-sponsored health coverage. This results in increased Medicaid enrollment and spending. At the same time, state revenues are declining, making it more difficult for states to afford their share of the increased spending. Since the start of the recession, Medicaid enrollment has increased by 6 million people as unemployment has roughly doubled (Figure 2).

Figure 2

Medicaid Enrollment Has Increased by Nearly 6 Million Since the Start of the Recession



SOURCE: Analysis for KCMU by Health Management Associates, using compiled state Medicaid enrollment reports

Medicaid is a jointly-funded state and federal program that provides financing for health care providers across the country, supporting jobs, income and economic activity in addition to providing coverage for low-income Americans. The federal government provides matching funds to states for qualifying Medicaid expenditures. Medicaid funding represents the single largest source of federal grant support to states, accounting for an estimated 44 percent of all federal grants to states in FY 2008. At the same time, states on average spent 16 percent of their funds on Medicaid, making it the second largest program in most states' general fund budgets following primary and secondary education.

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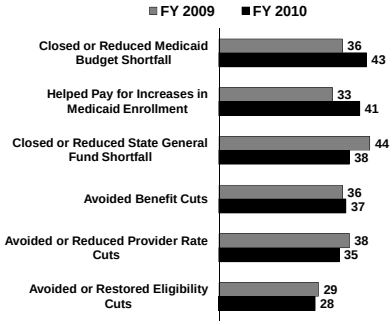
Federal Fiscal Relief

In an effort to boost an ailing economy, Congress passed the ARRA on February 17, 2009. Specifically, the Act included an estimated $87 billion for a temporary increase in the federal share of Medicaid costs from October 2008 through December 2010. The federal matching share (FMAP), calculated annually for each state and varied depending on the average personal income in the state, was increased from a range of 50 to 76 percent to a range of 62 percent to 84 percent under ARRA. In order to receive the funds, states had to agree to maintenance of eligibility (MOE) requirements which meant states could not restrict their Medicaid eligibility levels or enrollment processes. These additional funds were able to reach states quickly and used to address both overall state budget and Medicaid budget shortfalls; reduce or avoid cuts to providers, benefits and eligibility; and help support increased Medicaid enrollment (Figure 3).

Figure 3

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.

In August 2010, Congress passed a scaled back extension of the enhanced FMAP. Instead of the 6.2 percentage point increase received under ARRA, states will receive a 3.2 percentage point increase for the third quarter (January-March 2011) and a 1.2 percentage point increase for the fourth quarter (April-June 2011), reducing the overall cost of the extension from $24 billion to $16.1 billion. By the time Congress adopted the extension, budgets for FY 2011 were already adopted in all states except California and Michigan, with 26 states and DC assuming a full six-month extension and 24 states not assuming an extension. Since the extension was scaled back, states may need to make adjustments to their budgets.

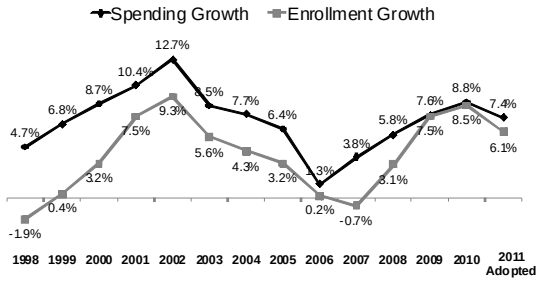
The budget difficulties states faced in their FY 2011 budgets over the uncertainty about the extension of enhanced funding is a prelude to the challenges states will likely face when the enhanced FMAP is eliminated in FY 2012. The state share of Medicaid costs is expected to increase by 25% or more over FY 2011 levels due to the elimination the enhanced FMAP alone.[5]

Medicaid Spending and Enrollment Growth

As a result of the recession, Medicaid spending and enrollment accelerated in FY 2010 and FY 2011. Total Medicaid spending growth averaged 8.8% in FY 2010, with enrollment growth of 8.5%, the highest rates of growth in eight years (Figure 4). Both the rates of growth for enrollment and spending were significantly higher than original projections of 6.3% spending growth and 6.6% enrollment growth, resulting in many states having had to make mid-year budget adjustments.

Figure 4

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 HealthManagement Associates, September 2010.

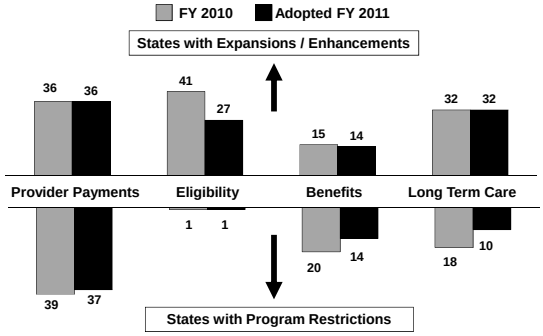
For FY 2011, states anticipate spending to increase by 7.4% over FY 2010 levels, which would be the first slowing of spending growth since FY 2006, with anticipated enrollment growth of 6.1%. However, as occurred in 2010, this initial growth rate may understate the eventual spending increase as Medicaid officials in over two-thirds of states believed there was a 50-50 chance that initial FY 2011 appropriations would be insufficient, including one-third of states that thought a shortfall was almost certain.

Policy Changes

Nearly every state implemented at least one new Medicaid policy to control spending in FY 2010 and FY 2011.

Figure 5

State Policy Actions Implemented in FY 2010 and Adopted for FY 2011



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, September 2010.

Provider Payment Rates

While the enhanced FMAP allowed states to avoid or lessen the extent of provider rate cuts, 39 states in FY 2010 had implemented provider rate cuts or freezes, and 37 states plan to do so in FY 2011. FY 2010 marks the first year since the start of the recession that more states cut rather than increased provider payments. Provider payment rates are one of the first areas states turn to for cutting costs in Medicaid programs as the savings from such cuts are more immediate than other potential cuts. However, such cuts can jeopardize provider participation and therefore access to care for Medicaid enrollees.[6]

The ACA increases payments in fee-for-service and managed care Medicaid programs for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100 percent of the Medicare payment rates for 2013 and 2014. The Federal government will fully finance the difference between the rates states had in place July 1, 2009 and the Medicare payment rate for these two years.

Eligibility

Medicaid eligibility was protected in FYs 2010 and 2011 due to the MOE requirements under ARRA, which have been extended until Health Insurance Exchanges are in place in 2014 under ACA.[7] Despite the economic downturn, 41 states in FY 2010 and 27 states in FY 2011 reported positive eligibility and application simplification changes. While many of the changes will only affect a small number of enrollees, a few states are implementing broader reforms.

The ACA provides states the opportunity to expand eligibility to childless adults prior to 2014. States would receive their regular amount of federal matching funds for this population until 2014 rather than the enhanced Medicaid matching funds. Connecticut and the District of Columbia have already taken advantage of a new option in health reform to cover childless adults. Additionally, four states - Colorado, Delaware, New Jersey and Washington – have indicated such an expansion is possible.

Benefits

After repeated cuts to provider rates, states have now turned to restricting benefits – either eliminating a benefit or applying utilization controls to a benefit. Twenty states reported benefit restrictions in FY 2010 – the largest number of states reporting such restrictions in one year since the annual surveys began in 2001. The majority of benefit restrictions were utilization controls in adult dental and therapeutic services as well as personal care services. Eight states in FY 2010 did however eliminate at least one benefit and 4 states indicated plans to do so in FY 2011.

The ACA provides states with a financial incentive to provide preventive services (identified by the U.S. Preventive Services Task Force) and adult vaccines without imposing cost sharing requirements. States that do so will receive a one percentage point increase in their federal matching funds for those services and vaccines beginning in January 2013. The majority of states are not sure whether they will qualify for this provision yet.

Pharmacy

Thirty-eight states in FY 2010 and 30 in FY 2011 implemented cost-containment initiatives in the area of prescription drugs. The majority of actions reported were additions, expansions or refinements of existing programs. There were several changes to pharmacy rebates made in the ACA, including increasing the federally required minimum rebate amount and allowing states to collect rebates for prescription drugs purchased by Medicaid MCO programs. Many states don't know what the impact of these changes will be yet as the impact will vary based on the state's level of supplemental rebates and whether prescription drugs were carved-out of their managed care programs.

Long Term Care

Overall, 32 states took actions that expanded long-term care services in FY 2010 and 32 states planned expansions for FY 2011. However, the number of states adopting new HCBS waivers or expanding existing waivers decreased from 38 states in FY 2008 to 23 states in FY 2010, suggesting that some states may be postponing additional balancing efforts due to the economy. 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.[8]

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.

Delivery System and Health Information Technology (HIT)

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.

States also continue to expand the use of health information technology to reduce costs by improving efficiency, quality and patient safety. States have a major role in the adoption and meaningful use of electronic health records and health information exchanges aided by new federal funding included in the ARRA.

States expressed interest in the options and new offices created under ACA 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 conditions; the various new grants provided to states for delivery system reform; the creation of the CMS Innovation Center to test payment and delivery models as well as the creation of the Federal Coordinated Health Care Office to coordinate policies for dual eligibles.

Looking Ahead to Health Reform

As part of health reform, Medicaid eligibility 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 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. States are concerned about their aging workforce, limitations on hiring processes and salary schedules as well as the effects of the recession on the state workforce, particularly with the amount of work required to implement health reform. 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.

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.

Outlook

States continue to struggle with the fiscal impacts of the recession and the resulting increased demand for services. The extension of the enhanced FMAP will provide some aid to states. However, states will continue to face budget shortfalls in the years to come, particularly after the elimination of the enhanced FMAP in FY 2012. The challenges of maintaining Medicaid programs with limited staff and resources while enrollment continues to increase without harming access to care will persist. Despite current fiscal challenges, states are intensely engaged in planning ahead for health reform implementation.

For additional information see:

Hoping for Economic Recovery, Planning for Health Reform and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011. http://www.kff.org/medicaid/upload/8105.pdf.

Medicaid Enrollment: December 2009 Data Snapshot. http://www.kff.org/medicaid/enrollmentreports.cfm.

Staying on Top of Health Reform: An Early Look at Workforce Challenges in Five States. Kaiser Family Foundation, September 2010. http://www.kff.org/healthreform/upload/8106.pdf

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[1] Government losses totaled 159,000 in September, reflecting both temporary Census jobs and local government losses. The private sector increased 64,000.
[2] *The Employment Situation – September 2010*. BLS, October 8, 2010.
[3] *Recession Continues to Batter State Budgets*. CBPP, July 15, 2010.
[4] *An Update on State Budget Cuts*. CBPP, August 4, 2010.
[5] For states with a base FMAP of 50% and an ARRA enhanced FMAP of 61.59% through December 2010, the enhanced FMAP will phase down in January-March to 58.77% and in April-June to 56.88%. Depending on spending trends, the FY 2011 FMAP will average 60%, and the state share 40%. For FY 2012, the FMAP returns to 50%, an increase of almost 25% in the state share of Medicaid spending due to the change in the federal matching rate. States with the highest base FMAPs will see FY 2012 increases in the state share by over 30%. This does not take into account other increases driven by caseload growth, reimbursement changes or changes in utilization.
[6] *Few Options for States to Control Medicaid Spending in a Declining Economy.* KCMU, April 2008.
[7] The only eligibility cuts listed refer to the waiting list that New Mexico has placed on its State Coverage Initiative. This is permissible under the MOE.
[8] While states can restrict services in HCBS programs or other long-term care services, the ARRA MOE prohibits increasing stringency in institutional level of care determination processes or from reducing waiver capacity.

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