kaiser commission on MEDICAID FACTS

medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

Updated November 2012

STATE FISCAL CONDITIONS AND MEDICAID PROGRAM CHANGES, FY 2012-2013

Covering over 62 million people, the Medicaid program provides health and long-term care coverage for low-income families who lack access to other affordable coverage options and for individuals with disabilities for whom private coverage is often not available or inadequate. Medicaid also plays a pivotal role in state budgets, as both an expenditure and a source of federal revenues. This factsheet provides a brief overview of Medicaid's role in state budgets, the impact of the recession, current fiscal conditions, as well as results from the most recent annual survey of Medicaid programs conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates.

Key Takeaways

1. Medicaid is an expenditure as well as a source of federal revenue in state budgets. Medicaid was the largest expenditure in state budgets in FY 2010. However, when federal funds for the program are excluded, state spending on Medicaid is a far second to education spending (16% of general fund spending compared to 35%). Medicaid is the largest source of federal revenue to states, representing over 42% of all federal funds coming into states.

2. Just as has occurred in prior recessions, states faced increased demands for public services like Medicaid at the same time as state revenues to pay for such services were declining during the economic downturn. Analysis shows that the decline in state revenues played a greater role in state budget shortfalls than the change in state Medicaid spending. Despite increased demand, state Medicaid spending actually declined during this period for the first time in the program's history due to the fiscal relief provided to states through the American Recovery and Reinvestment Act (ARRA).

3. States are continuing to recover from the most recent recession as the fiscal outlook begins to improve. State tax revenues have grown for ten consecutive quarters but have not yet returned to pre-recession levels. After falling to its lowest level since January 2009, unemployment ticked up slightly in October to 7.9%.

4. Medicaid spending slowed in FY 2012 to a near-record low as the economy began to improve and enrollment growth slowed. Slow program growth is expected to continue for FY 2013.

5. Cost containment remained a strong focus for Medicaid, but with small improvements in the economy, a number of states were able to make some targeted program improvements and investments, including continued expansions of community-based long-term care. Medicaid programs are also engaged in a range of delivery system changes, including managed care reforms and care coordination strategies. Some of the most significant of these are initiatives to better deliver care for those dually eligible for Medicare and Medicaid.

6. Looking ahead, states are preparing for the implementation of the ACA and are making decisions about the Medicaid expansion as well as assessing potential Medicaid implications from an intense national debate about the federal budget deficit.

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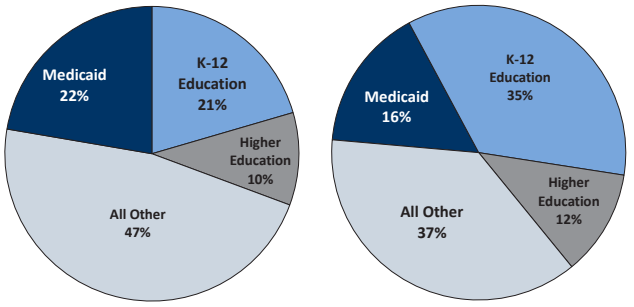
Medicaid's Role in State Budgets. Medicaid is both an expenditure and a source of federal revenue in state budgets. When looking at total spending (state funds plus federal funds), the largest state expenditures are K-12 education and Medicaid. In FY 2010, total spending on Medicaid exceeded total spending on K-12 education and is projected to do so in FY 2011.[1] (Figure 1) However, state general fund spending examines what states spend of their own funds on different programs. In FY 2010, K-12 education was the largest category of general fund spending (35%) followed by Medicaid (16%); these shares have remained fairly constant over the past decade. (Figure 2) At the same time, Medicaid is the largest source of federal funds for states, representing 42% of all federal funds spent by states in FY 2010.[2]

FIGURE 1

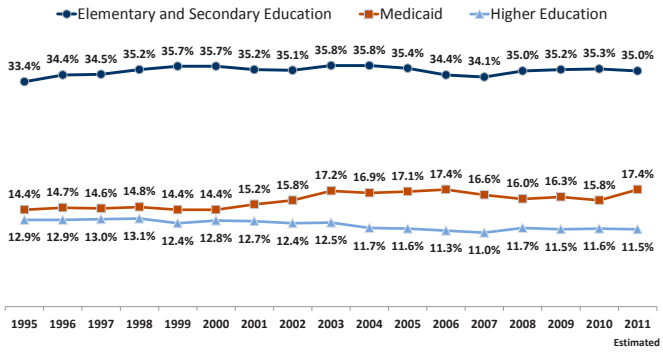
Total versus General Fund Spending, FY 2010



SOURCE: Actual FY 2010 data reported in: *State Expenditure Report.* NASBO, December 2011.

FIGURE 2

Share of State General Fund for Medicaid and Education Remained Fairly Stable, SFY 1995 – SFY 2011

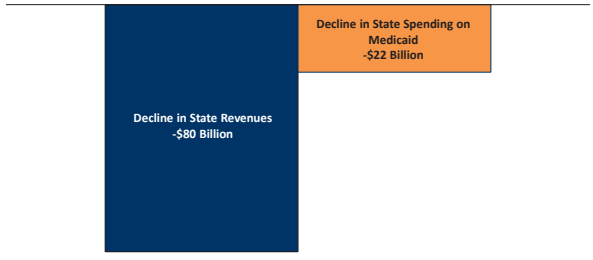


SOURCE: NASBO Data from 2010 State Expenditure Report.

Impact of the Recession on State Finances and Medicaid. The Great Recession, which technically lasted from December 2007 to June 2009, was the worst economic downturn since the Great Depression. Recognizing that states were facing a fiscal emergency, Congress enacted the American Recovery and Reinvestment Act of 2009 (ARRA), the largest component of which provided states with about $100 billion in federal fiscal relief in the form of a temporary increase in federal Medicaid matching funds (FMAP).[3] These funds were used by states as intended, both to address shortfalls in Medicaid and across state budgets. This federal support at the height of the downturn proved a critical source of state revenue, resulting in the first declines in state spending on Medicaid in the program's history.[4] During recessions, states are often faced with declining revenues at the same time that demand for public programs like Medicaid increases. There has been some debate on the relative magnitude of factors driving state budget shortfalls during the downturn. Analysis shows that the decline in state revenues played a greater role than the increase in Medicaid spending on state budget shortfalls between FYs 2008 and 2010. During this period, state revenues declined by $80 billion while the state share of spending on Medicaid actually declined due to the relief provided under ARRA.[5] (Figure 3)

FIGURE 3

Change in State Revenues and State Spending on Medicaid, FY 2008 - 2010



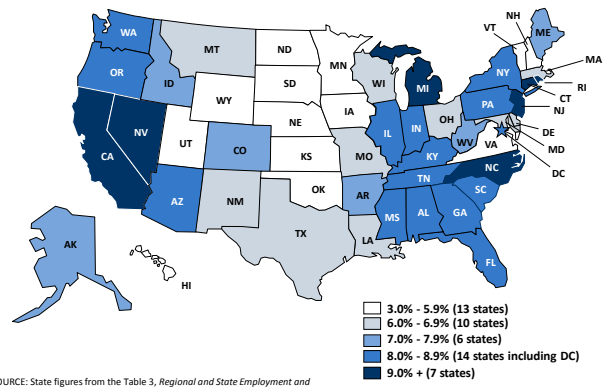
NOTES: Measures the change in state own source revenues (taxes, miscellaneous revenues, and charges) between state fiscal years 2008 and 2010 compared the change in state spending on Medicaid between state fiscal years 2008 and 2010. Medicaid spending does not include administrative costs, accounting adjustments, or the U.S. Territories.
SOURCES: 2008, 2009, and 2010 *Annual Survey of State Government Finances.* U.S. Census Bureau, 2012.
KCMU and Urban Institute estimates based on data from HCFA/CMS (Form 64), 2010.

[1] Total spending on K-12 education has matched or exceeded total spending on Medicaid in most years. *State Expenditure Report*. NASBO, December 2011.
[2] *State Expenditure Report*. NASBO, December 2011. http://www.nasbo.org
[3] Miller, V. et al. *Impact of the Medicaid Fiscal Relief Provisions in the ARRA*. KCMU, Oct 2011. http://www.kff.org/medicaid/8252.cfm.
[4] Smith, V. et al. *Medicaid Today; Preparing for Tomorrow*. KCMU, Oct 2012. http://www.kff.org/medicaid/8380.cfm.
[5] *Why Does Medicaid Spending Vary Across States?* KCMU, Oct 2012. http://www.kff.org/medicaid/8378.cfm.

Current State Fiscal Conditions. States are continuing to recover from the recent recession as the fiscal outlook for states has started to improve. After experiencing the largest collapse in state tax revenues on record during the most recent recession, state tax revenues have grown for ten consecutive quarters, but remain below nominal collections four years earlier. Preliminary figures from the Census Bureau show total collections in states for the second quarter of CY 2012 grew by 1.8% compared to one year earlier.[6] For the first time since January 2009, the unemployment rate fell below 8.0% in September (7.8%). Nationally, the unemployment rate edged up slightly to 7.9% in October 2012 as more people came back into the workforce.[7] An estimated 12.3 million people are unemployed, 5.0 million of whom are long-term unemployed (jobless for 27+ weeks). In October 2012, seven states had unemployment rates over nine percent. (Figure 4) States have faced collective shortfalls of over $540 billion since the start of the recession through FY 2012, with an additional $55 billion estimated for FY 2013.[8]

FIGURE 4

Unemployment Rates by State, October 2012

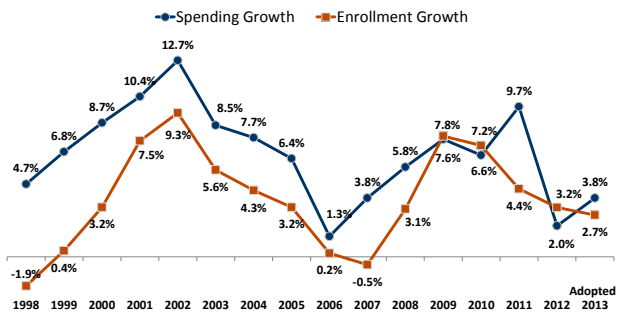


SOURCE: State figures from the Table 3, *Regional and State Employment and Unemployment: October 2012*, Bureau of Labor Statistics. (Figures are preliminary).

Medicaid Spending and Enrollment. Total Medicaid spending growth hit a near record low in FY 2012, with an increase of only 2.0% on average across all states. (Figure 5) Low spending growth was attributed to an improving economy which resulted in slower enrollment growth and intense state efforts to mitigate the increase in state spending driven by the expiration of the ARRA enhanced FMAP on June 30, 2011. After experiencing the only declines in state spending for Medicaid in the program's history, states faced a substantial increase in the state share of Medicaid spending (27.5%) once the ARRA enhancement expired and the FMAP shifted back to statutory calculated levels in FY 2012. Headed into FY 2013, Medicaid spending and enrollment growth are expected to remain much slower compared to rates during the height of the economic downturn. (Figure 5) While higher than for FY 2012, the 3.8% growth in spending is one of the lowest rates of growth in total Medicaid spending in the past 15 years.

FIGURE 5

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2013



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

SOURCE: *Medicaid Enrollment June 2011 Data Snapshot*, KCMU, June 2012. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2012 and FY 2013 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.

Medicaid Program Policy Changes (Figure 6). Cost containment remained a strong focus for Medicaid, with nearly each state in both years (48 and 47 respectively) implementing or planning to implement at least one new cost containment policy. As in prior years, rate restrictions were the most commonly reported cost containment effort. Some states increased or added new provider taxes that helped to mitigate these rate cuts. Other common cost containment strategies included benefit restrictions and new strategies to control spending for prescription drugs such as adopting "Actual Acquisition Cost" reimbursement methodology, "carving-in" prescription drugs to managed care, and improving control of behavioral health drug utilization. With small improvements in the economy, a number of states were able to make some targeted investments. In FY 2013, more states increased, rather than cut, rates for physicians, MCOs and nursing facilities. The ACA also provides federal funding to increase rates for primary care services to Medicare levels for 2013 and 2014. Rates are expected to increase in nearly all states, with increases of over 80% expected in six states.

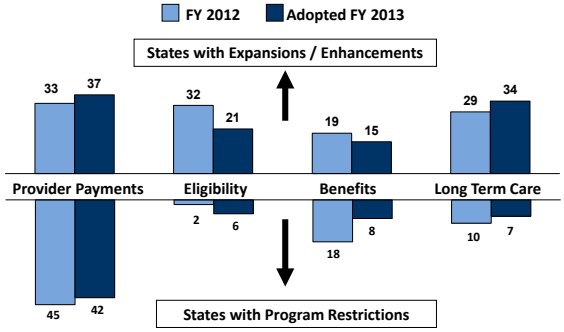
[6] Data collected by the Rockefeller Institute reports a higher rate of growth, 3.2 percent, during this period. http://www.rockinst.org/government_finance/.
[7] "Statement by Chad Stone On October Employment Report." CBPP, November 2, 2012. http://www.cbpp.org/cms/index.cfm?fa=view&id=3857.
[8] McNichol, E. et al. "States Continue to Feel Recession's Impact." CBPP, June 27, 2012. http://www.cbpp.org/cms/index.cfm?fa=view&id=711.

Medicaid eligibility levels remained stable in most states, as the ACA maintenance of eligibility (MOE) provisions[9] limited states from restricting Medicaid eligibility standards. A number of states reported targeted expansions or enrollment simplifications. In addition, several states continued efforts to expand long-term care services primarily through home and community-based service (HCBS) programs. Some states are also taking advantage of new LTC options to expand community based care made available by the ACA.

Managed Care Policy Changes and Initiatives. Medicaid programs are engaged in a range of delivery system changes, including managed care and care coordination strategies. (Figure 7) In FY 2012 and FY 2013, states expanded the use of managed care, primarily by expanding into new geographic areas or adding eligibility groups. For FY 2013, ten states are planning to implement managed long-term care.[10] States also reported that they have new care coordination efforts underway focused on improving care for populations with chronic and complex conditions and aligning payment incentives with performance goals.[11] States are focused on improving the delivery of care for individuals eligible for both Medicare and Medicaid. This includes 25 states working with the Medicare-Medicaid Coordination Office, a new office created by the ACA, on financial alignment demonstrations, and nine other states developing initiatives outside of these demonstrations.[12]

FIGURE 6

State Policy Actions Implemented in FY 2012 and Adopted for FY 2013

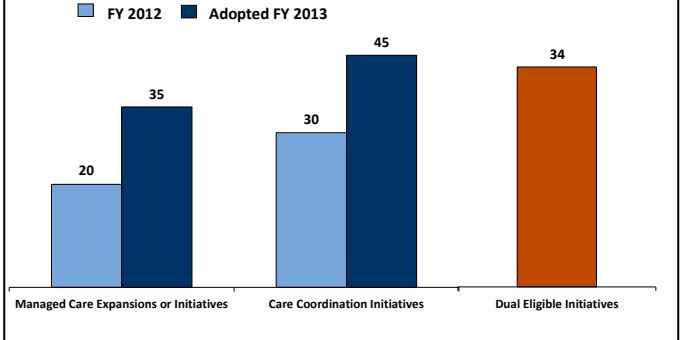


NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.

FIGURE 7

States With Managed Care, Care Coordination and Dual Eligible Initiatives, FY 2012 – FY 2013



NOTES: States were asked to report new initiatives in these areas. These counts for care coordination are not exclusive, some initiatives are counted in multiple areas. Duals initiatives include the 25 states participating in the financial alignment model through CMMO as well as nine other states (AR, DE, FL, IN, KS, LA, NH, NJ, and NM).

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.

Affordable Care Act (ACA). With just over a year before the ACA health coverage expansions go into effect, most states are immersed in multiple planning efforts, related to exchange models and how to proceed with the ACA Medicaid expansion. The June 2012 Supreme Court decision limited federal enforcement of the requirement to expand Medicaid, in effect making the expansion optional for states. The vast majority of the Medicaid expansion is funded with federal dollars, so states that do not expand will forgo these funds and will leave many without coverage. Even without the expansion, states must still streamline enrollment for coverage by 2014. Nearly every state is using the 90/10 federal financing to upgrade or replace antiquated Medicaid eligibility systems.

Outlook. While still a key priority, the singular focus on shortfalls and cost containment eased somewhat in FY 2013 compared to prior years. However, states face some uncertainty about Medicaid changes that may be included in the upcoming federal deficit reduction debates, the outcome of which could affect state decisions about implementing the ACA Medicaid expansion. Despite these uncertainties, Medicaid programs are focused on opportunities to improve care, enhance quality and control costs while also preparing for ACA implementation.

[9] Under the ACA, states must maintain Medicaid eligibility and enrollment standards that were in place as of March 23, 2010. The MOE remains until 2014 for adults and 2019 for children, with limited exceptions. Yet, a few states are moving forward with restrictions. More detail is located in the larger report.

[10] Managed care expansions include expanding to new geographic areas, adding new eligibility groups to managed care, transitioning more groups from voluntary to mandatory participation in managed care, the implementation or expansion of managed long term care as well as new quality initiatives.

[11] Care coordination initiatives include new initiatives or expansions of PCMHs, Health Homes, ACOs, as well as initiatives to coordinate physical and behavioral health, long term care and acute care services, additional quality efforts among other actions. Some initiatives are counted in multiple areas.

[12] For more information on the Financial Alignment Initiative, please see the following brief: Musumeci, M. *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS.* KCMU, Oct 2012. http://www.kff.org/medicaid/8369.cfm.

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