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The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession

Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2009 and 2010

Executive Summary

Prepared by
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and
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Kaiser Commission on Medicaid and the Uninsured
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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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Executive Summary

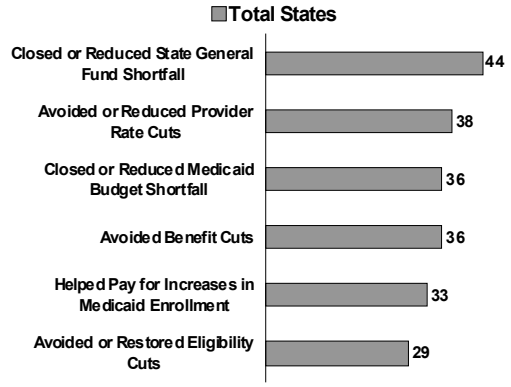
The recession was the dominant driver of Medicaid spending and enrollment growth as well as changes in policy for state fiscal years 2009 and 2010. Rising unemployment, sharp declines in state revenues and higher demands for public programs including Medicaid left states with severe budget gaps. The impact of the temporary Medicaid fiscal relief provided through the American Recovery and Reinvestment Act (ARRA) proved to be critical in helping states balance their budgets and protect their Medicaid programs, but states still felt pressure to control Medicaid spending growth. In addition to the issues related to the recession, states were also considering the effect of federal health reform proposals that would include a greater role for Medicaid. Today, Medicaid provides affordable and comprehensive health coverage and long-term care support services to 60 million individuals. The program is administered by the states within broad federal guidelines, but financing is shared by the states and the federal government.

For the ninth 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 state fiscal years (FYs) 2009 and 2010.

Facing severe state budget shortfalls in FY 2009 and FY 2010, the Medicaid fiscal relief funds in ARRA helped states to address budget shortfalls, preserve Medicaid eligibility and avoid or soften program cuts (Figure 1). At the end of state FY 2009 and headed into FY 2010, states were facing severe fiscal pressures from the recession. The national unemployment rate hit 9.7 percent in August 2009, up from 4.9 percent at the start of the recession in December 2007. States experienced the sharpest decline in revenue on record, projected budget shortfalls of at least $350 billion through 2011, and saw accelerating Medicaid caseload growth. Nearly all states had taken actions to cut program spending and cut spending for state employees. The ARRA provides an estimated $87 billion in relief to all states through enhanced federal Medicaid matching funds from October 1, 2008 through December 31, 2010. These funds were able to reach states quickly and were used to address both overall state budget and Medicaid budget shortfalls; avoid cuts to providers, benefits and eligibility, and help support increased Medicaid enrollment. Many states reported multiple uses for the ARRA funds meaning that a range of restrictions would have likely occurred without the additional federal funds.

ES Figure 1

How States Used ARRA Enhanced Medicaid Funding in FY 2009

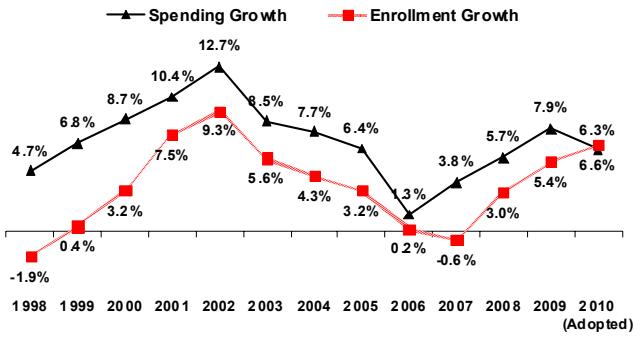


SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009.

As a result of the recession, Medicaid spending and enrollment growth accelerated in FY 2009 well above original projections and higher enrollment growth is expected again in FY 2010 (Figure 2). Total Medicaid spending growth averaged 7.9 percent across all states in FY 2009, the highest rate of growth in six years and higher than the original projections of 5.8 percent growth. Medicaid Directors overwhelmingly attributed the growth to higher than expected increases in caseload due to the recession. Enrollment growth averaged 5.4 percent in FY 2009, significantly higher than the 3.6 percent enrollment growth projected at the start of FY 2009. For FY 2010, states projected that Medicaid enrollment growth would continue to accelerate, increasing on average by 6.6 percent above FY 2009 levels. For FY 2010 spending, initial legislative appropriations authorized total spending growth that would average 6.3 percent above FY 2009 spending, lower than enrollment growth. However, Medicaid officials in three-fourths of the states believed there was at least a 50-50 chance that initial FY 2010 legislative appropriations would be insufficient, including a dozen states where a Medicaid budget shortfall was regarded as almost certain. Thus, the FY 2010 growth rate for total Medicaid spending is expected to be higher than 6.3 percent. Due to the enhanced FMAP from ARRA, state general fund spending for Medicaid declined by an average of 6.3 percent. Legislatures appropriated further reductions in state general funds that averaged 5.6 percent for FY 2010. These declines in state spending are the first in the program's history.

ES Figure 2

Percent Change in Total Medicaid Spending and Enrollment, FY 1998- FY 2010



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

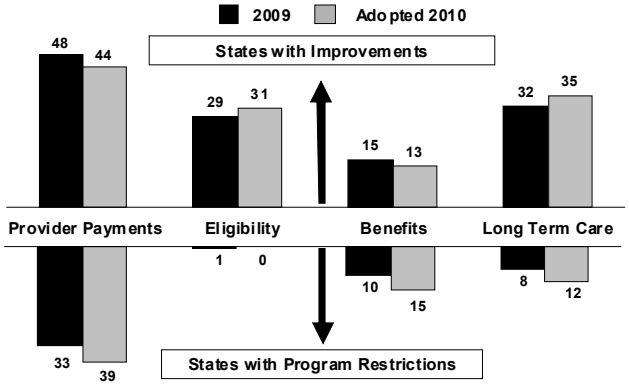
SOURCE: Enrollment Data for 1998-2008: *Medicaid Enrollment in 50 States*, KCMU. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2009 and FY 2010 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009.

Even with the relief from ARRA, nearly every state implemented at least one new Medicaid policy to control spending in FYs 2009 and 2010 with more states implementing provider cuts and benefit restrictions than in the previous few years (Figure 3). Some states reported program reductions in multiple areas and also reported that mid-year budget reductions were possible. While most states mentioned that ARRA helped to avoid or mitigate provider rate cuts, many more states cut or froze rates in FY 2009 than planned (33 versus 22 states) and even more states are cutting or freezing rates for FY 2010 (39 states). Several states are considering additional provider rate cuts that have not yet been implemented. More than any other policy area, provider payment rate changes have served as a barometer of fiscal conditions. All states cut provider rates during the last economic downturn from 2001 to 2004, but then worked to restore these cuts as the economy improved in 2005 to 2008, and now

states are once again turning to rate restrictions to generate program savings. Rate cuts can jeopardize provider participation and therefore access to needed care. ARRA also helped states avoid or mitigate the severity of Medicaid benefit cuts in FY 2009; however, the number of states reporting benefit restrictions for FY 2009 (10 states) or FY 2010 (15 states) increased significantly from FY 2008. These benefit cuts include the elimination of covered benefits, the application of utilization controls or limits for existing benefits. In California, Michigan and Utah, however, the benefit cuts were more extensive with multiple benefits eliminated.

ES Figure 3

State Policy Actions, FY 2009 – FY 2010



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. Eligibility includes eligibility and application expansions/restrictions.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009.

ARRA helped to protect Medicaid eligibility. 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. States that had implemented restrictions had to reverse the restrictions to come into compliance with the ARRA maintenance of eligibility requirements. According to this survey, ARRA requirements resulted in 14 states reversing and 5 states abandoning planned restrictions to eligibility. Separate from these eligibility changes tied to ARRA, 29 states in FY 2009 and 31 states in FY 2010 reported positive eligibility changes to increase eligibility standards or initiatives to streamline application processes despite worsening fiscal conditions. Some of the efforts to streamline enrollment could help states qualify for performance bonus payments related to increased Medicaid enrollment that were enacted as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA). Many eligibility changes are expected to affect only a small number of beneficiaries, but Colorado, Maryland, New York, Oklahoma, and Wisconsin are implementing broader reforms and eligibility expansions.

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 FY 2008. In FY 2009, 32 states took actions that expanded LTC services (primarily expanding home and community based services (HCBS) programs, and 35 states planned expansions for FY 2010 compared to 42 states in FY 2008. However, states reporting long-term care reductions (eight states in FY 2009 and 12 in FY 2010) tended to be more focused on HCBS services (rather than institutional services) than in the

past. Most states already have limits in place for HCBS such as coverage limits, enrollment caps, and waiting lists for services, but states' ability to impose certain eligibility HCBS restrictions is currently limited by the ARRA maintenance of eligibility (MOE) requirements. 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.

States continue to adopt policies to manage and coordinate care, to improve quality and to expand the use of health information technology. Nineteen states in FY 2009 and 20 states in FY 2010 have implemented or plan to expand managed care by expanding service areas, adding eligibility groups to managed care, requiring enrollment into managed care or implementing managed long-term care initiatives. Specifically, six states in FY 2009 and eight states in FY 2010 have been applying the principles of managed care in the long-term care area. Twelve states in FY 2009 and 14 states in FY 2010 are implementing new or expanded disease management programs. In FY 2010, there was a dramatic uptick in Medicaid health information technology (HIT) initiatives, such as e-prescribing or electronic health records, driven, in part, by federal funding made available to states from the DRA Medicaid Transformation Grants and the HIT funding included in ARRA.

Looking forward, states struggle with the major uncertainties related to the economy and the outcome of national health reform. As states look ahead to FY 2011, considerable uncertainty remains regarding the prospects for improved economic conditions. While the recession may have officially ended by then, improvements in state revenues and slower enrollment growth are expected to lag behind other economic recovery indicators. With few options left to achieve significant additional Medicaid cost reductions, and faced with the expiration of the ARRA enhanced FMAP in December 2010, many states believe they may be pressured to consider previously unthinkable eligibility and benefit reductions. Another enormous "unknown" for states as they plan for the future is the outcome of health care reform discussions currently underway at the federal level. While Medicaid Directors generally support the principles underpinning federal reform, these changes could bring dramatic changes to state Medicaid programs. It is highly likely that federal health care reform, if successful, will build on existing state Medicaid programs potentially resulting in new fiscal and administrative challenges for states. Along with these challenges, however, is the potential opportunity to address the long desired goals of better managing high need populations (including the dual eligibles), simplifying Medicaid eligibility rules, streamlining the enrollment process, and closing the gaps in the current health care social safety net.