kaiser commission on medicaid and the uninsured

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Waiting for Economic Recovery, Poised for Health Care Reform: A Mid-Year Update for FY 2011 - Looking Forward to FY 2012

Executive Summary

Fiscal stress remains a dominant concern for states as they cope with lingering effects of the recession. Many states are facing budget shortfalls and revenues remain depressed half-way through FY 2011. States, many with new governors and legislators, are preparing budgets for FY 2012, anticipating a slow economic recovery and expiration of temporary, enhanced federal Medicaid matching funds from the American Recovery and Reinvestment Act (ARRA) on June 30, 2011. At the same time, states are moving forward with implementation of the Patient Protection and Affordable Care Act (ACA). Even in these challenging times, Medicaid continues to play a vital role in supporting providers, ensuring access to long-term care services and providing coverage to many low-income individuals who would otherwise be uninsured. This report, based on structured discussions with leading Medicaid directors, augments the findings from the most recent comprehensive Medicaid budget survey published in September 2010 to provide a mid-year 2011 update on state Medicaid issues.[1] Key findings include:

State revenues are still far below pre-recession levels and revenue growth remains weak in almost all states. Although aggregate state tax revenue data show modest increases for 2010, most state revenue collections remain far below pre-recession levels. Economic conditions may be moving in the right direction, but states continue to face severe budget gaps.

Medicaid enrollment is rising at a slower but still high rate in 2011 compared to 2010 – and remains above original growth projections in some states. Medicaid is a counter-cyclical program, meaning more people need the program and enrollment increases during economic downturns; enrollment is the primary driver of Medicaid spending. Historical trends indicate that there will be less pressure on Medicaid enrollment growth (and spending growth) as the economy improves and unemployment declines. In December 2010 the national unemployment rate fell to 9.4% down from a high of 10.1% in October 2009. Following these trends, national Medicaid enrollment growth for FY 2011 was projected to be 6.1%, slower than the 8.5% rate in FY 2010, but still high.

Even with the enhanced FMAP, a number of states must make mid-year budget cuts to close shortfalls for FY 2011. The Medicaid ARRA funds have been critical to states in helping to manage their budgets and maintain Medicaid eligibility (to be eligible for the ARRA funds, states could not restrict Medicaid eligibility or make it more difficult to apply for coverage). However, even with the ARRA funds, states have implemented an array of Medicaid cost containment strategies including provider rate cuts, benefit restrictions, provider assessments and administrative cuts. Beyond cuts planned for FY 2011, several states (including Washington, Indiana and South Carolina) proposed mid-year cuts to Medicaid.

States, many with new gubernatorial and legislative leadership, are preparing budgets for FY 2012 that must account for the expiration of the ARRA enhanced Medicaid matching funds in June 2011. Headed into FY 2012, states do not expect revenue collections to recover to a level sufficient to avoid additional budget cuts. With the end of the ARRA Medicaid funds, the state share of Medicaid will increase by one-fourth to one-third adding more fiscal stress for Medicaid and state budgets in 2012. Developing FY 2012 budgets will be challenging due to the fiscal situation along with the need to educate many newly elected officials about the role of Medicaid on beneficiaries, providers and state economies.

States are moving forward with the implementation of health reform. As states implement health reform, officials remain concerned about issues such as workforce shortages and timelines to be ready for major changes in 2014. In the near term, there are some new opportunities for increased funding through Medicaid such as reimbursement up to 90% for new eligibility and enrollment systems, the new health home option and other grant and demonstration programs to test care delivery and payment system reforms. These options help to achieve cost savings and improve care.

[1] Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz, and Laura Snyder, "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends," The Kaiser Commission on Medicaid and the Uninsured. September 2010. http://www.kff.org/medicaid/8105.cfm.

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Introduction and Background

In the midst of the worst economic downturn since the Great Depression, states continue to struggle with revenue shortfalls and the need to balance overall state budgets at a time that spending for Medicaid continues to grow. The continuing fiscal stress is a dominant factor affecting the remainder of FY 2011, the preparation of FY 2012 budgets as well as state efforts to implement health reform. This report provides a mid-fiscal year 2011 update on state Medicaid issues, augmenting the findings from a comprehensive Medicaid budget survey conducted at the beginning of the fiscal year, in July and August of 2010.[2] This report updates the findings from the annual survey, based on structured discussions in November and December 2010 with leading Medicaid directors, including those who serve on the Executive Committee of the National Association of Medicaid Directors.

Medicaid is a federal entitlement program administered by the states. Medicaid provides health care and long-term care services and supports to low-income Americans. Subject to federal rules, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. In 2010, Medicaid served approximately 60 million individuals with estimated total expenditures of $427 billion.[3]

Medicaid is jointly financed by the states and federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage, or FMAP. A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all states prior to FY 2009 was 57 percent, but ranged from a federally established FMAP floor at 50 percent to as high as 76 percent. With the passage of the American Recovery and Reinvestment Act (ARRA) stimulus package, FMAP rates for all states increased by a minimum of 6.2 percentage points between October 1, 2009 and December 31, 2010, plus an additional increase adjusted quarterly based on the state's unemployment rate. In the 4th quarter of FFY 2010, the FMAPs across the states ranged from 61.59 percent to 84.86 percent.[4]

In August 2010, the President signed a bill extending the ARRA enhanced FMAP on a phased-down basis for two additional quarters through June 30, 2011.[5] The unemployment adjustment remained in the extension, but the law phased down the across-the-board base increase of 6.2 percentage points to 3.2 percentage points from January 1, 2011 to March 31, 2011, and to 1.2 percentage points from April 1, 2011 to June 30, 2011. Almost every state legislature had enacted its 2011 budgets prior to enactment of the extension, and with the uncertainty about whether Congress would extend the enhanced FMAP, each state was forced to make an assumption about whether the higher FMAP would continue beyond December 2010.

Even with fiscal relief provided by the extension of ARRA enhanced Medicaid matching rates and the fact that economists pegged June 2009 as the official "end" of the recession, state budgets remain under considerable stress in FY 2011, and without exception state policy leaders expect the fiscal stress to extend into 2012. Unemployment remains high, and state revenues remain depressed. The recession resulted in the highest rate of growth in Medicaid enrollment – 8.5 percent in FY 2010 – since 2002. Total growth in Medicaid spending averaged 8.8 percent across all states in FY 2010. In adopting Medicaid budgets for FY 2011, state legislatures authorized Medicaid spending and enrollment growth at slightly lower levels compared to FY 2010; however, state Medicaid officials in about two-thirds of states indicated that they expected that the

[2] Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz, and Laura Snyder, "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends," The Kaiser Commission on Medicaid and the Uninsured. September 2010. http://www.kff.org/medicaid/8105.cfm.

[3] Office of the Actuary, Centers for Medicare and Medicaid Services; National Health Expenditure Projections 2009-2019. The data include Children's Health Insurance Program (CHIP) enrollment and expenditures.

[4] Kaiser State Health Facts, accessed 12/20/10 at http://www.statehealthfacts.org/comparetable.jsp?ind=695&cat=4&sub=154&yr=1&typ=2.

[5] P.L 111-226

initial appropriations would be insufficient to sustain the program through the end of the fiscal year.[6] Mid-way through FY 2011, states were struggling to close budget shortfalls, anticipating the end of the ARRA enhanced matching rates and still working toward health reform implementation. Many states were also facing transitions in leadership as a result of the November elections. It was within this context that discussions took place with Medicaid directors in November 2010.

Methodology

The Kaiser Commission on Medicaid and the Uninsured invited Medicaid directors who serve on the Executive Committee of the National Association of Medicaid Directors (NAMD) to participate in a special discussion concerning the status of state Medicaid programs, the lingering effects of the recession, and state preparation for health reform. The forum focused on state economies, Medicaid enrollment and budget trends; policy directions including the impact of the state elections that occurred in November 2010; and state progress and concerns about implementing the ACA. The structured discussion took place on the evening before the NAMD annual meeting held in Crystal City, Virginia.

Participating in the discussion were nine state Medicaid directors representing the states of Alabama, Indiana, Kansas, Maine, Pennsylvania, South Carolina, Tennessee, Washington, and West Virginia. Also participating were staff from the American Public Human Services Association. Subsequent to the structured discussion with the Executive Committee, informal discussions occurred with over half of Medicaid directors from other states in person or by telephone in November and December 2010. This report reflects this collective input from Medicaid directors in over half of the states.

Key Findings

State revenue growth remains weak and revenue levels are still far below pre-recession levels in most states.

State revenues declined at all-time record rates for five consecutive quarters in fiscal year 2009 and 2010. In fact, total state revenues declined by 30.8% over the course of 2009 compared to 2008.[7] While some states are beginning to see positive revenue growth, collections remain below pre-recession levels. According to the U.S. Census Bureau, revenues increased by 4.8 percent in the third quarter of 2010 compared to the third quarter of 2009 (marking the fourth consecutive quarter of positive growth), but still fell below the 2008 third quarter results.[8] In our discussions, Pennsylvania and Indiana reported a slight uptick in revenue growth and some states like Delaware reported that revenues were finally flat instead of falling. A number of states still reported that revenue projections had proven to be too optimistic, contributing to budget shortfalls.

Recent reports show that states have had to close budget gaps of over $430 billion in FYs 2009, 2010, and 2011. For FY 2011, 46 states have reported budget gaps of $130 billion as of December 2010 that could reach an estimated $160 billion. The funding provided in the ARRA will partially offset $60 billion in state budget gaps over the course of FY 2011.[9] Resolving the budget shortfalls is now particularly difficult, since program reductions and one-time strategies to plug gaps have already been used in most states.

[6] V.Smith et.al. September 2010.
[7] "U.S. Census Bureau Reports State Government Revenues Decline Nearly 31 Percent." U.S. Census Bureau Release, January 5, 2011. http://www.census.gov/newsroom/releases/archives/governments/cb11-03.html.
[8] Quarterly Summary of State & Local Tax Revenue. U.S. Census Bureau, December 28, 2010.
[9] McNichol, Elizabeth, Phil Oliff and Nicholas Johnson. "States Continue to Feel Recession's Impact." Center for Budget and Policy Priorities, December 16, 2010. http://www.cbpp.org/cms/index.cfm?fa=view&id=711.

Medicaid enrollment is rising at a slower but still high rate in 2011 compared to 2010 – and remains above original growth projections in some states.

Overall, states projected Medicaid enrollment to increase on average by 6.1 percent in FY 2011, a somewhat lower rate of growth compared to the average 8.5 percent rise experienced in FY 2010. In contrast to the situation in mid-FY 2010, when 44 states indicated that enrollment was increasing faster than the original projection at the beginning of the fiscal year, the consensus among state Medicaid directors was that enrollment for FY 2011 was growing at a rate close to original projections with growth slowing or leveling from FY 2010 rates. However, a few states (e.g., Washington) described Medicaid enrollment growth as exceeding projections for FY 2011. The persistently high unemployment rate in many states continues to be a factor in the high rates of Medicaid enrollment growth.

The Bureau of Labor Statistics unemployment data showed that the national rate peaked at 10.1 percent in October 2009. In November 2010, over a year later, nine states had unemployment rates that remained at or above 10 percent. The U.S. unemployment rate fell to 9.4 percent in December 2010. While moving in the right direction, the rate is still high, contributing to ongoing robust Medicaid enrollment growth. Medicaid enrollment is the primary driver of Medicaid expenditures, so with Medicaid enrollment (and spending) still climbing at a strong pace while states experience budget shortfalls, state Medicaid officials are under great pressure to make difficult decisions around further program cuts.

A number of states must make mid-year budget cuts to close shortfalls for FY 2011.

Eleven states have reported new mid-year shortfalls for FY 2011 since budgets were originally adopted.[10] In our discussions, several states including South Carolina, Indiana, Washington, and Connecticut were facing mid-year budget cuts to cover FY 2011 budget shortfalls. In adopting Medicaid budgets for FY 2011, state legislatures authorized Medicaid spending and enrollment growth at slightly lower levels compared to FY 2010; however, state Medicaid officials in about two-thirds of states indicated at the time that they expected that the initial appropriations would be insufficient to sustain the program through the end of the fiscal year. Some budget shortfalls for FY 2011 may be a result of what states assumed about the extension of ARRA when they adopted their budgets. Twenty-six states and the District of Columbia adopted budgets that assumed a 6-month extension of the full 6.2 percent base FMAP enhancement.[11] These states needed to make mid-year budget corrections to address the lower level of federal support. On the other hand, almost half the states adopted budgets assuming no extension of the enhanced FMAP, and these states benefited from funding they had not accounted for that could be used to address Medicaid and statewide budget shortfalls in FY 2011.

As a condition of accepting ARRA stimulus funding, all states also accepted certain conditions including prohibitions on restricting Medicaid eligibility, either by cuts in eligibility levels or by implementing more restrictive enrollment standards, methodologies and processes under their State plan, waivers and demonstration programs than those that were in place on July 1, 2008. Since the start of the recession, all states have already implemented provider rate cuts or freezes, benefit cuts and restrictions, provider taxes and assessments, utilization controls, fraud and abuse reduction strategies and numerous administrative cuts (travel bans, hiring freezes, furloughs and layoffs) to reduce Medicaid cost growth. The annual survey of Medicaid programs showed that 20 states reduced Medicaid benefits in FY 2010, more than in any year in the past decade, and 14 states planned to reduce benefits in FY 2011.

[10] Ibid.
[11] V.Smith et.al. September 2010.

Medicaid directors noted further savings will be difficult to find, require tough decisions, and inevitably will have consequences on beneficiaries. In Washington, the elimination of Medicaid prescription drug coverage for adults is slated to go into effect in March to help close a budget shortfall in that state. The state legislature may act to prevent that cut from going into effect. Other states, including Tennessee and Illinois noted that they are running out of cash to pay providers as a result of state budget shortfalls.

In November and December of 2010, Indiana announced a series of cuts taking effect on January 1, 2011 including several provider rate cuts, limits on therapy visits, reductions in vision coverage and the imposition of prior authorization requirements on all non-emergent inpatient hospital admissions (excluding deliveries).[12] South Carolina also announced in December 2010 numerous Medicaid service cuts to help offset a budget shortfall of $228 million during FY 2011 including the elimination of podiatry, dental, vision, and hospice services for adults; insulin pumps for Type II diabetics; certain wheelchair accessories and standard circumcision for newborns. South Carolina planned to restrict services including rehabilitation; diabetic shoes and inserts; home health visits; chiropractic services; adult outpatient behavioral health visits, and power wheelchair replacements. South Carolina also eliminated and restricted several services from the Community Long Term Care Program. In addition, co-payments were increased for all non-exempt Medicaid enrollees.[13]

States, many with new leadership, will prepare budgets for FY 2012 that must account for on-going state budget shortfalls and the expiration the ARRA enhanced Medicaid matching fund.

For FY 2012, 40 states already project gaps that total $113 billion and that figure could grow to $140 billion.[14] The expiration of the enhanced Medicaid ARRA funds on July 1, 2011, is contributing to additional fiscal stress for Medicaid and aggregate state budgets as states develop budgets for FY 2012. As a result of the end of the enhanced FMAP, the state cost of Medicaid is expected to increase in FY 2012 by one-fourth to one-third compared to FY 2011. Medicaid directors communicated that it was hard for states to maintain Medicaid spending over the past three years even with the enhanced FMAP. While state revenues are starting to rebound, state budgets have not recovered to the extent that they can absorb the increase in fiscal burden that will occur in July 2011 when the enhanced FMAP is no longer in place. Medicaid directors stressed that there are no "magic bullets" to achieve substantial new savings.

Changes in governors, legislators and staff will have implications for the FY 2012 budget development process and Medicaid. The elections held in November 2010 resulted in an historic shift in state leadership for 2011. Gubernatorial elections took place in 37 states, with the election of 26 new governors taking office in January 2011. In fourteen states, the political party of the governor changed: a shift from a Democratic to Republican governor in 10 states—Iowa, Kansas, Michigan, New Mexico, Ohio, Oklahoma, Pennsylvania, Tennessee, Wisconsin, and Wyoming. A shift from a Republican to Democratic governor occurred in four states—California, Hawaii, Minnesota, and Vermont. New leadership at the state level typically extends to the appointment of key personnel in state Health and Human Service agencies, Medicaid agencies, and other state departments.

Developing a budget for FY 2012 is one of the first things new governors and legislatures will turn their attention to. Medicaid Directors noted that it inevitably will take time for the new leadership to thoroughly assess the severity of the budget crisis and the limited options available for addressing it, particularly when the focus is on achieving new savings in the Medicaid program. Directors noted the need to devote significant time towards working with and educating new leadership and staff about how Medicaid works,

[12] See Indiana Medicaid Provider Bulletins accessed at http://provider.indianamedicaid.com/ihcp/Publications/bulletin_results.asp.
[13] South Carolina Department of Health and Human Services. Medicaid Bulletin to Medicaid providers, December 14, 2010.
[14] E. McNichol et. al. December 16, 2010.

the role it plays for beneficiaries, providers, and state economies, and the limited ability to find significant new savings in the program, despite severe budget shortfalls.

States will also continue to move forward with the implementation of health reform.

Changes in leadership will also affect efforts to implement health reform as the new leadership grapples with budget issues and gets up to speed on policy issues. Compounding the challenges resulting from leadership changes are challenges associated with state workforce shortages and voids in institutional knowledge due to layoffs and early retirements occurring at record pace in many states. A few states are also moving forward with organizational changes that relate to health reform. For example, Washington is moving to create a Health Authority that would have primary responsibility for Medicaid and other health reform responsibilities. Meanwhile, new Kansas Governor Brownback has proposed to eliminate the Kansas Health Policy Authority that administers Medicaid and move its functions to the Department of Health and Environment.

States continue to move forward with health reform, but remain concerned about their ability to meet deadlines to implement major changes by 2014. Medicaid directors believed that the proposed rules released in November to reimburse new eligibility and enrollment systems at a 90 percent federal match rate would provide substantial help and resources to move forward in this area; however, many were still concerned about the timing and funding required to develop new eligibility systems. Also, a number of ACA provisions go into effect before 2014, including the new health home option that provides enhanced matching funds for care coordination as well as grant programs and new demonstrations to test care delivery systems and payment systems for high cost beneficiaries. These new opportunities may help to implement reform and provide some options to achieve cost savings and improve care in the interim.

Conclusion

Mid-way through state fiscal year 2011, many state Medicaid directors find themselves facing a need for yet more budget cuts, hard on the heels of two or more consecutive years of severe fiscal restraint. States continue to suffer the economic and programmatic effects of the recession as unemployment remains high. Demand for services continues to increase while the number of options available to cover the cost of those demands continues to shrink. The partial extension of the ARRA enhanced FMAP through July 1, 2011 (an additional six months) provided much needed additional relief to states and helped to alleviate some budget pressure, although significant budget shortfalls continue for a number of states. Without a more robust economic recovery, however, states do not expect to have the resources to replace the ARRA funds when the extension expires on June 30, 2011. Having already used many one-time strategies and program cuts to address Medicaid budget shortfalls (especially benefit and provider rate cuts), Medicaid directors said that it would be extremely difficult to find new options to contain costs that do not represent deep cuts to the program.

The ACA legislation maintains eligibility levels until broader health reform goes into effect; however, in the near term funding opportunities related to health reform, including increased federal funding for new state eligibility and enrollment systems, new state options to improve care coordination and other grant and demonstration programs to test new delivery and payment system reforms, particularly for high cost beneficiaries, may help states to achieve cost savings and improve care before broader health reform goes into effect in 2014. Nevertheless, states will continue to confront many challenges in the year ahead related to the slow economic recovery, fiscal stress, the end of federal fiscal relief in Medicaid and the continued push to implement reform along with transitions in leadership in many states. Even in these challenging circumstances, Medicaid continues to play a vital role in the nation's health care system, supporting providers, ensuring access to long-term care services and supports and providing health care to many low-income individuals who would otherwise be uninsured.

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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.