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Struggling with Financing: The Recession and National Health Reform Dominate State Medicaid Concerns Going into FY 2010

As most states faced the beginning of state fiscal year 2010, the two major forces now affecting states and their Medicaid programs were: the effects of the economic downturn and the federal health reform discussions that would include a greater role for Medicaid. Jointly financed and administered by the federal government and states, Medicaid provides affordable and comprehensive health and long-term care coverage to 60 million low-income Americans. This brief provides insights from discussions with leading Medicaid directors, from June 2009.

- ***The recession is having a major effect on state Medicaid programs.*** Medicaid directors across the country reported serious economic stress related to Medicaid enrollment increases and revenue shortfalls (in some states up to 40%). The national unemployment rate hit 9.5% in June 2009, up from 4.9% at the start of the recession in December 2007 which is expected to result in about 4.5 million new Medicaid/CHIP enrollees. One Medicaid director noted that new Medicaid enrollment over the most recent three month period equaled the total growth in enrollment that had occurred over the entire preceding year.

- ***The American Recovery and Relief Act of 2009 (ARRA) has been pivotal in helping states address budget shortfalls, avoid or soften Medicaid program cuts and preserve eligibility.*** The ARRA provides an estimated $87 billion that states will receive through enhanced federal Medicaid matching funds from October 2008 through December 2010. States were able to access these funds quickly and one director said "we would not have been able to make it through without the stimulus funding." Medicaid eligibility has been protected from other budget cuts because the ARRA requires that states not restrict Medicaid eligibility levels below the standards in place as of July 1, 2008. Directors fear that state economies will still be weak and that large budget gaps that will emerge when the enhanced FMAP ends in 2011.

- ***As the recession worsens there is an intense focus on Medicaid cost containment and significant Medicaid cuts are on the table.*** Even with the enhanced FMAP under ARRA, major cuts are still expected for Medicaid to help address severe budget gaps. Most directors reported that the primary goal for fiscal year 2010 is to maintain current programs. Because most states undertook aggressive cost containment actions during the 2001-2004 economic downturn, there are few opportunities for further savings. Despite economic challenges, a few states remain committed to maintaining and advancing initiatives to address the uninsured.

- ***States see health reform as critical, but have concerns.*** At the time of the discussions with the Medicaid directors, a specific reform proposal was not yet on the table but options under consideration included significant Medicaid expansions. While directors were supportive of federal reform efforts, they raised a number of concerns relating to the fiscal impact on states, provider and administrative capacity, how Medicaid would be integrated with the larger health care reform effort and the time needed for implementation of major reforms.

Serious economic conditions persist at the state level which will cause Medicaid enrollment to continue to rise. Enhanced federal Medicaid funds from ARRA have been key in helping states to address shortfalls and preserve Medicaid eligibility. Even as the economy starts to turn around, the effects on unemployment and Medicaid enrollment will lag behind and continue to rise at the same time that ARRA funds will expire resulting in further pressures on state budgets. While states struggle to maintain coverage, their ability to finance their current programs is in jeopardy and questions remain about any new financing responsibilities that states will face as a result of federal health reform discussions.

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INTRODUCTION

The purpose of this report is to highlight the issues, concerns and priorities of state Medicaid officials as they faced the beginning of state fiscal year 2010. The timing of this report is significant because of two major forces now affecting states and state Medicaid programs. The first relates to the effects of the economic downturn and its significant impact on state revenues, Medicaid enrollment and spending. The second relates to the ongoing federal health reform discussions, and the fact that all of the major proposals now under discussion envision a greater role for Medicaid. Given the significance of these forces, this promises to be a historic year for Medicaid and its role in the nation's health care system.

Medicaid is a federal – state program that has become the cornerstone of the nation's health care safety net. In 2009, Medicaid will assure health coverage for over 60 million low-income individuals and spending will total over $386 billion.[1] Medicaid is designed to be counter-cyclical. As a result, during a time of economic downturn such as the current recession, more persons qualify and enroll in the program, causing Medicaid spending to increase at exactly the same time state revenues are depressed and state budgets are strained. Since Medicaid is one of the largest programs in state budgets, policy makers face a difficult challenge in maintaining Medicaid programs during economic downturns.

Even a few months into the last state fiscal year, [2] the fiscal situation was dramatically worse for states than state policy makers had anticipated when the Medicaid budgets were adopted. States reported in mid-fiscal year 2009 that their Medicaid enrollment and spending had begun to grow at a pace faster than projected. Indeed, by mid-fiscal year 2009 some states had already begun to reduce provider rates, restrict benefits and consider or implement restrictions in eligibility policy or procedures. Several states indicated that if the fiscal situation continued or did not improve that they almost certainly would have to consider significant program cuts before the end of the fiscal year.[3]

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[1] Andrea Sisko, Christopher Truffer, Sheila Smith, Sean Keehan, Jonathan Cylus, John A. Poisal, M. Kent Clemens, and Joseph Lizonitz (CMS Office of the Actuary), "Health Spending Projections Through 2018: Recession Effects Add Uncertainty To The Outlook," *Health Affairs Web Exclusive*, 24 February 2009, pp. w346 - 357.

[2] State fiscal years begin on July 1 in 46 states. The state fiscal year begins on April 1 in New York, on September 1 in Texas, and on October 1 in Alabama, Michigan and the District of Columbia.

[3] Vernon K. Smith, Eileen Ellis, Barbara Edwards and Robin Rudowitz, *Medicaid in a Crunch: A Mid-FY 2009 Update on State Medicaid Issues in a Recession,* Kaiser Commission on Medicaid and the Uninsured, January 2009. This report is an update to: Vernon Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, Molly O'Malley and Caryn Marks, *Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn*, Kaiser Commission on Medicaid and the Uninsured, September 2008. Available at: http://www.kff.org/medicaid/upload/7815.pdf.

Unfortunately for states, the economy did not improve in early calendar 2009. Job and revenue losses continued. The latest data from the U.S. Department of Labor indicate that an additional 467,000 jobs were lost during June 2009, bringing the net total of jobs lost in the eighteen months since the beginning of the recession to over 6.5 million. The U.S. unemployment rate in June increased to 9.5 percent, the highest level since 1983.[4]

For states, the full effect of the economic downturn was seen in two significant ways. First, the rising rate of unemployment resulted in increases in Medicaid and CHIP enrollment and in state costs for these programs.[5] Second, the economic downturn caused dramatic drops in state tax revenues and challenged the ability of states to finance these programs. The latest data on overall state tax collections in the January – March quarter showed a decrease of 11.7 percent from the same period in the prior year, the largest decline on record. Actual decreases in revenue occurred in 47 states. Further, as reported by The Rockefeller Institute of Government, "Early figures for April and May of 2009 show an overall decline of nearly 20 percent for total taxes, a further dramatic worsening of fiscal conditions nationwide."[6]

Congress took two significant actions early in calendar year 2009 that were designed to assist states in assuring and financing coverage through Medicaid and CHIP. First, Congress adopted the Child Health Insurance Program Reauthorization Act (CHIPRA). CHIPRA was significant because it renewed and expanded funding for children's coverage and provided new tools and incentives for states to increase participation for children eligible but not yet enrolled in CHIP and Medicaid.

The second major Congressional action was the American Recovery and Reinvestment Act of 2009 (ARRA). Responding to the dire economic situations across the states and building on the experience of an enhanced Medicaid formula in the previous recession in 2003 and 2004, ARRA provided approximately $87 billion to states through enhanced federal Medicaid matching funds over the period from October 2008 (retroactively) through December 2010. To qualify for these funds, states had to assure both prompt payment to medical providers, and that eligibility levels and processes were not more restrictive than those in effect in July 2008. The Act provides all states with a 6.2 percent increase in federal Medicaid match rates and then targets additional help for states experiencing the greatest increase in unemployment rates.

Now on the horizon is national health reform. Even though the details are not yet developed, the attention to the issue is already affecting state Medicaid leaders as they consider policy options in the current economic environment.

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[4] U.S. Department of Labor, July 3, 2009.

[5] A one percent increase in U.S. unemployment rate was associated with an increase of 1.0 million Medicaid and CHIP enrollees, an increase of 1.1 million uninsured and $3.4 billion in state and federal expenditures for Medicaid and CHIP. See: Stan Dorn, Bowen Garrett, John Holahan, and Aimee Williams, "Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses," Kaiser Commission on Medicaid and the Uninsured, April 2008.

[6] Donald J. Boyd and Lucy Dadayan, "State Tax Decline in Early 2009 Was the Sharpest on Record," The Rockefeller Institute of Government, *State Revenue Report*, July 2009, No. 76.

METHODOLOGY

This report is based on a structured discussion and interviews with the Executive Committee of the National Association of State Medicaid Directors (NASMD), and selected additional Medicaid directors, in June 2009. The Executive Committee of NASMD is comprised of eleven leading Medicaid directors, including two each from four geographic regions of the country (the Northeast, Midwest, South and West) plus the Chair, Vice-Chair and Immediate Past Chair. Executive Committee members are elected by their peers in each region and the officers are elected by all state Medicaid directors. To include states with both severe and less severe economic conditions, three additional Medicaid directors were included in the discussion and interviews. The views expressed in this report reflect the discussions with these directors, who represented a total of 13 states.

Health Management Associates facilitated the discussion and follow up interviews regarding the current status and direction of the Medicaid programs across the states. We thank Medicaid directors from Alabama, Arizona, California, Colorado, Connecticut, Illinois, Massachusetts, Nevada, New Mexico, Oklahoma, Pennsylvania, Tennessee and Washington for participating in the discussion of current Medicaid issues. We especially thank the Executive Director and staff of the National Association of State Medicaid Directors for their cooperation and participation.

KEY ISSUES

The struggling economy and its implications for Medicaid were uppermost in the minds of Medicaid directors who, along with other state policy makers, are facing the challenges created by state budget shortfalls of historic proportions. In the states represented, a strong aversion to tax increases has led to enormous pressure for state spending cuts across the board. While federal stimulus funds have been helpful, they have been inadequate in some cases to fully address Medicaid and other state general fund budget shortfalls, and Medicaid directors are concerned about what will happen when the enhanced federal funding ends. Directors were also focused on current federal health care reform discussions, including the prospect for Medicaid eligibility expansions that might place further demands on state financing. A discussion of these key issues follows.

1. The recession is having a major effect on state Medicaid programs.

Medicaid directors from all areas of the country reported serious economic stress, with state revenue shortfalls placing great pressure on Medicaid and all other state programs. While a few states have experienced less severe recessionary impacts, states hardest hit by reversals in the housing and other markets, such as California, Nevada and Arizona, reported unprecedented reductions in state revenues – as high as 30 to 40 percent.

At the same time that state resources for administering Medicaid and other programs are diminishing, demand for services in the form of enrollment growth has surged in many states – especially in the eligibility categories most impacted by unemployment increases, low-income families and children. One Medicaid director noted that new Medicaid enrollment over the most recent three month period equaled the total growth in enrollment that had occurred over the entire preceding year. Medicaid directors in two other states with waiver programs that offer subsidized coverage for uninsured individuals also reported that enrollment has grown dramatically in these programs as well.

Despite the great pressure to cut spending to address growing budget shortfalls, several Medicaid directors observed that state policymakers are generally reluctant to cut Medicaid, often protecting Medicaid during economic downturns from the severity of budget cuts felt by most other state funded programs. Unlike state funded programs, every state dollar spent on Medicaid at a minimum draws down one dollar in federal Medicaid matching funds making Medicaid an important state economic driver. In some states with higher federal matching rates, the ratio can be as high as three federal dollars for every state dollar. In these states, every state dollar cut from Medicaid results in a total loss of four dollars in the state's health care economy creating a strong disincentive for cuts. Nevertheless, the depth of the current fiscal crisis and the anticipated prolonged duration of depressed state revenues are leading many states to consider or enact serious Medicaid cuts.

A number of states, including California, Michigan, Ohio and Hawaii, are experiencing layoffs and unpaid furlough days for Medicaid staff (along with other state employees) which adds to the challenges of administering Medicaid programs faced with increasing demand as a result of the recession.

2. The American Recovery and Relief Act of 2009 (ARRA) has been pivotal in helping states address Medicaid and other budget shortfalls, avoid or soften Medicaid program cuts and to preserve eligibility.

Directors reported that the federal stimulus funds flowing to Medicaid under ARRA have clearly mitigated or prevented more serious cuts to the program. The ARRA provides an estimated $87 billion that states will receive through enhanced federal Medicaid matching (known as Federal Medical Assistance Participation, or FMAP) rates for nine quarters (October 2008-December 2010). The enhanced FMAP for the first two quarters became available to states on February 25th – less than two weeks after the act was signed by President Obama on February 17, 2009 – while most state legislatures were in the midst of crafting budgets for FY 2010.

One Medicaid director noted that the ARRA funds were vital to preserving funding for the Medicaid program stating "we would not have been able to make it through without the stimulus funding." Reflecting the views of several directors, another observed that the severity of the fiscal crisis would have forced his state to consider enrollment cuts, noting, "I don't know how we could have addressed a hole of that size without cutting

eligibility." Other directors also mentioned the likelihood of eligibility cuts in the absence of the ARRA funds including one director who indicated that *all* optional eligibility categories would have been cut including optional aged and disabled nursing home residents.

Because the ARRA requires that states not reduce Medicaid eligibility levels below the standards in place as of July 1, 2008 to be eligible for the enhanced FMAP, several states reported that recent restrictions in eligibility standards or eligibility processes had to be reversed. ARRA does not prohibit cuts to benefits or provider rates.

A few states reported that, even with the enhanced FMAP under ARRA, the size of the state's revenue shortfall is so significant that serious cuts are still expected for Medicaid. Other directors report that, as new estimates of revenue continue to be adjusted downward, they expect to face new calls for program spending reductions.

3. As the recession worsens there is an intense focus on Medicaid cost containment and significant Medicaid cuts are on the table.

The unprecedented nature of the current economic situation in states has dramatically narrowed the focus of many Medicaid directors in state fiscal years 2009 and 2010. In state fiscal years 2007, 2008 and even early in 2009, many states had reported efforts to restore program cuts and restrictions enacted during the previous recession. Several states were also engaged at that time in implementing initiatives to expand coverage to the uninsured, reform service delivery arrangements to improve quality, and rebalance long-term care systems to respond to consumer demand for community based services. With a few notable exceptions, the focus at the end of fiscal year 2009 has shifted substantially to developing and implementing cost containment and revenue maximization strategies to respond to the state fiscal emergency. Again, with only a few exceptions, directors reported that ARRA stimulus funds and revenues identified through savings or program reforms are targeted in this environment not to program enhancement, but to minimize cuts to benefits and provider rates.

Most directors reported that the primary goal for fiscal year 2010 is to maintain as much of the current program coverage and value as possible and to minimize loss of services and erosion of access for individuals. Because most states undertook aggressive cost containment actions during the last economic downturn in 2003, 2004 and 2005, many directors see few opportunities for further significant savings. Previous rate cuts and freezes, for example, make it difficult for states to consider additional cuts without compromising access or subjecting themselves to court challenges. Also, some states have Medicaid programs that cover little more than is federally mandated. In these "bare bones" Medicaid programs, directors reported that, before the enhanced FMAP under ARRA, they really had no viable alternatives for closing funding gaps.

With eligibility reductions off the table due to the ARRA maintenance of effort requirements, some states are nevertheless looking at benefit reductions and rate cuts for savings. For example:

- California, facing the largest state budget shortfall in the country, eliminated adult dental coverage and nine other benefits for adults, effective July 1, 2009. Because of the depth of the fiscal crisis in California, there is concern that further cuts may be needed.
- For FY 2010, Colorado will reduce all physical health provider reimbursement rates by 2 percent with the exception of those for primary and preventive care, oral health and direct care providers.
- In FY 2010, Washington State will cut inpatient and outpatient hospital rates and laboratory services by 4 percent and mental health regional support network rates by 3.4 percent. Washington will also reduce reimbursement for prescription drug ingredient costs by 2 percent (to AWP minus 16 percent).

Directors noted that they have placed a priority on holding on to key program enhancements implemented in recent years, such as pay-for-performance and other quality improvement strategies, which they regard as central to their long-term efforts to improve performance and sustainability of their programs. Nevertheless, these initiatives remain vulnerable to the intense need for short-term budget cuts, and new initiatives are difficult to advance with limited administrative resources. One director commented that he still sees the opportunity to pursue new quality initiatives in Medicaid, but only if the legislature is convinced that these activities will be budget neutral over the near term, even if they are not a source of immediate savings. A few directors reported a continued focus on efforts to improve service integration and management for people with chronic conditions, because these initiatives control costs and improve quality and overall program performance.

A few directors noted that the extraordinary fiscal pressures have created an opportunity to take on issues that otherwise might be difficult to address, such as initiatives designed to improve cost-effective utilization of certain drug classes or certain diagnostic procedures, to clarify definitions of medical necessity, or to address the rate of growth in costs for specific services. In some states, there has also been increased political support for full- risk managed care strategies for some or all Medicaid populations, such as persons with disabilities or chronic conditions, even in states where such strategies had not been supported in the past.

4. Despite the recession, some states continue to move forward with coverage initiatives.

Despite economic challenges, three states, Oklahoma, Colorado and Massachusetts, reported that their states continue to maintain or even expand efforts to cover the uninsured. Each of these states has experienced some revenue stress, but each remains committed to coverage expansion. While the Oklahoma and Massachusetts programs pre-date the current recession, Colorado has more recently enacted a provider tax to implement a significant expansion for adults and children.

Like Colorado, a number of other states have also continued to move forward with coverage expansions for children funded through CHIP, even in the face of deteriorating fiscal conditions.[7] Many of these expansions, however, were enacted prior to the current recession or the recent passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA). The directors also took note of certain helpful CHIPRA provisions including new federal funding available for states that had already moved to cover legal immigrants in their state programs and endorsement of Express Lane strategies already adopted for streamlining enrollment. A number of directors also noted that they were awaiting guidance from CMS for some CHIPRA provisions before making plans to move forward. Doubts were expressed, however, regarding the ability of the Social Security Administration to effectively interface with states to facilitate new citizenship documentation options.

5. Directors are seriously concerned about the impact to Medicaid when the enhanced FMAP ends in 2011.

Directors reported that they see a financial "cliff" for the Medicaid program when the enhanced FMAP ends in December 2010. Directors are especially concerned about potential program consequences in states where ARRA funds have been used to backfill state fund reductions in the Medicaid budget. Few if any states expect state revenues to have fully recovered by 2011, with one director reporting that economists in his state were projecting that revenues would not recover to the original projections for FY 2009 until at least FY 2014.

Some directors cautioned that the availability of federal funds in this year and next may be masking the seriousness of state economic difficulties and the on-going challenge of financing Medicaid beyond 2010. They expressed a sense of urgency over the need for policymakers to acknowledge and plan for what happens when the federal stimulus funds expire.

Directors generally described a lack of "reasonable policy options" to make further reductions in Medicaid spending beyond 2010 and predicted that the situation may force states to consider "horrible cuts" to Medicaid in the not-too-distant future. With the expiration of the enhanced FMAP and ARRA's maintenance of effort provisions, cuts could include eligibility reductions that states would normally be loathe to consider. For example, one state noted that it has been forced to consider reducing eligibility for long-term care to federal minimum standards, which would eliminate coverage for many frail elderly who are currently supported in nursing homes and community long-term care settings.

The timing of the end of the enhanced FMAP – in the middle of FY 2011 for most states – may further complicate the budgeting process for states that cannot afford to wait until the last minute to address significant budget gaps. Given the time needed to implement

[7] Kevin Sack, "*Defying Slump, 13 States Insure More Children*," The New York Times, July 19, 2009.

cost containment actions (e.g., to adopt rule changes, satisfy notice requirements, make system changes, etc.), some state legislatures may find it necessary to address potential January 2011 cuts during their 2010 legislative sessions.

6. States see health reform as critical, but have concerns.

The discussion with Medicaid directors occurred while federal policy makers were developing proposals for federal health reform. Although a specific reform proposal was not yet on the table, numerous options had been widely discussed, including options that expanded Medicaid. While directors were strongly supportive of the need for a federal solution to the problem of the uninsured, they raised a number of state concerns relating to the fiscal impact on states, provider and administrative capacity, how Medicaid will be integrated with the larger health care reform effort and the time needed to implement major systems changes.

Given the current fiscal environment, many directors expressed fundamental doubts over the ability of states to absorb new coverage mandates for low-income individuals without full federal funding. One director commented that, without realistic financing strategies, federal reform proposals potentially "make a scary situation scarier" for states and state Medicaid programs. With the recent memory of Medicare Part D transition and the "Clawback" obligation which requires states to help finance the federal Medicare program, Medicaid directors were universally wary of proposals that involve unfunded federal mandates or requirements for maintenance of state fiscal efforts. Some directors suggested, however, that the federal reform debate could provide an opportunity to explore options for adjusting federal and state Medicaid financing responsibilities to better match fiscal capacity including, for example, an expansion of federal responsibility for long-term care services and supports. Another proposal that generated considerable fiscal concern was the possibility that federal reform might mandate Medicaid provider payment rate increases to support access to care that states could not afford.

While state fiscal challenges are the main barrier, some states noted that the talk of a maintenance of effort (MOE) requirement for states under a federal reform strategy has dampened interest in expanding coverage pre-federal reform.

A number of directors also expressed concerns regarding the administrative capacity of states to support implementation efforts including the system changes that would be needed to coordinate Medicaid with coverage provided through a potential new insurance exchange. Allowing sufficient time to plan for implementation was also a concern as were issues relating to the sufficiency and capacity of local provider communities to handle the likely increased demand for health care services.

Finally, directors noted that state officials have long-standing experience with some of the reform strategies under consideration and believed strongly that states should be included in the federal discussions. They believed that state officials could contribute to discussions about the state and federal roles in financing health care reform.

CONCLUSION

The severe economic downturn and the associated dramatic drops in state revenues have made this a difficult and challenging time for states and for their Medicaid programs. The issues uppermost on the minds of Medicaid officials now relate to how to deal with the financing of the program in a time of severe state budgetary stress. In some states it is almost at a level of basic program survival. State budget shortfalls have forced states to consider difficult budget-driven program restrictions and cuts. These cuts have been mitigated by the federal stimulus funds that flow to Medicaid through enhanced federal Medicaid matching funds. In particular, the conditions for receiving the enhanced federal Medicaid funds prohibit states from cutting eligibility or implementing restrictive enrollment processes. Nevertheless, the state focus is on reducing the rates of growth in spending at a time when Medicaid enrollment is increasing to record levels.

The fiscal concerns of states extend to consideration of potential federal health reform. In particular, state officials are concerned about the possibility of federal mandates for coverage expansions or reimbursement reforms that they believe states are not in a position to afford. Still, there is broad support for a federal solution to the issue of the uninsured, and a belief that the experience of state Medicaid directors can contribute to good and workable solutions.

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