kaiser commission on medicaid and the uninsured

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Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends

Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012

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Executive Summary

The Great Recession continued to affect states at the end of state fiscal year (FY) 2011 and heading into FY 2012, although positive signs were beginning to emerge. State revenues were still below pre-recession levels, but were moving in a positive direction and Medicaid enrollment and spending growth were starting to taper. While Medicaid directors noted some positive signs of economic recovery, improvements remained fragile and slow in many states. State budgets for FY 2012 had to account for the expiration of the temporary federal fiscal relief provided through the American Recovery and Reinvestment Act of 2009 (ARRA). Thus, for FY 2012, nearly every state continued to focus on actions to control costs in Medicaid including restrictions on provider rates and benefits and new controls on prescription drug spending. At the same time, states also were moving forward with payment and delivery system reforms by expanding managed care programs and by continuing to re-orient long-term care programs to community-based care models. Eligibility for Medicaid remained stable due to the maintenance of eligibility (MOE) protections that were part of ARRA and health reform, and a number of states reported targeted eligibility expansions or simplified enrollment procedures.

Despite historically difficult budget conditions, states were also planning for the implementation of the Patient Protection and Affordable Care Act (ACA). Under the ACA, states will play key roles in implementing both Medicaid and private insurance coverage changes set to take effect in 2014. Medicaid is the foundation for the ACA coverage expansions for the low-income population, which will significantly reduce the number of uninsured. While the program is set to expand under the ACA in 2014, states worry about the implications of looming federal deficit reduction efforts and the policy and financing implications for Medicaid and states.

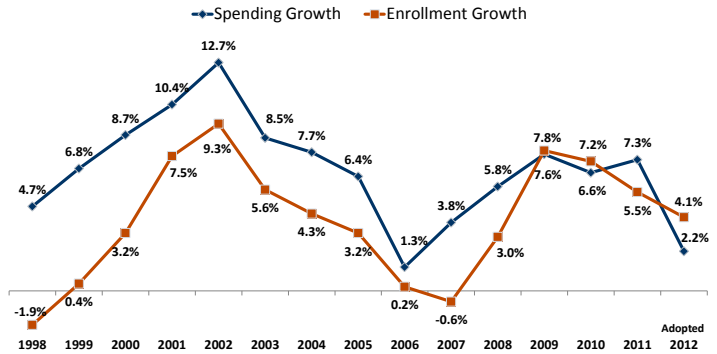
These findings are drawn from the 11th consecutive year of the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) budget survey of Medicaid officials in all 50 states and the District of Columbia. The annual survey tracks trends in Medicaid spending, enrollment and policy initiatives with data for FY 2011 and FY 2012. The report provides detailed appendices with state-by-state information as well as a more in depth look through case studies of the Medicaid budget and policy conditions in Minnesota, New York and Tennessee. Key findings from the survey are highlighted below.

As a result of the recession, states experienced robust Medicaid spending and enrollment growth in FY 2011, but states are projecting lower growth for FY 2012 (Figure ES-1). Medicaid spending increased on average by 7.3 percent across all states in FY 2011 – very close to original projections of 7.4 percent growth. For FY 2012, legislatures authorized spending growth that averaged 2.2 percent, one of the lowest rates on record. Eleven states projected actual spending decreases. In some cases, these projections may understate actual spending increases for FY 2012 given that Medicaid officials in over half of the states reported a 50-50 chance of a Medicaid budget shortfall and almost one-quarter indicated a Medicaid budget shortfall was almost certain for FY 2012.

Enrollment growth, which drives spending growth, averaged 5.5 percent in FY 2011, somewhat lower than the 6.1 percent growth rate projected at the start of FY 2011. For FY 2012, states projected that the rate of enrollment growth, on average, would slow to 4.1 percent.

ES - 1

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2012

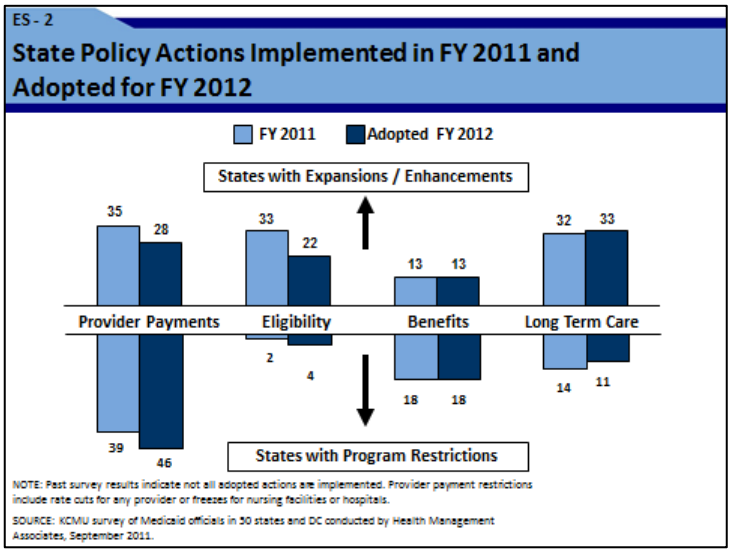


NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

SOURCE: *Medicaid Enrollment June 2010 Data Snapshot*, KCMU, February 2011. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2011 and FY 2012 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2011.

Increased federal assistance through the ARRA enhanced Federal Matching Percentage (FMAP) reduced the state share of Medicaid costs in FY 2009 and FY 2010, but the expiration of these funds means large increases in state funding for Medicaid in FY 2012. From October 2008 through June 2011 states received federal fiscal relief from ARRA in the form of an enhanced federal match rate for Medicaid. These funds helped states support state budgets and their Medicaid programs. The ARRA enhanced FMAP reduced the state costs for Medicaid by increasing the federal share, resulting in an average decline in state spending for Medicaid of 4.9 percent in FY 2010, following a drop of 10.9 percent in FY 2009. These were the only two declines in state annual spending for Medicaid in the program's history. As the ARRA enhanced FMAP began to phase down over the final two quarters of the 2011 state fiscal year, state spending increased on average by 10.8 percent for FY 2011. ARRA funds expired entirely as most states began FY 2012 when federal matching rates returned to statutory calculated levels. As a result, state spending had to be increased to replace the enhanced federal funds, contributing to large increases in state spending for Medicaid of 28.7 percent in FY 2012.

Nearly every state implemented at least one new Medicaid policy to control spending in FYs 2011 and 2012, but many states also implemented some expansions in eligibility and home and community based long-term care (ES-2). In FY 2011, 47 states implemented at least one new policy to control Medicaid costs and 50 states planned to do so in FY 2012. Most states reported program reductions in multiple areas. Highlights of Medicaid policy changes for FY 2011 and FY 2012 include the following:



- ***The ARRA and ACA MOE provisions prevented states from restricting their Medicaid eligibility standards, methodologies or procedures, and despite tight budgets, many states reported eligibility expansions or enrollment simplifications.*** Thirty-three states in FY 2011 and 22 states in FY 2012 reported moving forward with positive eligibility changes. Minnesota joined Connecticut and the District of Columbia in implementing Medicaid coverage for childless adults under a new option in the ACA and several other states expanded coverage to this population through 1115 waivers. More states opted to cover legal immigrant children and pregnant women living in the United States for less than five years (the "ICHIA" option)[1] and several states also moved to expand coverage for family planning services (oftentimes using new authority in the ACA to do so through a state plan

[1] Taking its name from the earlier proposed Immigrant Children's Health Improvement Act (ICHIA).

amendment instead of a wavier). In addition, many states reported efforts to streamline their enrollment processes in FY 2011 and FY 2012. More states reported new or enhanced abilities to apply or renew Medicaid coverage through on-line applications, implementation or expansion of Express Lane Eligibility, and changes to administrative and passive renewals. A number of these changes help states qualify for performance bonus payments enacted as part of the Children's Health Insurance Program Reauthorization Act. Two states made notable eligibility restrictions that are allowed under MOE exceptions for expiring waivers (Arizona) and for coverage of adults with incomes above 133 percent of poverty in states with budget deficits (Hawaii, for January, 2012 pending approval).

- ***As in previous years, provider rate restrictions were the most commonly reported cost containment strategy.*** During economic downturns, states tend to freeze or reduce provider rates, but often restore or enhance them when conditions improve. A total of 39 states restricted provider rates in FY 2011 and 46 states reported plans to do so in FY 2012. A number of states, however, increased or imposed new provider taxes that mitigated provider cuts in some cases. States must balance the goal of controlling costs through provider rate cuts with the need to comply with the federal requirement to ensure that provider rates are sufficient to maintain adequate provider participation and access to services for enrollees. On October 3, 2011, the Supreme Court heard oral arguments in a group of cases from California that challenged reimbursement rate reductions. The court will be ruling on the narrower question of whether Medicaid providers and beneficiaries should be allowed to bring this lawsuit seeking to enforce federal Medicaid law. In May 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would, for the first time, provide federal regulatory guidance regarding what states must do to demonstrate compliance with Medicaid's statutory access requirements.

- ***States continue to restrict benefits and implement cost containment strategies focused on prescription drugs.*** Eighteen states in both FYs 2011 and 2012 reported eliminating, reducing or restricting benefits. Elimination of, or limits on, dental, therapies, medical supplies and DME and personal care services were most frequently reported. Over the past decade, almost all state Medicaid programs have made substantial changes in their pharmacy programs by employing a variety of sophisticated pharmacy management tools including preferred drug lists (PDLs), supplemental rebates, prior authorization and other utilization management efforts. States continue to implement and refine these strategies. Many states are also looking at new reimbursement methodologies for prescription drugs and implementing initiatives that focus on specialty drugs which represent a large and growing share of prescription drug spending.

- ***There is a notable increase in the number of states raising or imposing new copayments on beneficiaries.*** Copayments are currently required by most state Medicaid programs for various services - particularly prescription drugs for adults. States are generally permitted to impose nominal copayments on services for certain beneficiaries, although the Deficit Reduction Act (DRA) allowed more flexibility under certain circumstances. Most children on Medicaid have been exempt from paying copayments under federal law. Five states in FY 2011 and 14 states in FY 2012 increased copayment amounts or imposed new copayments. In contrast, only one state did so in FY 2010. Most copayment changes were for pharmacy and emergency room visits, although a few states, including Arizona, California and Florida are requesting broader authority through waivers to impose copayments beyond nominal levels and to exempt populations. A recent Federal Court of Appeals decision questions the authority of the Secretary to use waiver demonstration authority to allow states to impose copayments, which may affect how CMS will rule on these pending waiver requests.

- ***States continue to re-orient the delivery of long-term care to shift care away from institutions and into community settings.*** Thirty-two states in FY 2011 and 33 states in FY 2012 took actions that expanded LTC services (primarily expanding home and community-based service (HCBS) programs). Conversely, a total of 14 states in FY 2011 and 11 states in FY 2012 took action to restrict LTC services. The ACA included a number of new long-term care options designed to increase community based long-term services and supports. Most states are still undecided as to whether to adopt these options, although four states were moving forward with the State Balancing Incentive Payment Program (Connecticut, Missouri, New Jersey and Rhode Island) and three states planned to implement the Community First Choice Option (Alaska, Rhode Island and Washington). By 2012, 43 states reported that they had implemented or plan to implement the Money Follows the Person Rebalancing Demonstration (with funding extended by the ACA).

States continue to adopt policies to expand managed care and enhance quality. Seventeen states in FY 2011 and nearly half (24 states) in FY 2012 reported that they were expanding their managed care programs primarily by expanding the areas and populations covered by managed care programs. Some states including Kentucky, Louisiana, New Jersey, New York and Texas are implementing either new or significant expansions of comprehensive managed care programs. States are also expanding the use of disease and care management programs and patient centered medical homes to help coordinate care and focus on high-cost and high-need populations. States are using managed care as a vehicle to implement quality and performance strategies such as tying payment or default enrollment to performance and adding quality measures for reporting.

New initiatives related to systems of integrated, coordinated care to serve dual Medicare – Medicaid eligibles were a top priority in FY 2011 and FY 2012. The ACA created two new offices (the Medicare-Medicaid Coordination Office and the Center on Medicare and Medicaid Innovation) that are working with states to facilitate new approaches to improve the care for this population. In April 2011, CMS awarded $1 million in planning contracts to each of 15 states for the development of integrated systems to serve dual eligibles. In July 2011, CMS released guidance that it would assist additional states in developing payment and delivery systems that would facilitate the coordination and integration of care for duals. Many states, including several of the 15 states who received contracts in April 2011, indicated that they had planned to submit proposals. Since the time of the survey, CMS has announced that 37 states have submitted letters of intent related to the opportunities announced by CMS in July 2011.[2] Tied to the grants and guidance and other state efforts, several states reported efforts to implement or expand managed long-term care programs for duals and other long-term care populations including New York, Tennessee, Texas, and California.

A number of states are pursuing Section 1115 Medicaid Demonstration Waivers to make program changes not otherwise allowable under federal Medicaid law. The majority of states with waiver plans reported significant delivery system and/or provider payment reforms for broad or targeted populations including duals or individuals with disabilities and special health care needs. Some states have approval from CMS for certain program changes or have applications pending; other states are still developing proposals and have not yet submitted formal applications to CMS.

Over the next few years, states will be required to implement significant health information technology (HIT) changes. Four major HIT initiatives are common across most states, with timelines for implementation that are driven by national deadlines: Medicaid Electronic Health Record (EHR) certification and incentive programs; major upgrades to claims payment systems; updates to the coding system for medical claims, and implementation of health reform in 2014, which requires major Medicaid IT development, particularly for Medicaid eligibility systems, and integration with new systems developed for state Health Insurance

[2] For more information, including a list of states that submitted letters of intent, see: http://www.cms.gov/medicare-medicaid-coordination/Downloads/StatesSubmittingLettersofIntentFinancialAlignmentModels.pdf.

Exchanges. In addition, states are also using data systems to monitor for fraud and abuse to assure the highest level of fiscal and program integrity.

As states continue to grapple with historically difficult budget conditions, they must also plan for the implementation of the ACA which envisions new roles for Medicaid and for states. Under health reform, Medicaid will be expanded to cover nearly all individuals with incomes below 133 percent of poverty resulting in a large adult expansion in most states. Medicaid officials are playing a lead role in preparing for health reform implementation, in many cases alongside insurance commissioners. While reform presents the opportunity to dramatically reduce the number of uninsured, states identified a number of concerns related to ACA implementation including the fiscal impact of health care reform, tight implementation timelines, lack of clear federal guidance, limited staff and administrative resources, the need to streamline eligibility and coordinate with new exchanges, systems and IT issues, provider access issues, and political challenges in states with significant ACA opposition. State officials also discussed some of the issues and questions associated with transitioning to the new Modified Adjusted Gross Income (MAGI) eligibility methodology. (Concerns about MAGI were largely raised prior to the release of a proposed rule on these issues by CMS on August 4, 2011). To help develop new eligibility systems, three-quarters of the states indicated that they would take advantage of the new 90 percent federal match rate for eligibility systems made available under a final CMS regulation adopted in April 2011.

Looking to the future, Medicaid is poised to play a greater role in health care coverage, to lead the way in innovative payment and delivery models, and to remain front and center in state and federal budget discussions. Despite the intense focus on cost containment efforts due to unrelenting fiscal pressure, Medicaid directors pointed to a range of program improvements and strategies now underway particularly related to care delivery and payment systems. These initiatives are designed to improve the program in the near term and to better position the program for the ACA required eligibility expansions to cover more low-income Americans. However, as states take on the immediate challenges of running their programs and look to the implementation of health reform, they raised concerns that federal discussions related to debt and deficit reduction might achieve federal savings by shifting more Medicaid costs to states, thereby compromising their ability to move forward. In many ways, Medicaid programs have proven to be a resilient part of the nation's health care infrastructure, innovating and adapting to opportunities afforded by an evolving health care system and implementing new provisions of federal law while holding down cost increases. The current challenges may appear daunting, but Medicaid directors communicated that they and their programs are poised for a greater role in health care delivery and are committed to assuring access to high quality care delivered in the most effective manner possible.

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