

medicaid
and the uninsured

**Headed for a Crunch:
An Update on Medicaid Spending, Coverage and
Policy Heading into an Economic Downturn**

**Results from a 50-State Medicaid Budget Survey for
State Fiscal Years 2008 and 2009**

Prepared by

Vernon Smith, Ph.D., Kathleen Gifford and Eileen Ellis
Health Management Associates

and

Robin Rudowitz, Molly O'Malley and Caryn Marks
Kaiser Commission on Medicaid and the Uninsured
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September 2008

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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 bipartisan group of national leaders and experts in health care and public policy.

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Acknowledgements

We thank the Medicaid directors and their staff in all 50 states and the District of Columbia, who took the time to complete the survey on which this study is based. Officials in every state provided information about their programs and their plans for the future, participated in structured interviews and responded to our follow-up questions. Without their help the study could not be done, and we truly appreciate their assistance.

We offer special thanks Dennis Roberts at Health Management Associates who developed and managed the data base. His work as usual was excellent and invaluable. Donna Marks from Health Management Associates assisted with data entry and the case studies and we thank her for her excellent work.

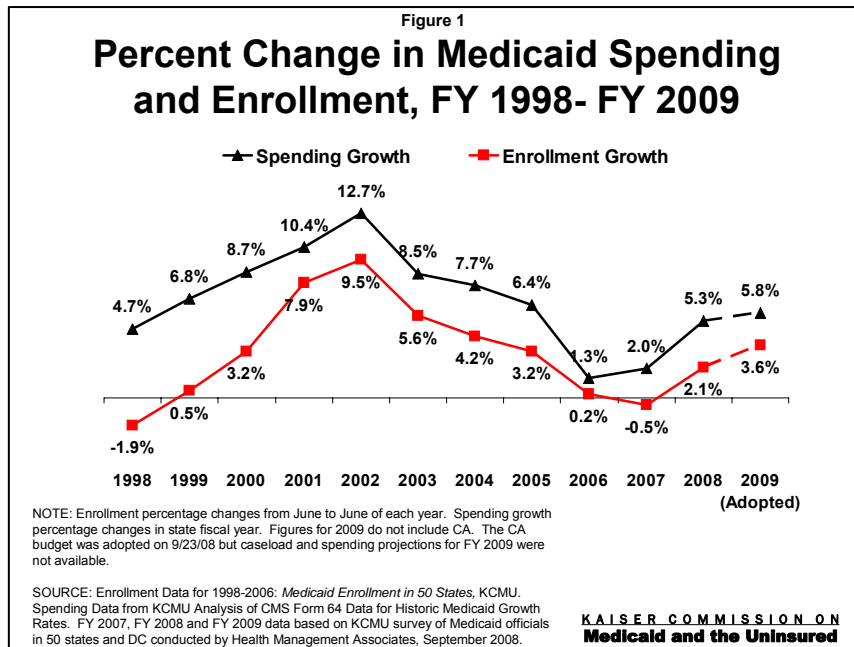
Executive Summary

As states finalized Medicaid policy decisions for fiscal year 2009, they faced a dramatically different situation than the prior year. At the start of state fiscal year 2008, the economy was generally strong and many states were restoring cuts from the last economic downturn and moving forward with Medicaid improvements and expansions to cover more low-income uninsured individuals. A year later, over half of all states faced significant budget shortfalls and slower than anticipated state revenue growth. For some states, plans to expand Medicaid were put on hold as states struggled to allocate funding and balance their budgets. Despite the budget crunch, few states took significant actions to cut Medicaid. During the last economic downturn from 2001 to 2004, most of the major Medicaid restrictions came later in the downturn cycle, not at the very beginning.

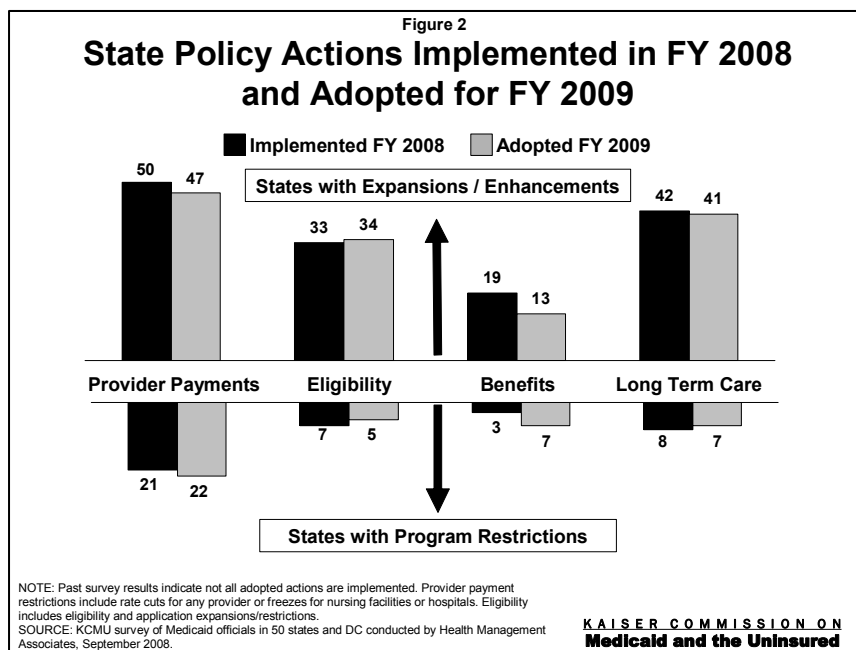
The Medicaid program provides health coverage and long-term care support services to 59 million individuals. Medicaid is administered by the states within broad federal guidelines, but financing is shared by the states and the federal government. During an economic downturn, unemployment rises and puts upward pressure on Medicaid enrollment and therefore Medicaid spending, as individuals lose employer sponsored coverage and incomes decline. At the same time, increases in unemployment have a negative impact on state revenues making it even more difficult for states to pay for Medicaid spending increases.

For the eighth 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 presents findings for state fiscal years 2008 and 2009.

After hitting low points in 2006 and 2007, Medicaid spending and enrollment growth increased in 2008 and is projected to grow faster in 2009. The implementation of Medicare Part D and an improving economy were the primary factors contributing to record low Medicaid spending growth of just 1.3 percent in 2006. Medicaid spending growth reached 5.3 percent in 2008 due to a combination of program restorations and enhancements (particularly for provider payment rates) as well as enrollment increases related to the economy and policy changes to expand eligibility, simplify enrollment or implement marketing or outreach campaigns to enroll more individuals. Looking ahead to FY 2009, states legislatures appropriated spending growth for FY 2009 that averaged 5.8 percent (Figure 1). However, the initial appropriation for Medicaid may understate actual growth in total Medicaid spending in FY 2009. Medicaid directors in two-thirds of states indicated that the likelihood of a Medicaid budget shortfall in their state this year was at least 50-50. One reason is an expected increase in the number of persons enrolled in the program. For FY 2009, Medicaid officials projected growth in Medicaid enrollment that would average 3.6 percent across all states. Medicaid directors primarily attributed the higher enrollment growth projections in FY 2009 to the worsening economy. The FY 2009 California budget was adopted on September 23, 2008 but estimates for California spending and enrollment growth were not available and therefore not included in the national averages. The report reflects the Medicaid policy actions that were included in the FY 2009 budget for California.



In both FY 2008 and FY 2009, states made more Medicaid restorations, enhancements and expansions than cuts despite the change in the economy. The economy was generally favorable as states prepared their budgets for fiscal year 2008. This enabled them to implement an array of positive changes for Medicaid including provider payment rate increases, eligibility expansions and simplifications, targeted benefit improvements or restorations of cuts, community-based long-term care expansions as well as continued strategies to improve quality of care. Even in a favorable economic climate, Medicaid directors remained focused on efforts to control Medicaid spending growth. For FY 2009, despite the economic downturn, states moved cautiously with respect to Medicaid. States adopted more positive policy changes than restrictions related to provider payments, eligibility, benefits and long-term care, but there were fewer and smaller expansions compared to FY 2008 (Figure 2). This response was similar to the experience in the last economic downturn when states did not immediately implement widespread actions to cut Medicaid as the economy faltered; significant cuts to Medicaid came further into the downturn cycle.



States continued to report negative implications related to the citizenship and identity documentation requirements imposed by the Deficit Reduction Act (DRA). Thirty states reported that the new citizenship and identity requirements moderately or significantly increased the time needed to determine eligibility; 24 states reported increased backlogs of applications and 22 states reported an increase in the number of applications denied. More than half of states saw enrollment dip in June 2007 compared to the previous year as they implemented the new requirements and then increase as delayed applications were processed or individuals returned after being dropped from coverage. The citizenship documentation requirement was the most frequently cited reason for drops in enrollment in 2007. Medicaid directors in one-quarter of states indicated that the requirements continued to have a significant impact on enrollment in 2008. Overwhelmingly, Medicaid directors indicated the new requirements were cumbersome, burdensome and that they pose new barriers for those applying for benefits.

A few more states opted to use new DRA options around benefits and cost sharing, but overall adoption has remained low. The DRA allowed states new options to alter benefit packages, impose or eliminate cost sharing and make copays enforceable (meaning that providers or pharmacists could deny services for individuals who could not pay their copay at the time of service) for certain groups. By FY 2008, eight states were using DRA authority related to benefit changes, four states were using DRA authority to make at least some copays enforceable and Wisconsin was using DRA authority to extend nominal copayment requirements to certain parents and children in managed care. For FY 2009, Nevada plans to use the DRA to implement new copayment requirements for adults and to make these copays enforceable. Two states, Oregon and Pennsylvania also used DRA authority to eliminate co-pays.

Again this year, most states reported taking steps to expand or enhance home and community-based service options for long-term care. In FY 2008, 42 states took actions that expanded long-term care services (primarily expanding HCBS programs), and a similar number (41 states) planned expansions in long-term care for FY 2009. While the DRA included new provisions intended to give states increased flexibility to deliver long-term services and supports, only nine states thus far have reported implementing or adopting plans to implement the DRA self-directed personal assistance services option (cash and counseling) and only five states have reported implementing or adopting plans to implement the HCBS State Plan option. However, a total of 38 states are moving forward with Long Term Care Partnership programs.

States continue to develop managed care delivery systems and implement strategies to improve quality. In FY 2008, nearly one-third of states expanded their use of managed care by including persons with disabilities in managed care, expanding managed care service areas and requiring enrollment into managed care when it had previously been voluntary. Managed care continues to be a vehicle for quality improvement initiatives in Medicaid through the use of performance measures and reporting the results for health plans. There is a clear trend towards pay for performance arrangements, with three-fourths of states using some form of P4P in FY 2009, compared to less than half three years earlier. States continue to develop new generation disease management and care management initiatives to assure better care for persons with chronic conditions and disabilities whose care tends to be the highest cost. Almost a third of states implemented new or expanded care management initiatives in FY 2008, and over a quarter of states did so in FY 2009. More states are also moving forward to encourage new technologies such as e-prescribing and electronic health records to improve health care quality.

Overall, Medicaid programs provide access to quality health services, but Medicaid officials recognized access problems for dental care and some specialists and they raised concerns about behavioral health care. A large body of research has shown that low provider rates are a primary factor affecting provider participation in Medicaid and access to services for Medicaid beneficiaries. This survey gauged Medicaid directors' perceptions about access to care for primary care physicians, specialists and dentists. Access to primary care physicians was generally regarded as favorable, but 39 states reported some or significant problems accessing dental care and two-thirds of states reported access issues for specialty physician services. Medicaid officials noted that access issues for Medicaid often parallel those that exist for the general population. On the positive side, Medicaid officials frequently indicated that access improved in the past year, largely due to state initiatives to improve provider rates and specifically to address dental access. Medicaid plays a critical role in delivering and financing mental health services, but nearly all states indicated moderate or significant issues with the growing cost of behavioral health care, behavioral health drug utilization, mental health related emergency room use and inpatient hospital admissions for mental health services.

A majority of states mentioned a strained federal-state relationship as a significant current challenge for Medicaid. States continue to express frustration over the administrative burden imposed by various federal audits and oversight activities. Of 50 states responding, 41 states reported that the administrative burden was ranked as a 4 or a 5 on a scale of one to five, including 23 states that described the administrative impact as a "5." Most states indicated that a series of proposed federal regulations would have significant fiscal and beneficiary implications in their states. Directors noted that state and federal elections and the prospect of national health reform could have implications for the currently strained federal-state partnership and they were hopeful that the future would bring a more collaborative partnership that would help states accomplish key program goals.

Looking ahead, federal policy actions, as well as the downturn in the economy, are likely to hinder state efforts maintain current Medicaid coverage and to cover more uninsured. Medicaid officials indicated that they continue to look at strategies to control costs as they also focus on improving quality and health care outcomes for Medicaid beneficiaries, and on strategies to reduce the number of persons without health coverage. Federal issues including SCHIP policy limits and the uncertainty of ongoing funding due to the temporary nature of the current authorization of SCHIP resulted in a number of states limiting their coverage expansions for children, including some expansions already approved by the state legislature. While some states continue to explore options to address the issue of the uninsured, the economic downturn has caused some states to proceed more slowly or to scale back plans. Given rising health care costs and a growing uninsured problem, coupled with state requirements to balance their budgets and the economic downturn, there is heightened state concern about Medicaid financing. A new Administration and Congress, the potential for large-scale health reform, as well as uncertainty about the direction of the economy all have important implications for the immediate future of the Medicaid program nationally and across all fifty states.

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