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Chapter 7: Medicaid and the Children's Health Insurance Program Present Opportunities and Challenges

Medicaid agencies have long pioneered cost-containment initiatives that became models across the health system. The extraordinary fiscal crisis in states, only partly offset by Recovery Act funding, placed new pressures on the ingenuity of Medicaid administrators. States have shown creativity in how they applied rate reductions to minimize negative impact on access to care. Medicaid agencies have significantly increased the scope of managed care to include more special needs populations, and they have developed new initiatives to work with providers to better manage chronic illness. In these and other respects, Medicaid continues to be an important area of innovation in cost containment and health care financing.

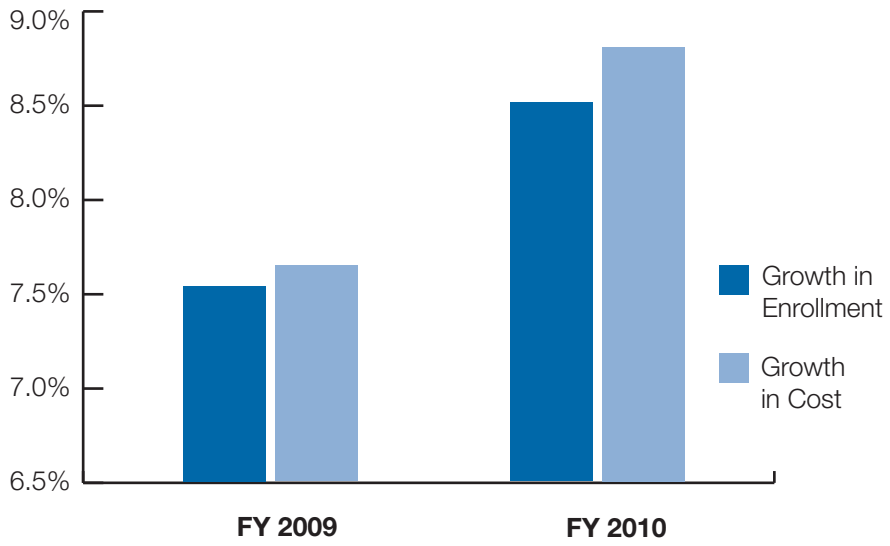
MEDICAID AND COST-CONTAINMENT

For the fourth consecutive fiscal year the state budget environment has been enormously difficult for states. General revenues declined in absolute terms in fiscal years 2008-2010, the first time states ever experienced even two years of back-to-back annual revenue drops.[1] However, with federal fiscal relief for states phasing out, most states anticipate ongoing significant budget shortfalls next year. As of December 2010, 40 states have projected gaps that total $113 billion for fiscal year 2012, a level almost as large as that for 2010.[2]

In August 2010, H.R. 1586 extended enhanced Medicaid funding through June 2011 in the form of a higher Federal Medical Assistance Percentage, or FMAP. Over the course of the final two quarters of the fiscal year (the first half of calendar year 2011), this enhanced FMAP is being phased out, and will no longer be available in FY 2012. Enhanced FMAP and the State Fiscal Stabilization Fund together covered about 35 percent of the state budget shortfall for FY 2011.[3] A significant proportion of this federal budget relief, however, was absorbed by increased Medicaid costs themselves. Enhanced federal match had a major impact on states' ability to deal with Medicaid enrollment growth during the recession. Despite overall Medicaid cost growth, enhanced FMAP reduced state expenditures for Medicaid, resulting in an average decline in state general fund spending for Medicaid of 7.1 percent in FY 2010 and 10.9 percent in FY 2009.[4]

States are now confronting the end of enhanced FMAP in their budgeting for 2012. Although FMAP began to be phased out in January 2011, the end of enhanced FMAP still represents a withdrawal of $40 billion of federal resources that were available to states in FY 2010, between the ARRA and the partial extension of enhanced FMAP for the last two quarters of the fiscal year. A preview of the potential impact of the end of enhanced FMAP was provided in the spring of 2010 by how states handled the possibility that enhanced match would end during FY 2011.[5] Most states had to adopt budgets for FY 2011 during the spring of 2010, when states did not know whether the enhanced FMAP would be extended beyond its original December 2010 ending date. States varied on whether they incorporated an extension into their budget projections. States that did not incorporate an ARRA extension had to project substantially higher rates of state Medicaid spending,

Figure 1: **Medicaid Enrollment and Cost Growth**



Source: Kaiser Commission on Medicaid and the Uninsured. Hoping for Economic Recovery, Preparing for Health Reform.

although total (federal and state) projected Medicaid spending was similar in the two groups of states. Those states that assumed an extension of the ARRA enhanced FMAP in their FY 2011 budgets budgeted for 5.3 percent state Medicaid spending growth on average. Those states that did not assume an extension of the enhanced FMAP budgeted for 25.6 percent spending growth on average.

States experienced the most rapid growth in their Medicaid spending in eight years in 2010.[6] This cost growth was almost entirely driven by growth in Medicaid enrollment. As indicated in **Figure 1**, in 2009 cost growth exceeded enrollment growth by only 0.1 percentage points, and in 2010 by 0.3 percentage points.[7] States projected continued modest per capita cost growth in their 2011 budgets.

These flat per capita cost trends reflect, in part, that Medicaid had a surge in enrollment of parents and children, relatively low-cost categories. Children alone accounted for 60 percent of the growth in Medicaid enrollment in calendar year 2009.[8] This surge was clearly driven by the recession and growth in unemployment among working-age parents.

State cost-containment actions were also instrumental in restraining the per capita growth of Medicaid spending. Maintenance of Effort requirements in the Recovery Act—continued in the ACA—prohibited states from reducing Medicaid eligibility. State cost-containment actions therefore focused on reducing per-enrollee spending. Cost containment was focused in the following areas, reviewed in more detail below:

- Reducing and freezing reimbursement rates;
- Increasing the scope of managed care;
- Implementing disease management programs;
- Maximizing the federal match; and
- Reducing benefits.

RATE REDUCTIONS AND FREEZES

Freezes or reductions in Medicaid rates were the most common form of cost containment adopted by states in 2010. During fiscal years 2010 and 2011, 41 states restricted provider reimbursement rates, with most of those states enacting cuts in both years.[9]

States employed a number of strategies to minimize the beneficiary and provider impact of these reductions, however. Medicaid rates for some categories of providers are generally adjusted for inflation every year. Typically hospitals and nursing homes both receive automatic inflation-based increases in base rates. For provider types who normally receive annual inflation-adjustments to rates, state rate "reductions" may in fact be increases or flat funding in absolute terms. Some states, seeking to minimize actual reductions in rates, focus rate adjustments on these providers. This tendency was reflected in the recent round of Medicaid cost actions, with hospitals the most common target for rate restriction and nursing homes the second most common. While three quarters of states restricted hospital rates and about half of states restricted nursing home rates during the fiscal crisis, most of these actions represented rate freezes rather than actual rate cuts.[10]

Physician services is another major cost center for Medicaid programs and physicians were the next most common target of rate reductions. A significant minority of states cut at least some physician rates in FY 2010 or FY 2011.[11] A number of states had increased physician rates in recent years, so these cuts were, in some cases, reversals of recent increases. It is also important to note that Federally Qualified Health Centers (FQHCs) are rapidly growing as a source of Medicaid physician services. Because FQHCs generally receive Medicaid payment based on a relatively high federal rate schedule, their growth represents an effective increase in average rates that Medicaid pays physicians.

State rate reduction actions in other major cost centers were less common. States are constrained from reducing managed care capitation rates by federal requirements for actuarially sound rates so those reductions were relatively rare.[12] State use of preferred drug lists and supplemental rebates to reduce pharmacy costs is well-established and robust, so state activity to add drugs to these mechanisms is routine and ongoing.[13]

The Affordable Care Act clawed back a portion of the supplemental rebates used in some states by increasing the minimum 50

percent state rebate amount and designating the increase as payable 100 percent to the federal government. However, the ACA also allows states for the first time to collect rebates on drugs purchased for Medicaid recipients by managed care organizations. State implementation of this provision is likely to be an important area for savings in states with managed care programs going forward.

An important legal challenge to Medicaid rate reductions has played out in the 9th U.S. Circuit Court of Appeals. The circuit court has made multiple decisions in 2009 and 2010 giving Medicaid providers legal standing to sue to stop Medicaid rate reductions. The Supreme Court has not ruled on whether this holding applies nationally, but unless and until the Supreme Court rules otherwise, states in the 9th Circuit (the largest in the nation including nine Western states) will face additional requirements to demonstrate that rate reductions will not damage quality and access in order to reduce rates.[14] California has appealed to the U.S. Supreme Court, and more than 20 states have filed papers supporting California's appeal.

INCREASED SHIFT TO MANAGED CARE

The last two years have seen a shift toward risk-based Medicaid managed care. The number of Medicaid enrollees in capitated, comprehensive, risk-based health plans nationally increased by over 12 percent over the year ending in June 2009.[15] Thirty-four states now have risk-based capitated Medicaid managed care.[16] Managed care growth in the last two years has involved multiple forms of expansion: expansion into new counties, the addition of new eligibility groups to managed care, a shift from voluntary enrollment into managed care to mandatory enrollment, or implementation of managed long-term care programs.

An important new aspect of the growth of managed care in Medicaid is a new emphasis on managed care for people with disabilities and dual eligibles. Enrollment of the Aged, Blind, and Disabled eligibility category into managed care has accelerated in the last three years.[17]

Managed long-term care, once an unusual strategy employed in a handful of states, has reached broader acceptance. Managed long-term care is now utilized in twelve states with a significant number of additional states actively planning to introduce it. Of these managed long-term care programs, six are mandatory for some or all long-term-care-eligible populations.

Almost half of state Medicaid agencies implemented new disease management or care coordination programs during State Fiscal Years 2010 and 2011.[18] Medically complex and/or disabled individuals represent an extraordinarily high share of costs in Medicaid programs, and a significant proportion of these costs are due to poorly managed chronic conditions. Unlike the early 2000s trend toward vendor-based disease management in both the public and private sector, however, recent Medicaid disease management and care management initiatives fall predominantly into two categories: provider-based initiatives, including both primary-care based programs and other provider-run initiatives; and managed care-based programs.

States Expanding Managed Care for Special Needs Populations: Two State Examples

Illinois created a new mandatory managed care system called the Integrated Care Delivery System in several counties in 2010 targeted at adults with disabilities and older adults in the Medicaid program. Rather than an expansion of existing managed care contracts, Illinois created a procurement for stand-alone plans for Aged, Blind, and Disabled eligibility categories. Illinois awarded contracts to Aetna and Centene in September 2010, with enrollment beginning in 2011. Expansion to managed long-term care is proposed as a next step.

Tennessee implemented mandatory managed long-term care in 2010, through its Choices in Long-Term Care program. Tennessee has historically had a long-term care system almost entirely dependent on institutions. In 2008, the legislature passed the Long-Term Care Community Choices Act calling for integration of long-term care services for the elderly and adults with physical disabilities into the existing TennCare managed care system. The state received approval for an amendment to its TennCare waiver in mid-2009. Tennessee rolled out managed long-term care unusually quickly, expediting this process by adding long-term care risk on to existing Tenncare contracts rather than conducting on new procurement process specific to long-term care.

BENEFIT REDUCTIONS

Despite the fiscal crisis, states prioritized maintenance of Medicaid benefits overall, and almost as many states reported increases to benefits as reductions or benefit limits.[19] Those reductions that did take place have focused on non-elderly adult beneficiaries.

Many states are now actively pursuing Medicaid Health Homes (aka medical homes) programs, created by Section 2703 of the Affordable Care Act and taking effect in January 2011 (See *State Efforts Improve Quality, Contain Costs and Improve Health* for more information). This new State Plan option has both short-term and long-term cost containment implications. In the short-term, because many states have existing care management and medical home programs for people with chronic physical and mental health conditions, these programs will be eligible, at least in part, for two years of 90 percent federal matching under the ACA. The Health Homes program also provides an opportunity for states to pursue long-term cost savings through medical home and care management programs for chronically ill Medicaid beneficiaries. For participating states, the 90 percent match provision of

the program is both a way to derive savings for existing activities and to pilot new care management programs for two years with limited financial exposure.

Growth in provider tax mechanisms has been a major source of revenue for states during the recent fiscal crisis. Many states employ provider taxes both as a mechanism for generating revenue directly and, in many cases, for generating additional federal match revenue. Over the past three years, the number of states with hospital taxes grew significantly, from 19 to 34.[20] Other provider taxes and taxes on managed care organizations have also grown significantly, and increases in provider tax rates have occurred as well. A significant minority of states have also increased the percentage of provider taxes retained by state rather than returned to providers in rate enhancements.[21]

States also have cost reduction opportunities related to Medicare Advantage (MA) changes. The Medicare Improvements for Patients and Providers Act (MIPPA) Act of 2008 imposed a requirement on Special Needs Plans (SNPs) for Dual Eligibles to contract with state Medicaid agencies, and the deadline for this requirement was extended to the end of 2012 by Section 3205 of the ACA. Many Medicare Advantage Duals SNPs were designed to shift costs onto Medicaid programs. That is, since non-SNP MA plans typically cover some Medicare premiums and cost-sharing (or other wrap-around benefits) that are also covered by Medicaid, MA plans created duals SNPs that did not cover those benefits and sought to make sure they were not paying anything for duals for which Medicaid would otherwise pay. The contracting requirement gives Medicaid programs an opportunity to work out a different arrangement with MA SNPs on Medicare cost-sharing, premiums and other wrap-around costs that is more favorable to the state Medicaid agency.

The end of enhanced FMAP and the ongoing economic challenges facing states will continue to pose profound fiscal challenges to state budgets in fiscal year 2012. At the same time, most states now have new governors who are going into their initial budgeting cycle. Together, these conditions are contributing to an environment in which major innovations in Medicaid cost-control are being actively discussed in many states.

STATES AND ACA ELIGIBILITY EXPANSIONS

State action to modify or expand eligibility in Medicaid or CHIP has been significantly constrained in 2010 by a combination of two factors. First, the maintenance of effort requirements of the ACA effectively prohibit states from reducing eligibility standards and processes until 2019. Meanwhile, the ongoing budget challenges states are dealing with have reduced activity to expand eligibility to large populations. However, some states have taken steps to increase eligibility for public programs because of the emergence of important new opportunities for states with state-funded coverage programs to convert those programs to federally matched Medicaid programs.

The ACA provided an option for states to cover adults without children, a primary population targeted by the 2014 Medicaid expansion, under the Medicaid state plan starting in 2010. Under the ACA, states are authorized to extend coverage without a waiver and therefore without demonstrating any offsetting savings to the federal government. Although this population will be covered with a significantly enhanced federal matching rate in 2014, states are required to finance any expansion using existing (lower than in 2014) federal matching rates. For this reason, it was most likely that states that exercised the option were doing so to receive federal match for an existing program that was funded with state money separately from the state Medicaid program.[22]

Connecticut was the first state to implement the ACA option. The expansion is expected to cover 47,000 individuals who had been receiving coverage under the state's Charter Oak insurance program. The expansion was announced in June 2010, but was made retroactive to April 1. The state estimated it would save $53 million by July 2011.[23] In July 2010, the District of Columbia became the second Medicaid program to exercise the option, moving a state-funded program known as the Alliance into Medicaid and covering 32,000 individuals. New Jersey also submitted a plan for approval of a similar expansion to adults without children.[24] A few other states have sought to expand coverage to this same group under an 1115 waiver, using the ACA option as an opportunity to use that financing vehicle more flexibly. Washington has sought authority under its existing waiver to cover individuals who are presently covered by the Basic Health Plan. California received approval in late 2010 of an 1115 waiver that authorized a phased-in (by county) expansion of coverage to this population. A number of other states are considering their options based on the ACA option—again, primarily to maximize federal funding opportunities for existing state programs.

The financing changes utilized by states typically had the effect of both enhancing the program for enrollees and creating net savings to the state. For example, in Connecticut and the District of Columbia, benefits were broadened to meet Medicaid minimum requirements.

STATES TAKE ADVANTAGE OF CHIPRA EXPANSIONS

A similar dynamic is taking place based on a new opportunity for states in CHIPRA. Enacted and signed into law in 2009, CHIPRA gives states the option to cover legal immigrant children and pregnant women, eliminating the five-year bar

created by the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Effective April 1, 2009, states that offered state-funded coverage for legal immigrants and pregnant women could use federal funds, and other states could expand eligibility and receive federal funds. In 2010, 23 states adopted or planned to adopt in 2011 this CHIPRA option. Most of these states previously covered the immigrants who qualify (pregnant women or children) using state-only funds.[25]

STATES, CHIPRA AND ENROLLMENT STRATEGIES

CHIPRA provides states with a significant set of tools to enhance and maximize enrollment and retention of children in CHIP and Medicaid coverage. Implementing these tools and incentives has been a high priority of the Obama administration and, in general, states were very active in this arena in 2010. A quote from an article published in *Health Affairs* by U.S. Health and Human Services Secretary Kathleen Sebelius portrays state activity under CHIPRA:

> *"Despite the economic downturn, in the year and a half since CHIPRA was enacted, more than half of the states have embraced these opportunities and used the new tools to enroll more children and improve their children's coverage programs. In particular: (1) Sixteen states have expanded income eligibility levels in their CHIP or Medicaid programs, or both. (2) Twenty-one states have taken steps to further streamline their enrollment and renewal processes. (3) Four states have received approval for the new Express Lane Eligibility option in Medicaid or CHIP, or both. (4) Twenty-nine states have elected to lift the five-year waiting period for eligible children or pregnant women who are lawfully residing in the United States. (5) Twenty-eight states are using, with the help of the Centers for Medicare and Medicaid Services (CMS) and the Social Security Administration, a data-matching process to verify citizenship for purposes of Medicaid and CHIP eligibility."*[26]

Table 1: CHIPRA Performance Bonus Enrollment and Retention Strategies

1. Continuous Eligibility
2. Liberalization of Asset or Resource Requirement
3. Elimination of In-person Interviews
4. The Same Application and Renewal Process for Medicaid and CHIP
5. Automatic/Administrative Renewal
6. Presumptive Eligibility for Children
7. Express Lane Eligibility
8. Premium Assistance

One of the powerful incentives in CHIPRA is the Performance Bonus Program for which states can qualify from 2009 to 2013. Intended to encourage states to improve their take-up rates for children in public programs, the performance bonuses provide added federal funding to states to offset the cost of increased Medicaid child enrollment. Children in Medicaid and in CHIP-funded Medicaid expansions are included in the program.[27] To qualify for a performance bonus, states must demonstrate in a given year implementation of at least five of eight specified enrollment and retention strategies. (See Table 1 for a full list of these strategies.)

The Performance Bonus program began in 2009. Nine states received performance bonuses totaling $73 million. In 2010, 15 states qualified for performance bonuses, and received a total of $206 million in bonus payments.

Alabama received by far the highest bonus because its relative enrollment increase – a 36 percent increase over the state 2010 baseline – was substantially higher than the next highest state, Wisconsin, which saw a 23 percent increase. In 2010, Alabama had the following strategies in place: 12-month continuous enrollment; liberalization of the state's asset test; elimination of in-person interview requirements; use of the same application forms for Medicaid and CHIP; and automatic or administrative renewal.[28] Alabama, along with 10 other states, received a "Tier Two" payment, a much higher bonus for states that exceed a 10 percent increase over the state-specific baseline.

STATES AND MEDICAID AGENCIES MOVE AHEAD ON HEALTH REFORM IMPLEMENTATION

Implementation of the provisions and requirements of the ACA is in full swing in many states, although progress has slowed slightly due to the 2010 elections and the need to get new administrations briefed on the issues. In particular, Medicaid agencies are deeply involved in planning efforts in most states, with a particular focus on planning for implementation of the new eligibility requirements of the ACA.

The ACA will require significant interaction between those developing state-based exchanges and staff in the Medicaid and CHIP programs, particularly in the area of eligibility systems and processes.[29] The ACA includes a series of requirements intended to simplify, streamline, and integrate eligibility for Medicaid, CHIP, and exchange-based subsidized insurance. Specifically, the law requires:

- The development of Web portals through which individuals can shop for and compare insurance options;

- The creation of a single application form that covers Medicaid, CHIP, and federal exchange-based subsidies, which can be utilized by applicants online, by mail, over the phone, or in-person; and
- The establishment of electronic data interfaces to exchange information with state and federal agencies.

State exchanges can contract with Medicaid agencies to determine eligibility for the new premium subsidies. Virtually every state is now engaged in a process, supported by the exchange planning grants, to assess technical infrastructure and capacity to meet these requirements and to understand how existing programs like Medicaid and CHIP will integrate with the exchange.[30]

To help pay for needed technology enhancements, HHS published a proposed regulation to make Medicaid eligibility system development eligible for the enhanced federal match (90 percent federal and 10 percent state, up from the previous 50 percent match rate). Taken together with the fact that exchange development will be 100 percent funded by the federal government, most of the development costs for ACA technology will be borne by the federal government.[31]

HHS also announced a competitive process for states to receive "innovator grants" for the design and development of the IT infrastructure necessary to operate exchanges. The grants are intended to reward states that demonstrate leadership in developing innovative components of IT infrastructure, and technology developed under the grants will be made available to other states. The grants will be awarded in early 2011.

In addition to these exchange-related technology challenges, state Medicaid agencies will need to implement a new income eligibility standard know as modified adjusted gross income (MAGI) in 2014. Planning for this change in combination with the Medicaid expansion in the ACA is a high priority for states.[32]

Louisiana's Experience with Express Lane Eligibility

Louisiana is an example of a state that has taken advantage of a new CHIPRA tool to support children's enrollment. CHIPRA authorizes an Express Lane Eligibility option (ELE) for states, through which a state can use information from a state-designated agency to determine whether a child satisfies an eligibility requirement of Medicaid or CHIP. In Louisiana, the Department of Social Services provides information from the State's Supplemental Nutrition Assistance Program (SNAP) that the Department of Health and Hospitals then uses to determine eligibility for Medicaid and CHIP.[33]

Using this process, more than 10,000 Louisiana children were automatically enrolled in the state's Medicaid program on one day in February 2010. Families received their Medicaid cards in the mail and were told that the first time they use the card, they would be asked to confirm that they want to enroll their child in Medicaid.[34]

Louisiana Medicaid and SNAP officials worked together to transfer information about all children receiving SNAP benefits to the Medicaid program. Specifically, the state was able to utilize data about income (as determined by food stamp rules), Social Security numbers, residency, and age to support eligibility determinations for Medicaid and CHIP.[35]

The practice of considering the use of the Medicaid card as legally-required affirmative consent for automatic enrollment into coverage will be replaced going forward. For new SNAP applicants, the state will provide a check-box through which applicants can agree to share their information and be automatically enrolled into Medicaid.[36]

Before the implementation of ELE, Louisiana had prioritized streamlining eligibility in public programs. It was one of nine states to receive CHIPRA performance bonuses in both 2009 and 2010. In 2009, the state had implemented the following strategies: continuous eligibility; liberalization of asset requirements; elimination of in-person interviews; common Medicaid/CHIP applications; and automatic or administrative renewal.

Optimizing eligibility processes in this way can create administrative efficiencies as well. While the volume of eligibility processing has not declined, the state was able to accomplish this innovation in enrollment despite a 12 percent reduction in the Medicaid workforce over the previous two years.[37]

Health reform also presents opportunities for states to improve outdated processes and systems and to undertake an efficient and thoughtful information-gathering process. A number of states have already contemplated that new systems and core functions will need to take into account new reform-related requirements. In Michigan, the state's procurement of a new enrollment vendor included language to authorize the state to use the selected vendor to perform health reform-related functions. Kansas has recently released a request for proposals to develop a new, integrated enrollment system that will be the operational base for enrollment into both Medicaid and the Exchange, and state policymakers are separately assessing how to maximize opportunities to simplify eligibility under the ACA, and how to construct Medicaid benefit packages for expansion populations that will integrate with existing Medicaid and with exchange plans.

CONCLUSION

States have been able to maintain and in some cases expand the availability of Medicaid as a critical source of access to medical care during a period of historically high unemployment. Without these efforts, uninsurance would have increased far more dramatically than it did through 2009 and 2010. As states move forward in to Health Reform implementation, they can build on long-standing efforts in many states.

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