Medicaid and Health Reform: Fiscal Implications for the States

ASTHO
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Health Management Associates

The Two Primary Issues for Medicaid Now: Budget Pressures and Implementing Reform

- Fiscal pressure dominates state decisions about Medicaid.
  - *"Medicaid growth is simply unsustainable and threatens to consume the core functions of state government."*
    - Governor Jan Brewer, (R – Arizona), January 24, 2011, signing request for waiver of "Maintenance of Effort" law to cut 250,000 adults from Medicaid.
  - *"Medicaid's growth is out of control. We must manage it better."*
    - *Governor Chris Christie, (R – New Jersey), February 25, 2011.*
  - *"[Medicaid] is not sustainable for a state trying to balance its budget."*
    - *Governor Sam Brownback, (R – Kansas), March 8, 2011.*
- Preparing for health reform is a huge issue for states, whether the Governor supports or opposes it.

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

Medicaid Today: America's Largest Health Program

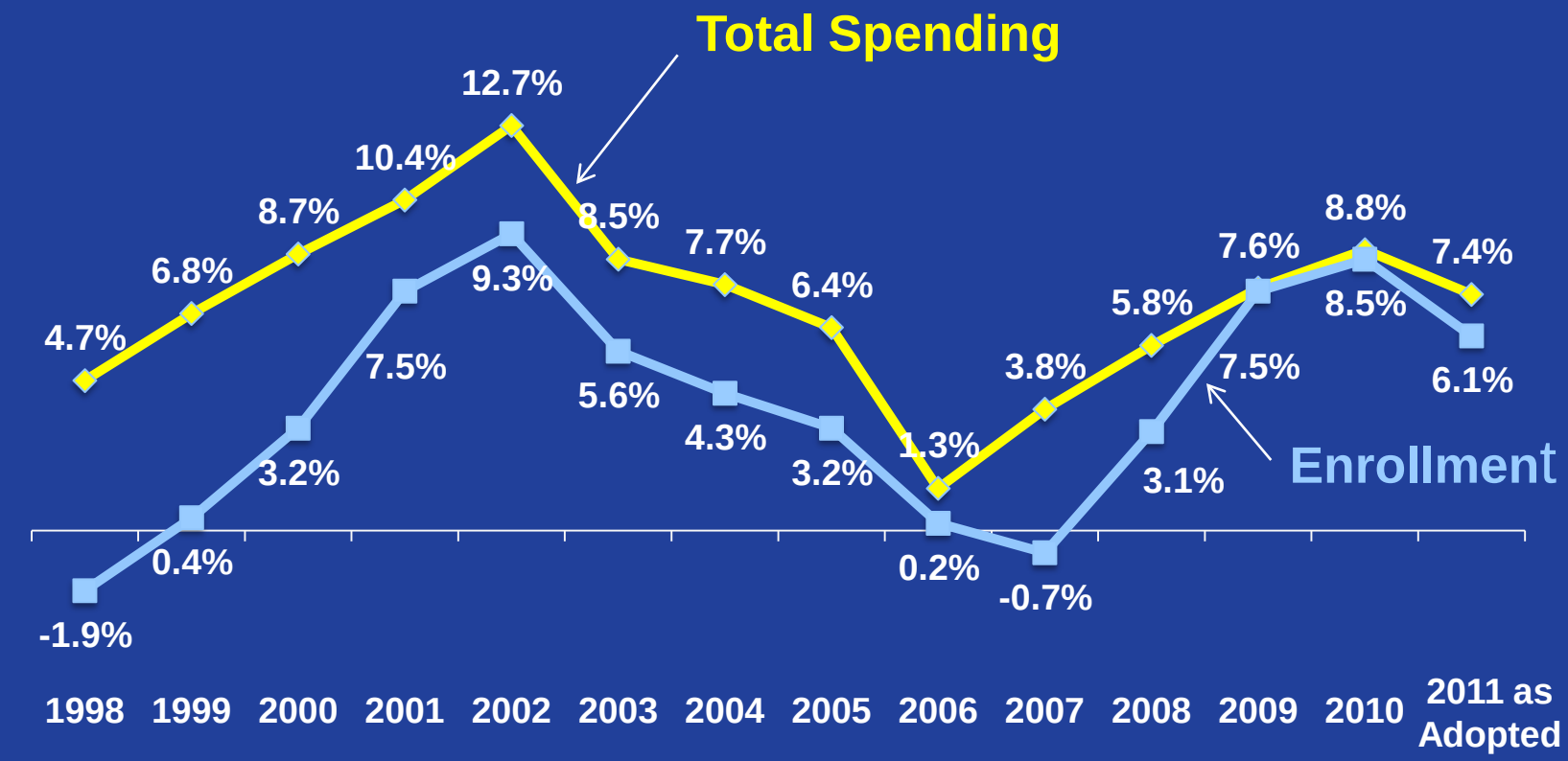
- Medicaid enrollment in 2011:
  - 57 Million Average Monthly Enrollment
    - With turnover and new enrollees, 70 million will have Medicaid coverage at some time during the year
  - Medicaid 2011 projected spending: $447 billion
    - Historically, federal funds finance 57% of Medicaid
- States administer and partially fund Medicaid
  - State spending must meet federal rules to qualify for federal matching funds

Sources: HMA projections for Federal FY 2011, based on: CBO, *Medicaid Baseline*, August 2010; and CMS, Office of the Actuary, *2010 Actuarial Report on the Financial Outlook for Medicaid*, December 2010.

Medicaid Is the "Workhorse" of the U.S. Health Care System

- Health insurance for low-income families, persons with disabilities and the elderly
- Assistance to low-income Medicare beneficiaries
  - 15% of beneficiaries, 40% of Medicaid spending
- Long-term care including care in the home and community
- Support for safety net providers who serve the uninsured – hospitals and community health centers
- Financial support for other programs such as mental health, school health and public health

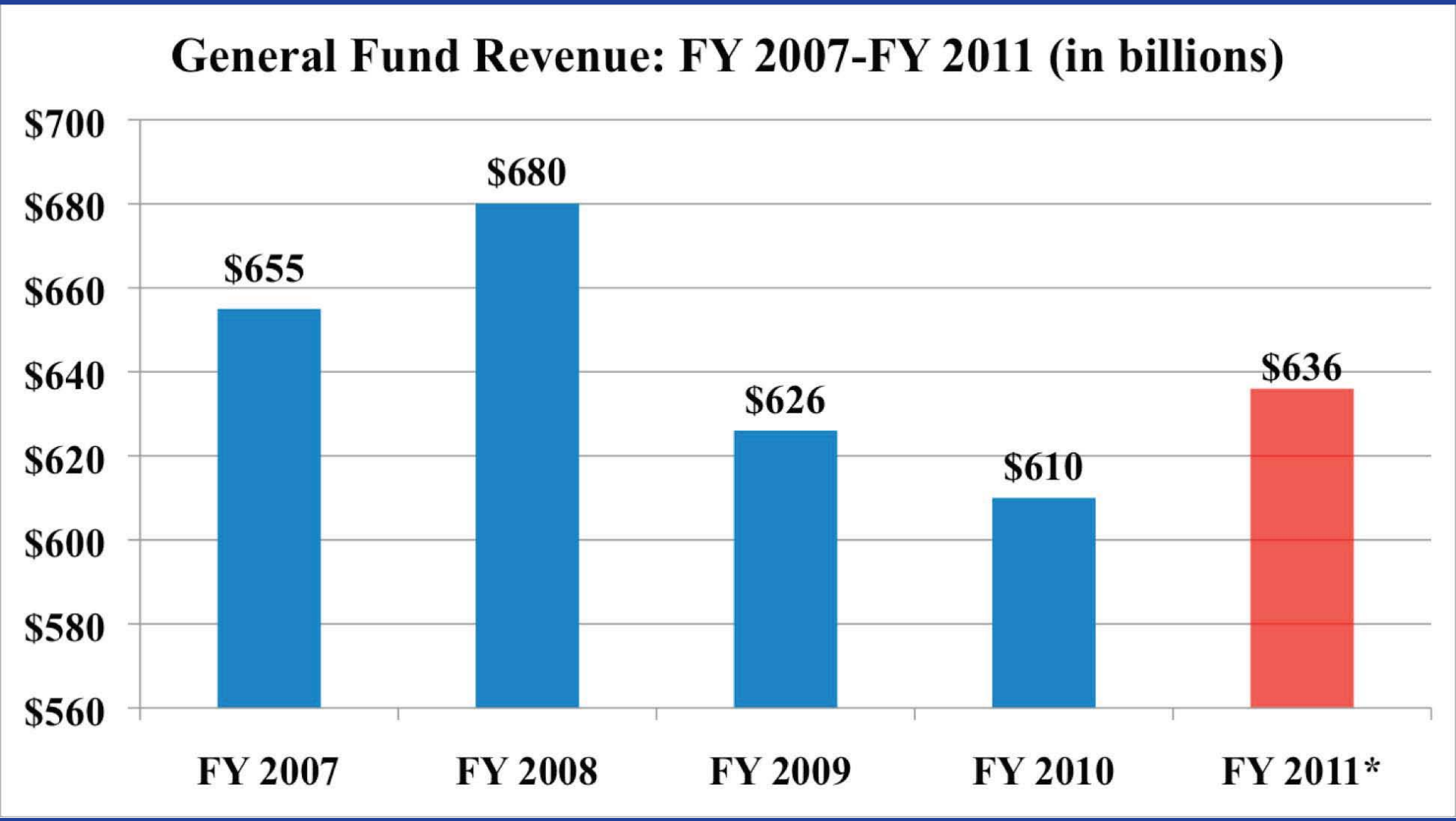
U.S. Medicaid Spending and Enrollment Percent Changes, FY 1998 – FY 2011



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

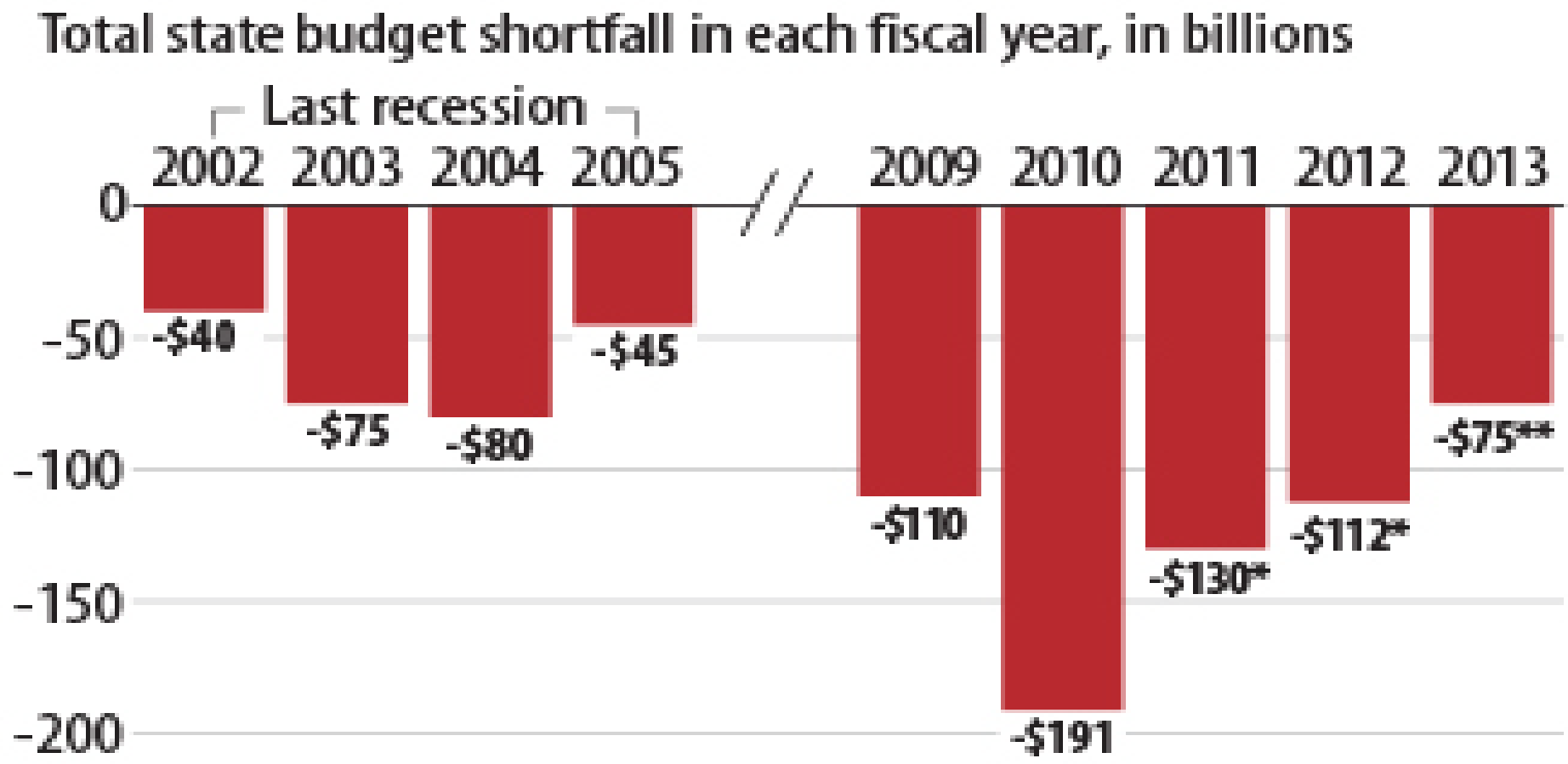
NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

2011 State Revenues Remain Below 2007



** FY 2007, 2008, and 2009 are actual. FY 2010 is preliminary actual and FY 2011 is enacted. Source: NASBO, 2011.*

Figure 1:
Largest State Budget Shortfalls on Record



*Reported to date.

**Preliminary

Source: CBPP survey, revised March 2011.

Center on Budget and Policy Priorities | cbpp.org

State Budget Shortfalls, Projected for FY 2011($ Billions)

(Selected States – Group 1)

"The upcoming fiscal year is shaping up as one of the most difficult budget years on record."

AZ	$ 1.0	NV	$ 1.5
CA	$25.4	NY	$10.0
FL	$ 3.6	OH	$ 3.0
IA	$ 0.2	OR	$ 1.8
IL	$ 4.9	TX	$13.4
MA	$ 1.8	UT	$ 0.4
MI	$ 1.3	VA	$ 2.0
MN	$ 3.8	WA	$ 2.5
NC	$ 2.4	WI	$ 1.8

Source: Source: McNichol, Oliff and Johnson, "States Continue to Feel Recession's Impact," Center on Budget and Policy Priorities, March 9, 2011.

State Budget Shortfalls Projected for FY 2011($ Billions)

(Selected States – Group 2)

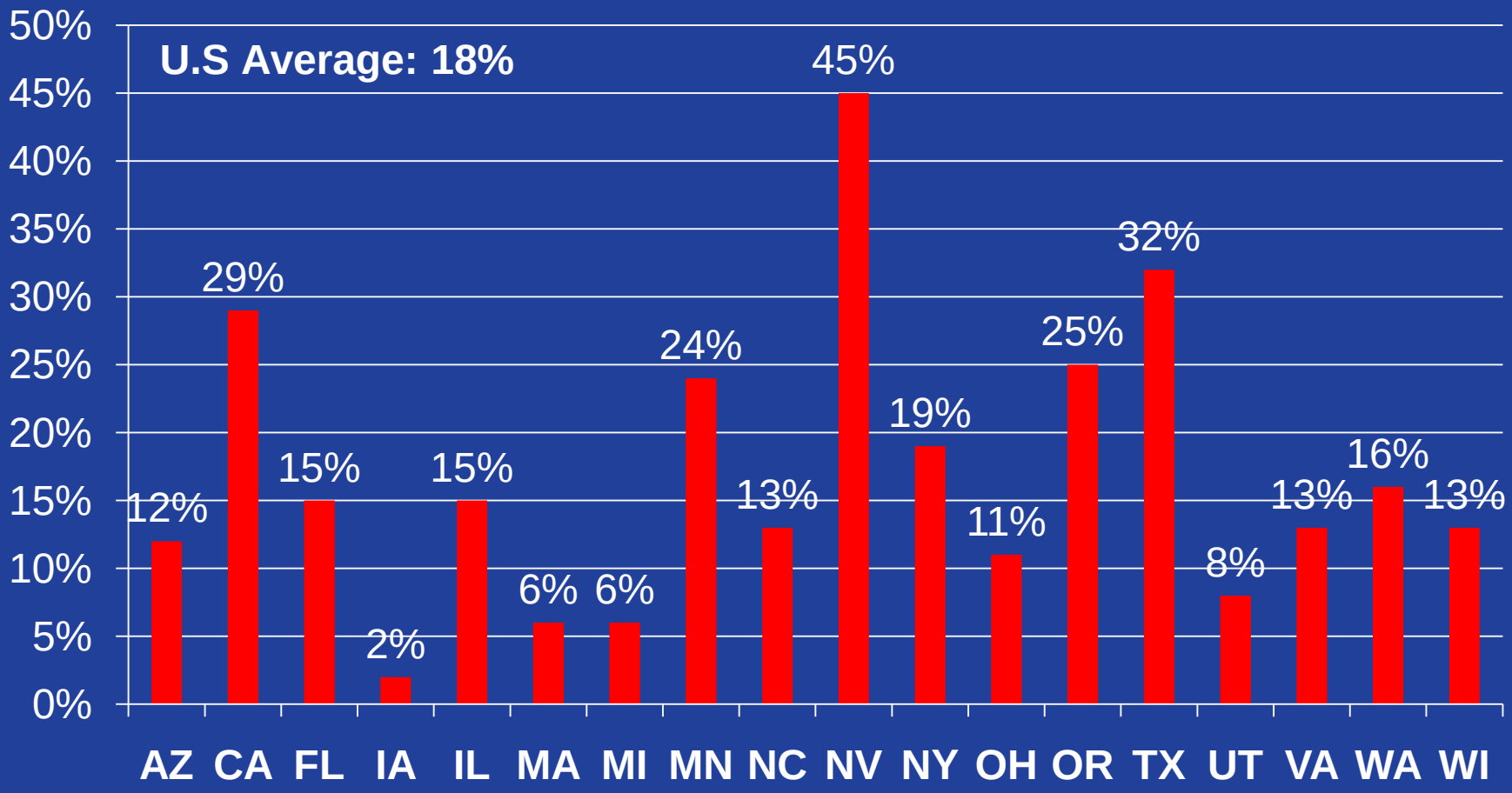
"The upcoming fiscal year is shaping up as one of the most difficult budget years on record."

AL	$ 1.0	MS	$ 0.6
CT	$ 3.2	MO	$ 0.7
GA	$ 1.3	NM	$ 0.5
IN	$ 0.3	OK	$ 0.5
KS	$ 0.5	RI	$ 0.3
KY	$ 0.8	SC	$ 0.9
LA	$ 1.6	SD	$ 0.1

Source: Source: McNichol, Oliff and Johnson, "States Continue to Feel Recession's Impact," Center on Budget and Policy Priorities, March 9, 2011.

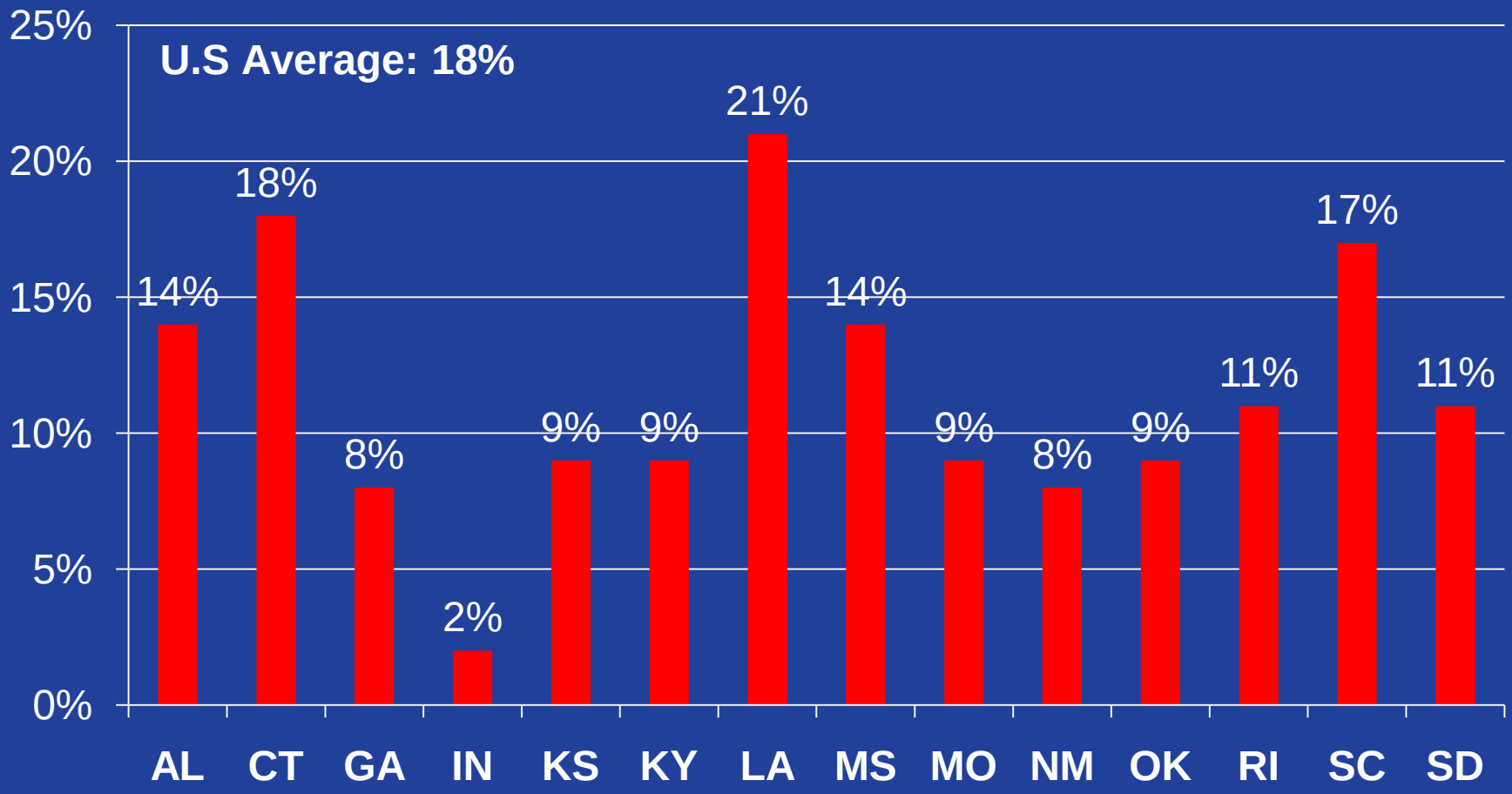
FY 2012 State Budget Shortfalls, as % of FY 2011 Budgets

(Selected States Group 1)



Source: HMA analysis of: McNichol, Oliff and Johnson, "States Continue to Feel Recession's Impact," Center on Budget and Policy Priorities, March 9, 2011.

FY 2012 State Budget Shortfalls as % of FY 2011 Budgets
(Selected States – Group 2)



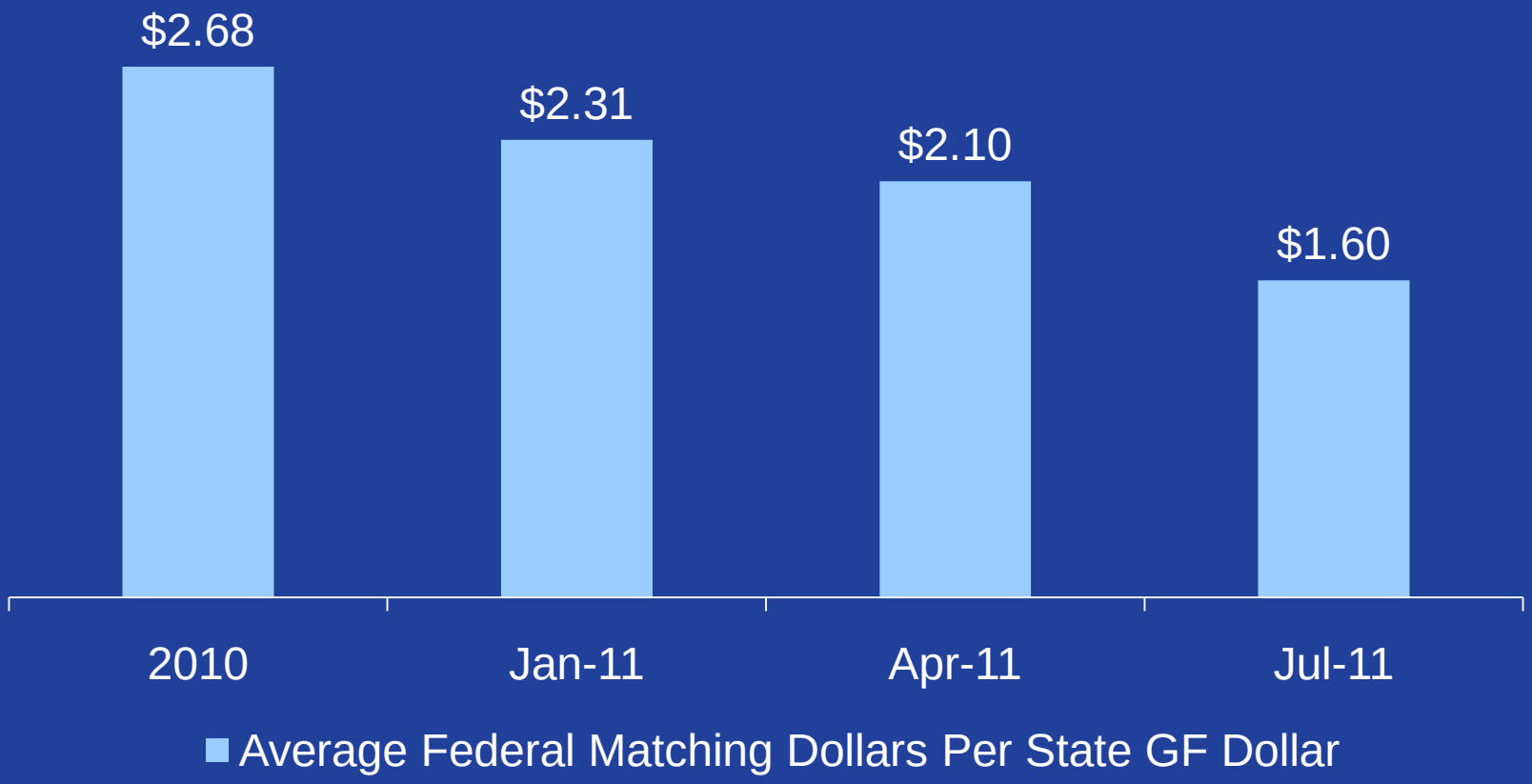
Source: HMA analysis of: McNichol, Oliff and Johnson, "States Continue to Feel Recession's Impact," Center on Budget and Policy Priorities, March 9, 2011.

Governors Attribute 2012 State Budget Woes to Medicaid

- Medicaid, the largest single state program, often the only one growing, with growth far outpacing revenues
- End of enhanced FMAP increases 2012 GF cost of Medicaid by over 25%, across all states
  - $39.1 billion annual growth in the state share
    - From $157.6 billion (FY 11) to $196.7 billion (FY12)
    - Two-year growth averages 48%

Source: *2010 Actuarial Report on the Financial Outlook for Medicaid*, CMS, Office of the Actuary, December 21, 2010.

Shrinking Federal Medicaid Funding is a Challenge for States



Source: Council on State Government.

Medicaid State General Fund Cost Will Jump 2010 to 2012 on Average by 48%

(Selected states - Group 1)

AZ	+61%	NC	+26%
CA	+44%	NV	+25%
CT	+41%	NY	+50%
FL	+57%	OH	+47%
KY	+58%	OR	+87%
IA	+58%	TX	+58%
IL	+27%	UT	+55%
MA	+44%	VA	+43%
MI	+35%	WA	+58%
MN	+52%	WI	+53%

Source: CMS, PBS News Hour, 2/17/ 2011.

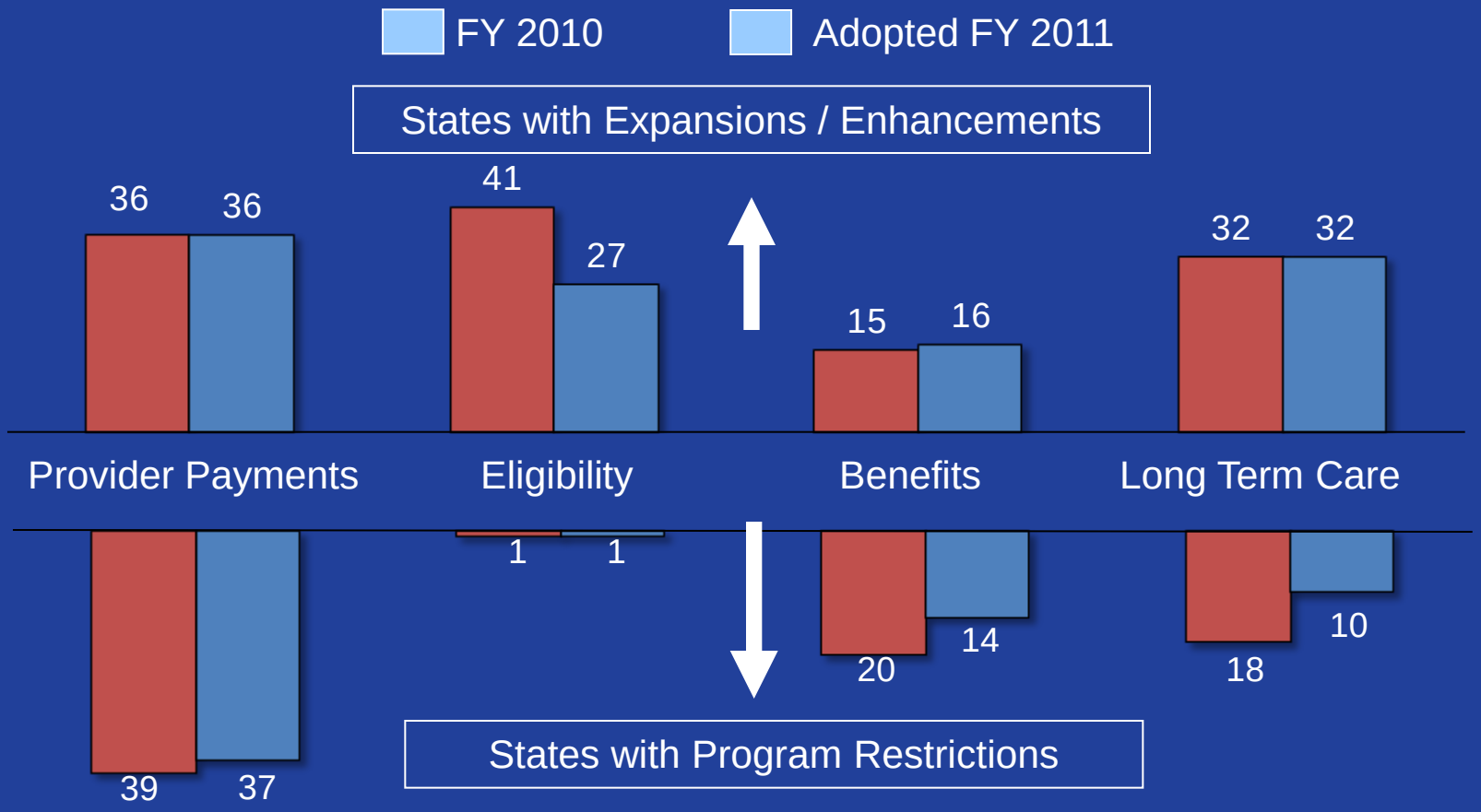
Medicaid State General Fund Cost Will Jump 2010 to 2012 on Average by 48%

(Selected States – Group 2)

AK	+49%	MO	+48%
AL	+62%	NH	+48%
AR	+73%	NM	+81%
CT	+41%	ND	+70%
GA	+40%	OK	+82%
IN	+62%	RI	+43%
KS	+53%	SC	+46%
KY	+58%	SD	+46%
LA	+72%	TN	+39%
MS	+45%	WV	+69%

Source: CMS, PBS News Hour, 2/17/ 2011.

To Control Costs, States Took Numerous Medicaid Policy Actions for FY 2010 and FY 2011

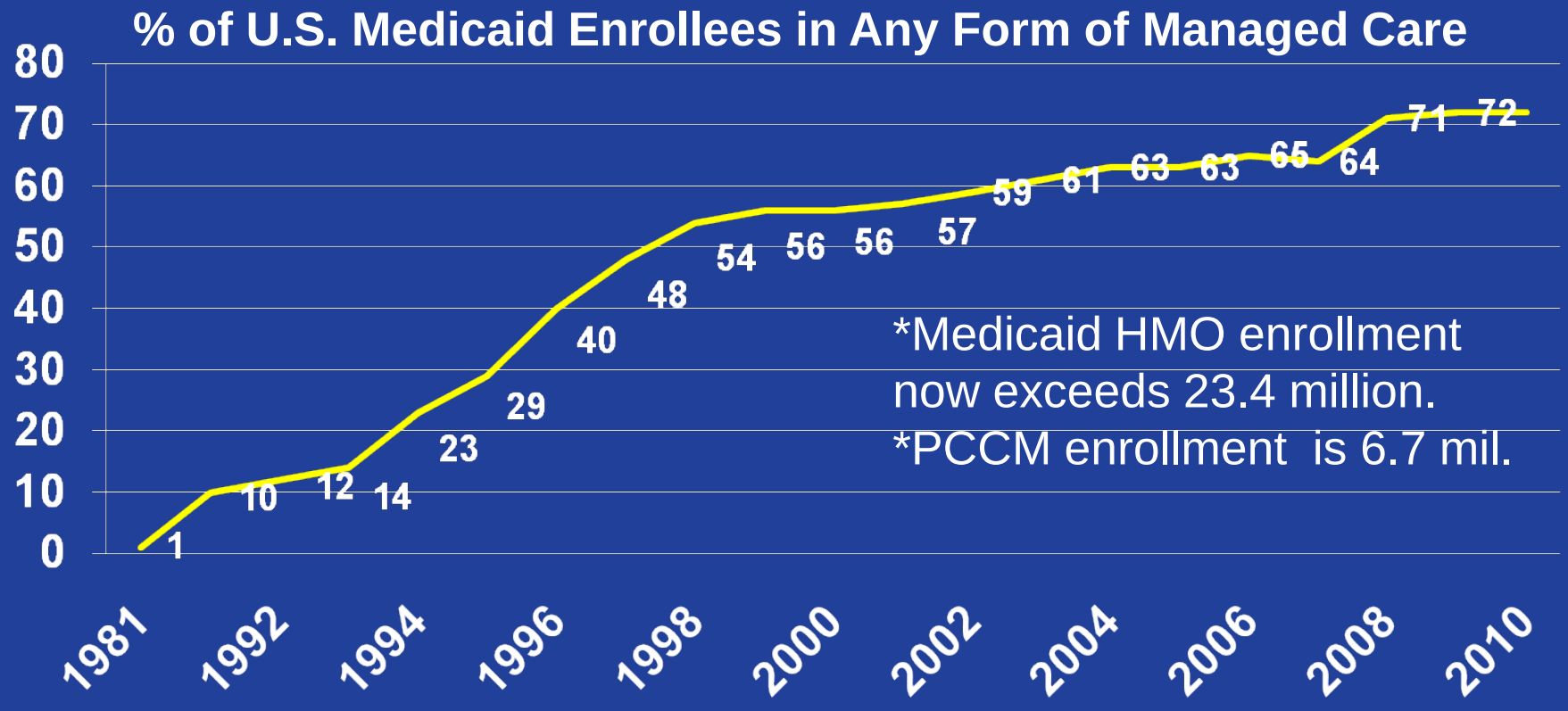


NOTE: Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals.
SOURCE: Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder, "Hoping for Economic Recovery, Preparing for Health Reform: Medicaid Spending, Coverage and Policy Trends," The Kaiser Commission on Medicaid and the Uninsured, September 2010. http://www.kff.org/medicaid/8105.cfm

Provider Payments Remain Under Pressure

- Provider rate cuts remain the preferred Medicaid cost control method
  - For MCOs, actuarial soundness requirement provides some protection
    - E.g., proposed cuts to MCOs averted in Florida
  - Supreme Court will hear California appeal, signaling potential future rate cuts
- Eligibility cuts remain off the table due to the “Maintenance of Effort” law.

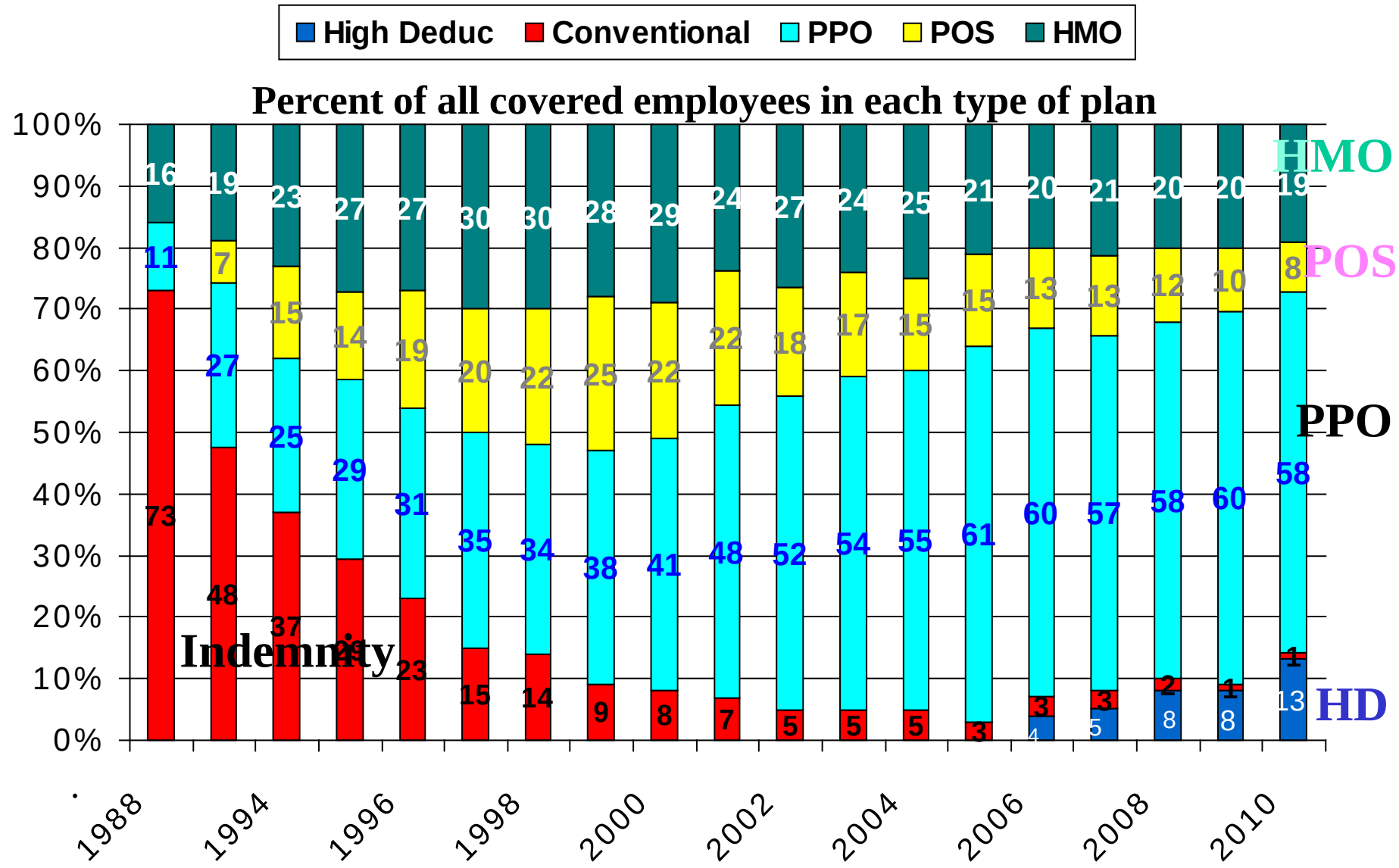
Expect Medicaid to Rely More on Managed Care to Save Costs and Improve Quality



Note: "Managed Care" includes HMOs, PIHPs, HIOs and state-administered Primary Care Case Management Plans (PCCMs).
Source: CMS, Medicaid Managed Care Reports, 1994-2010.

Figure 18

Medicaid Managed Care Trend Contrasts with Commercial Health Insurance Market



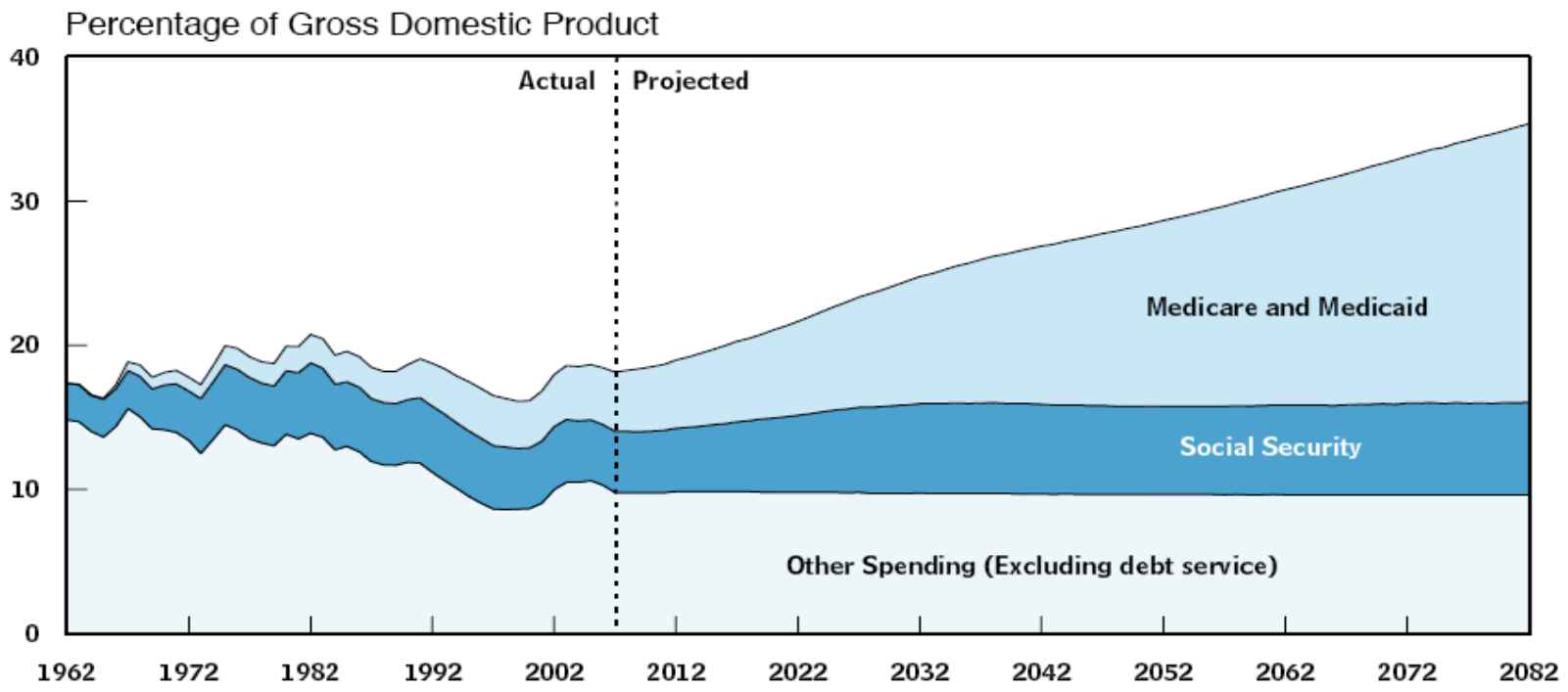
Source: Kaiser/HRET Survey of Employers, 2009.

Across the States, Medicaid Is Now a Leader in Innovation, Quality Improvement and Value

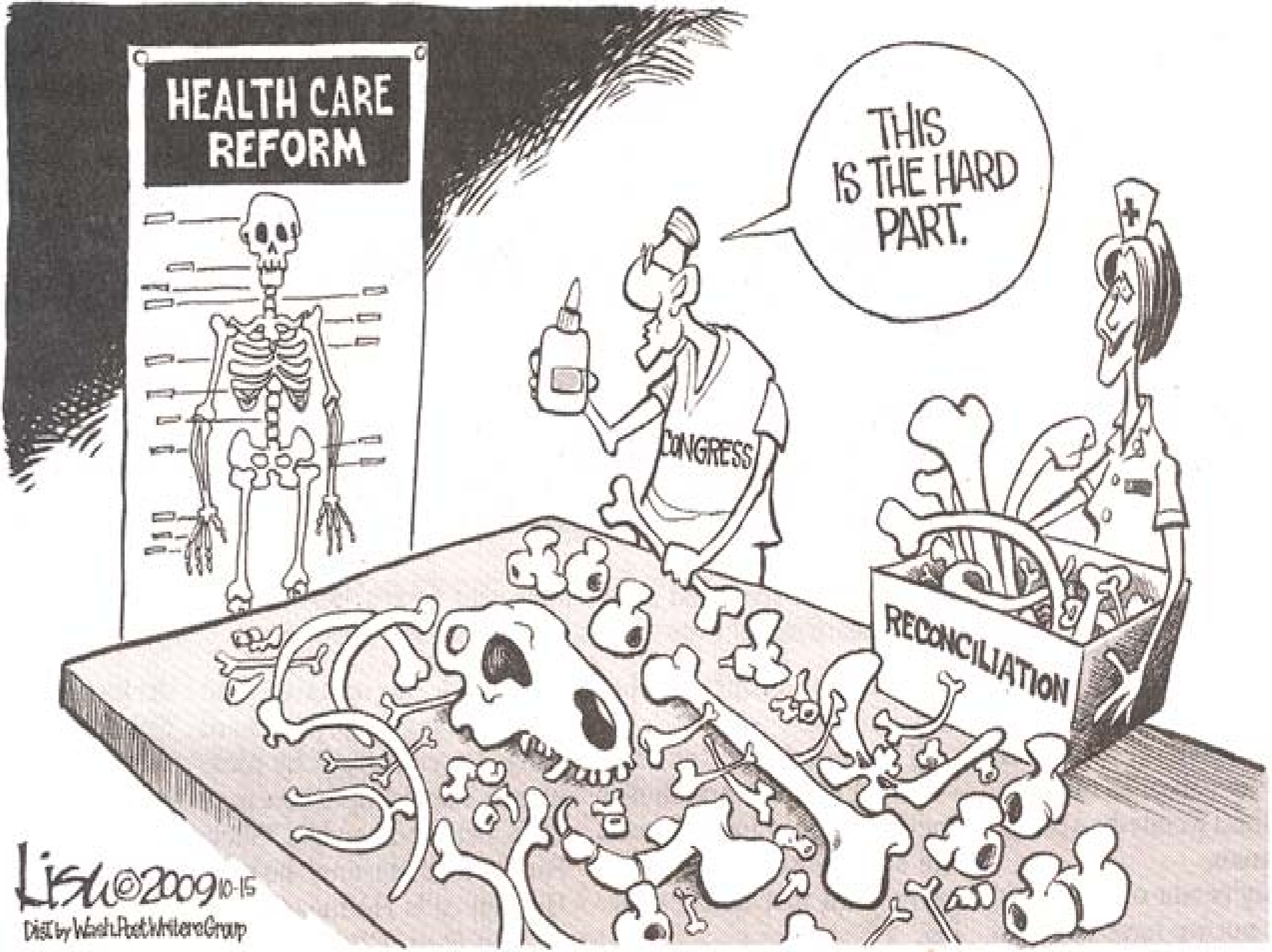
- **Better information on best practices and performance**
  - **Consumer guides and MCO performance report cards**
  - **Encouraging best practices that improve care**
- **Quality Initiatives**
  - **Care management programs for high risk / high cost patients**
  - **Performance improvement projects; E.g., reducing avoidable emergency visits**
  - **Focused work groups to improve service delivery**
  - **Strong contract requirements and enforcement**
- **Reimbursement Strategies**
  - **Bonus payments for high performance on selected HEDIS® or CAHPS® quality performance measures that change annually**
  - **Penalties for poor performance**
  - **Prohibit payment for "Never events"**
  - **Higher payment when meet medical home or chronic care management standards**

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

Medicare and Medicaid Are *the* Primary Drivers of Future Federal Spending Growth and Deficits



Source: CBO, "Key Issues in Analyzing Major Health Insurance Proposals," December 2008.


HEALTH CARE REFORM
THIS IS THE HARD PART.
CONGRESS
RECONCILIATION
Lisi ©2009 10-15
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Health Reform: Significant Medicaid Impacts

- Quality Improvements
  - Payment and delivery system reforms
- Coverage expansions
  - Health insurance exchanges
  - Medicaid expansions

ACA Elevated Health Care Quality to a National Priority, Medicaid to a leading role

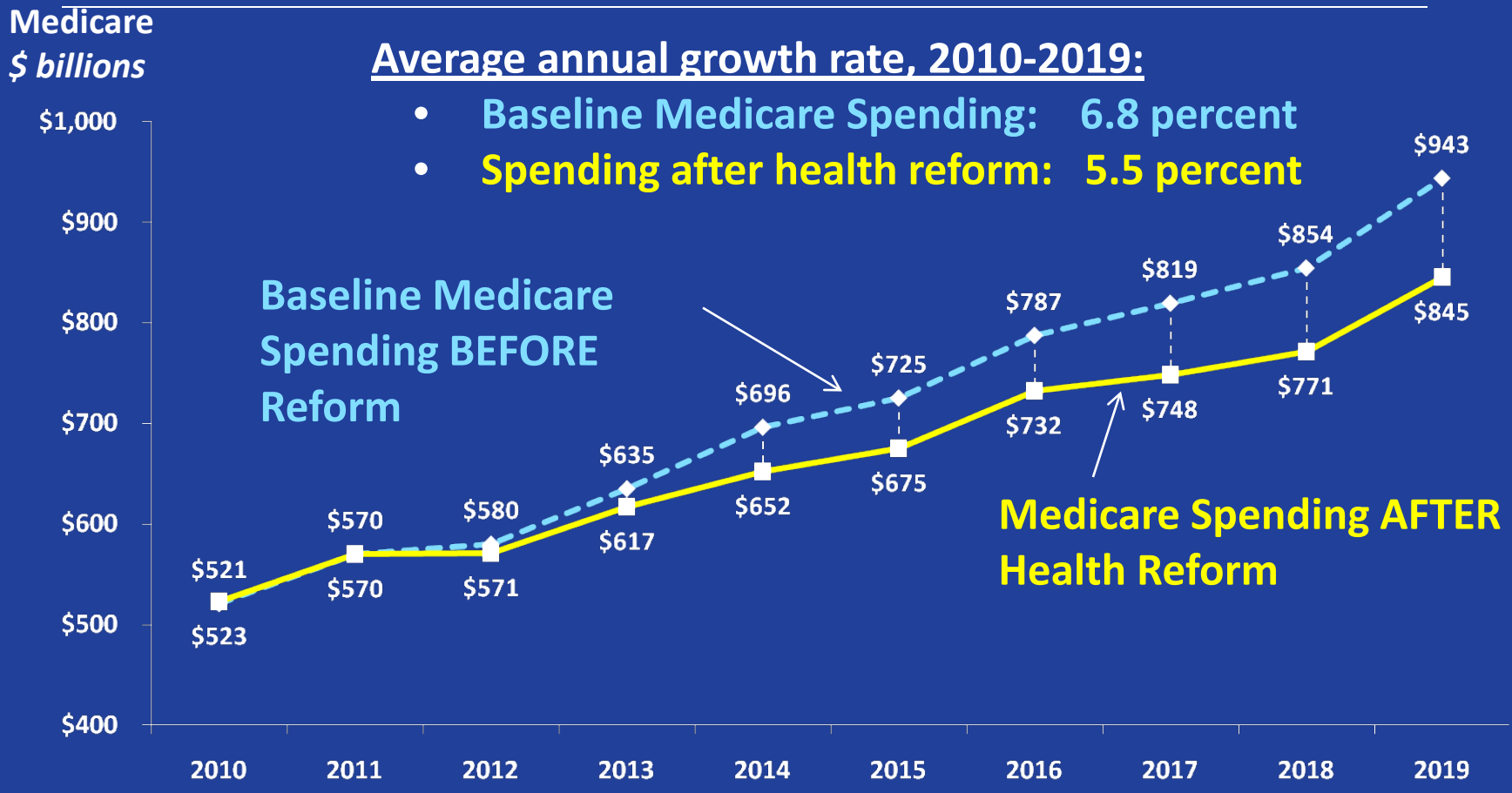
- New "National Strategy for Quality Improvement" and "National Strategy for Prevention."
- New options for states to improve care
  - Health Home Option - enhanced funding for care coordination for individuals with chronic care needs
  - CMS "Innovation Center" (CMI) will test payment and delivery models, and take them to scale
  - CMS Coordinated Health Care Office to encourage Medicaid and Medicare to improve coordination for dual eligibles
    - Duals are 15% of Medicaid beneficiaries, 40% of spending
    - Awards April 15 to 15 states: CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, WI

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

Medicaid Demo and Payment Reform Options to Improve Care and Reduce Costs

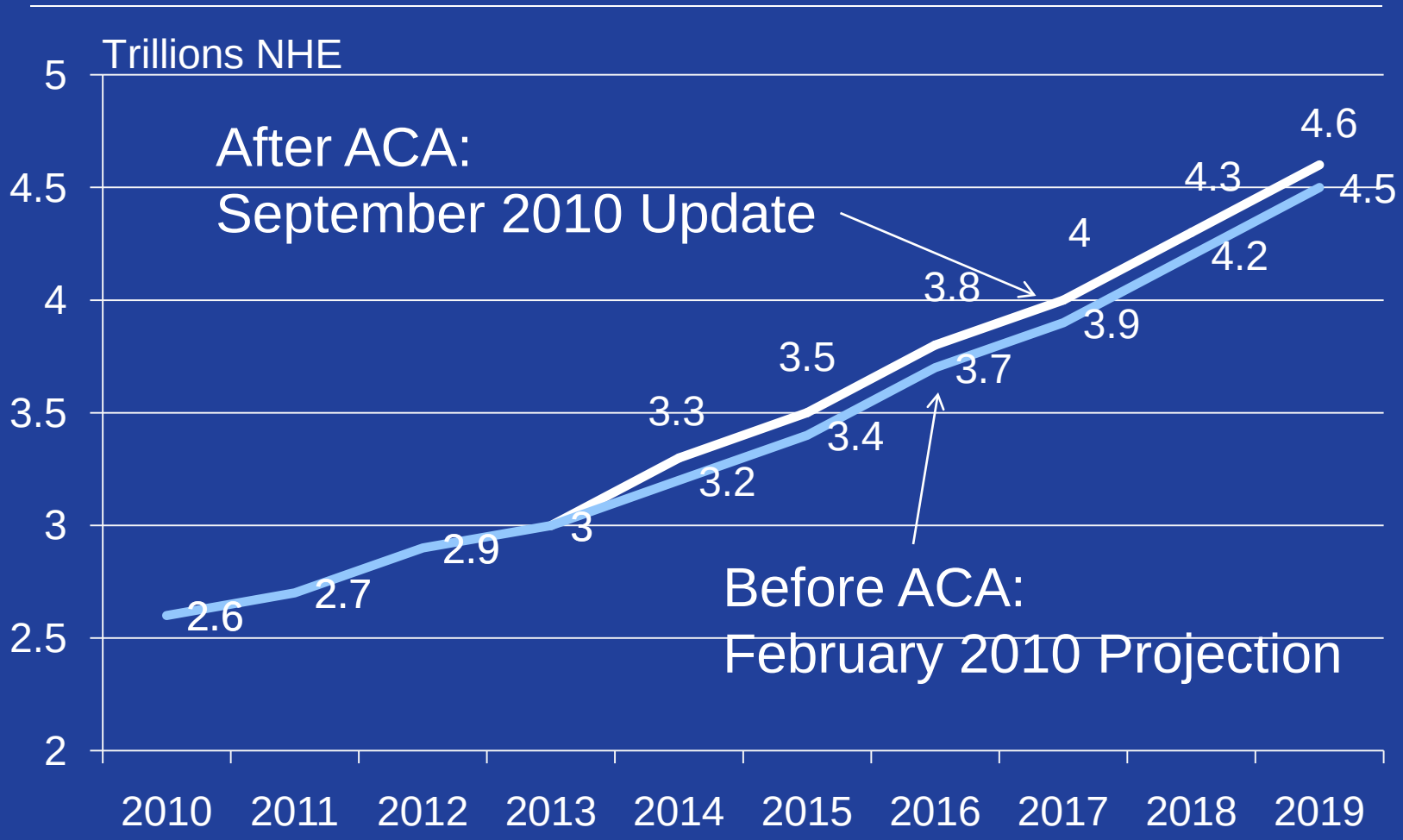
- Global capitation payments to large safety net hospital systems
  - Demos in 5 states, 2011 – 2012
- Bundled Medicaid payment demos for episodes of care that include hospitalizations
  - Demos in 8 states, 2012 – 2016
- Accountable Care Organizations for pediatric providers in Medicaid and CHIP
  - Demos for pediatric providers organized as ACOs (2012-2016)
  - Medicaid also in Medicare ACOs, beginning in 2012
- Primary care fees to 100% of Medicare, 2013 – 2014, at all federal funds for increase

Health reform law will "bend the curve:" E.g., Slower Medicare spending growth



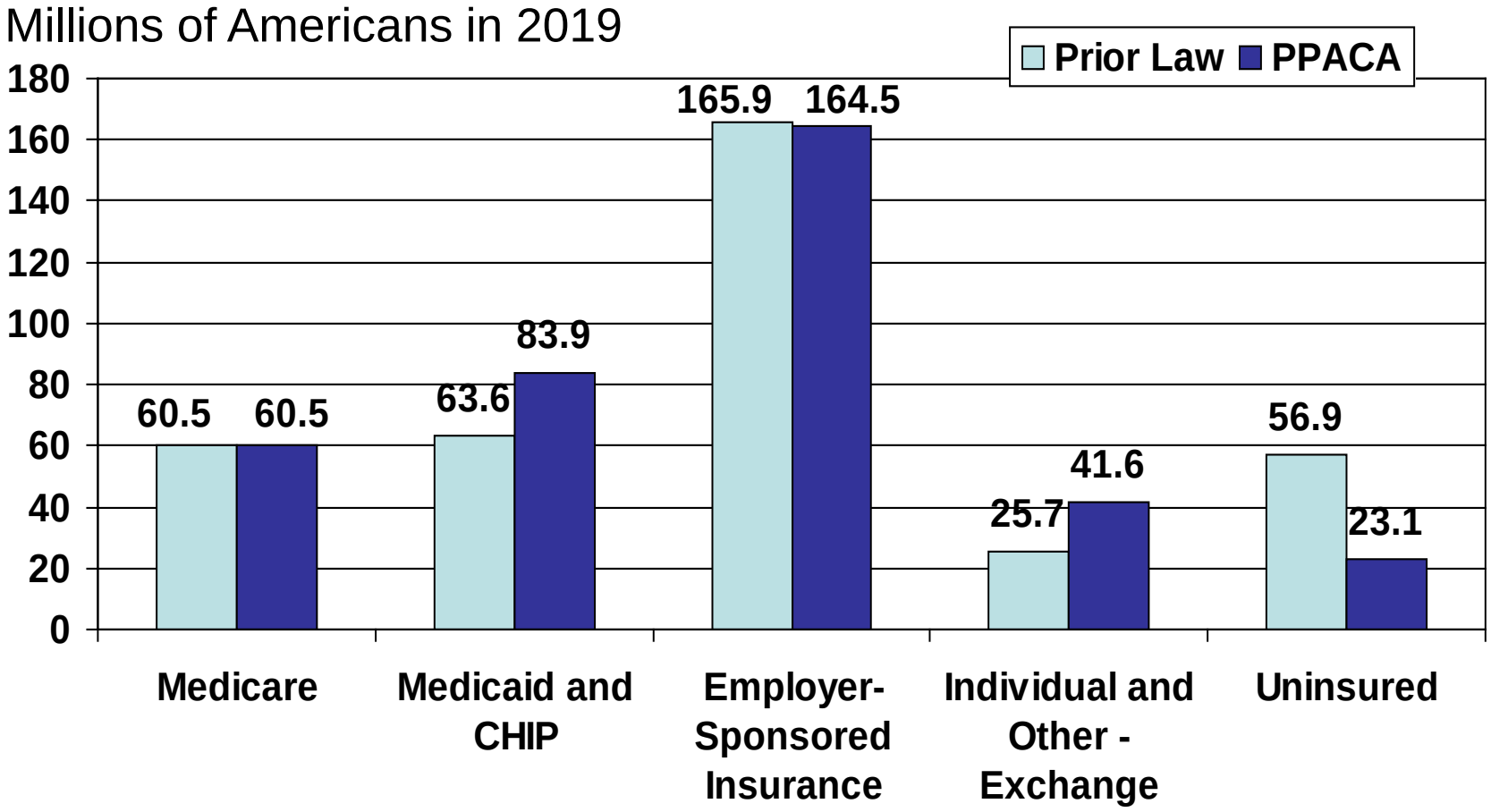
NOTE: Estimates do not take into account future changes to the Sustainable Growth Rate formula to prevent reduction in fees.
SOURCE: Medicare Baseline Spending before reform from CBO, March 2009 Baseline: MEDICARE; after reform from Kaiser Family Foundation analysis of CBO cost estimates of health reform legislation, March 20, 2010.

But With Expansions, National Health Expenditures Will Increase



Source: CMS data and statistics, 2010.

Coverage Reforms Build on Current System: Employers, Medicaid and Medicare



Source: Richard Foster, Chief Actuary, CMS, 2010.

Health Insurance Exchanges 2014

States have broad latitude in design of new health insurance exchanges for 2014

- Can be a state agency or non-profit entity
- Will offer only "qualified health plans," standardized benefits, can be selective
- Guaranteed issue, no medical underwriting

Exchange to serve individuals and small groups

- Incomes 133% to 400% FPL ($29,326 to $88,200 for family of 4)
- Sliding scale subsidies
- 16 million persons expected to buy coverage

Subsidies (and related credits) through 2019 to total $466 billion

Medicaid Expansion in 2014

Medicaid to be integrated with Exchange

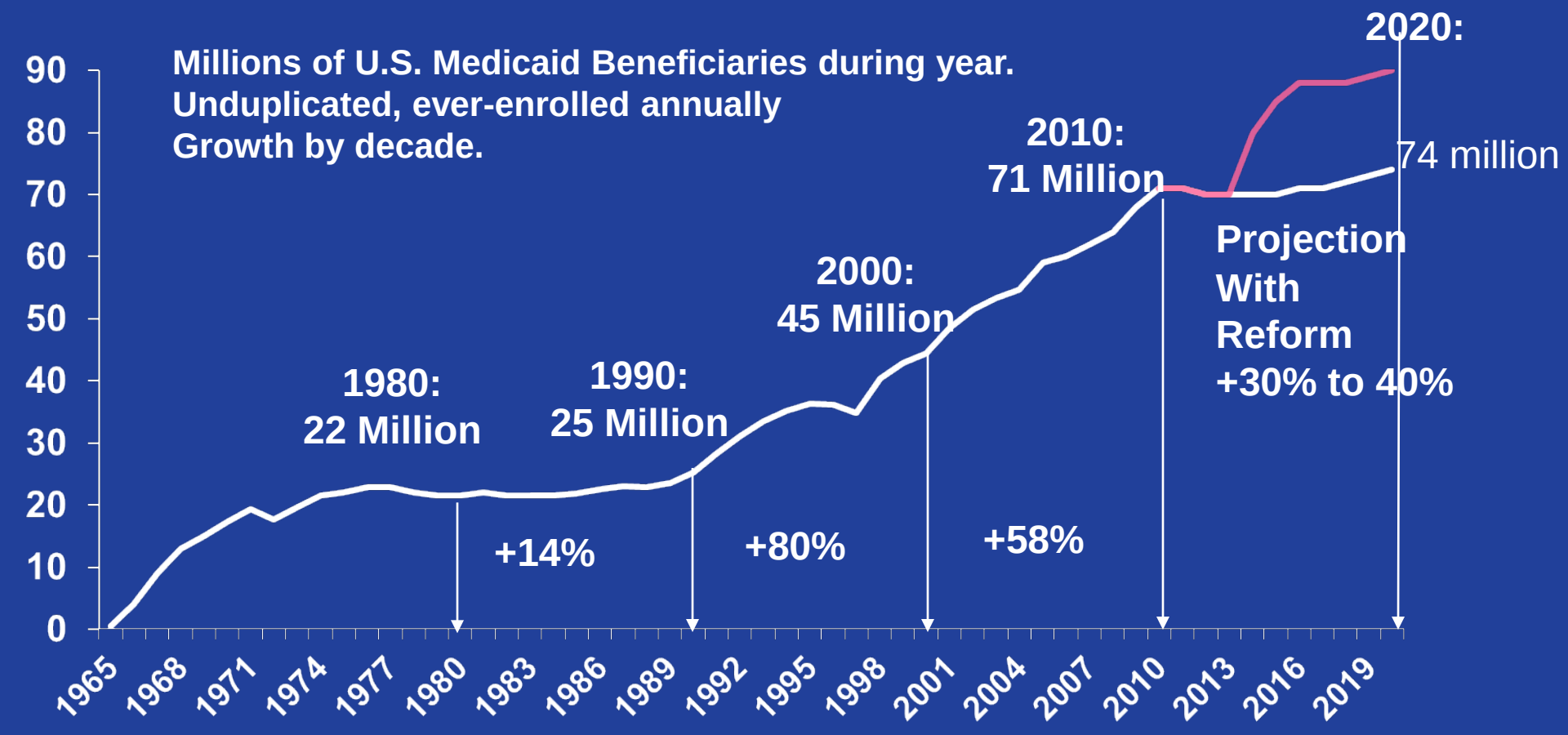
New national eligibility level @ 133% of FPL

- To use new MAGI income definition
- Federal funds pay most new Medicaid costs
  - 100% in 2014, 2015 and 2016;
  - 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and thereafter
- Feds to pay most current and new CHIP costs

Medicaid enrollment will grow by 16 million

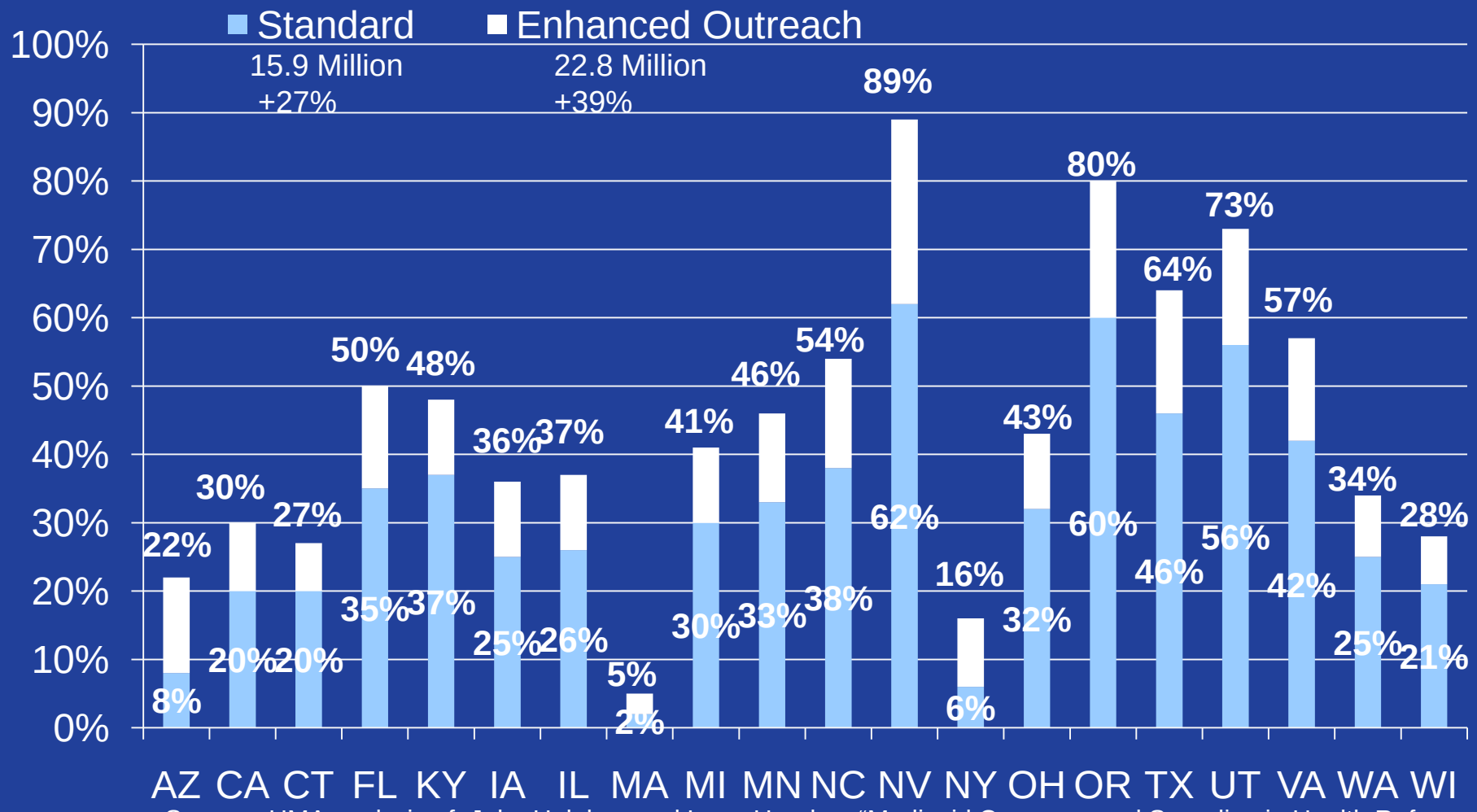
- Total cost 2014 to 2019:
  - Federal funds $434 Billion
  - State share $20 Billion

U.S. Medicaid Enrollment will Grow By 16+ Million With Coverage to 133% of Poverty Level



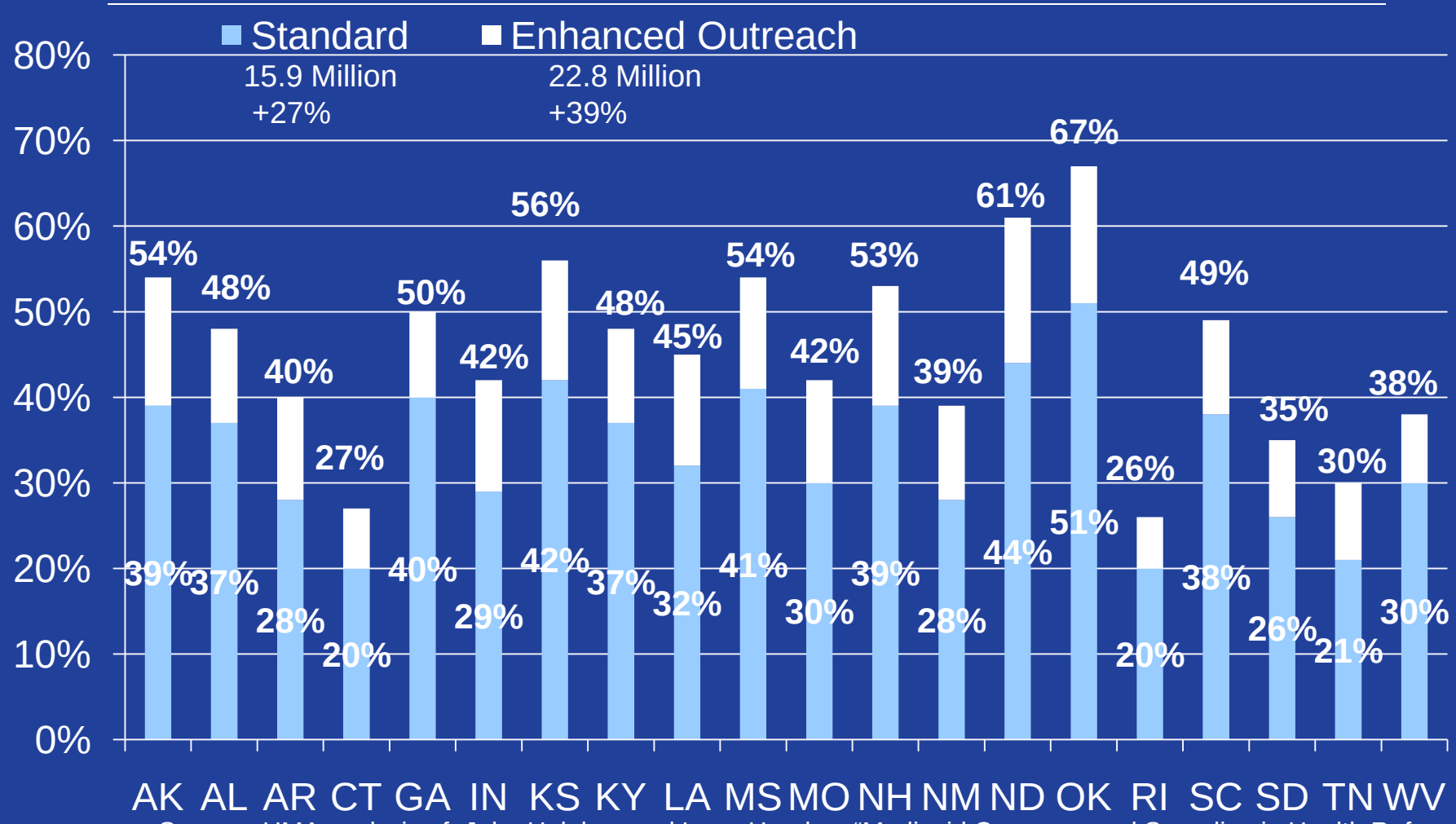
SOURCE: 1966 – 2009: HMA analysis of CMS and CBO historical data. 2010-2019: HMA calculations based on CBO Medicaid projections, 2010.

% Medicaid Enrollment Growth, Under Health Reform, Selected States



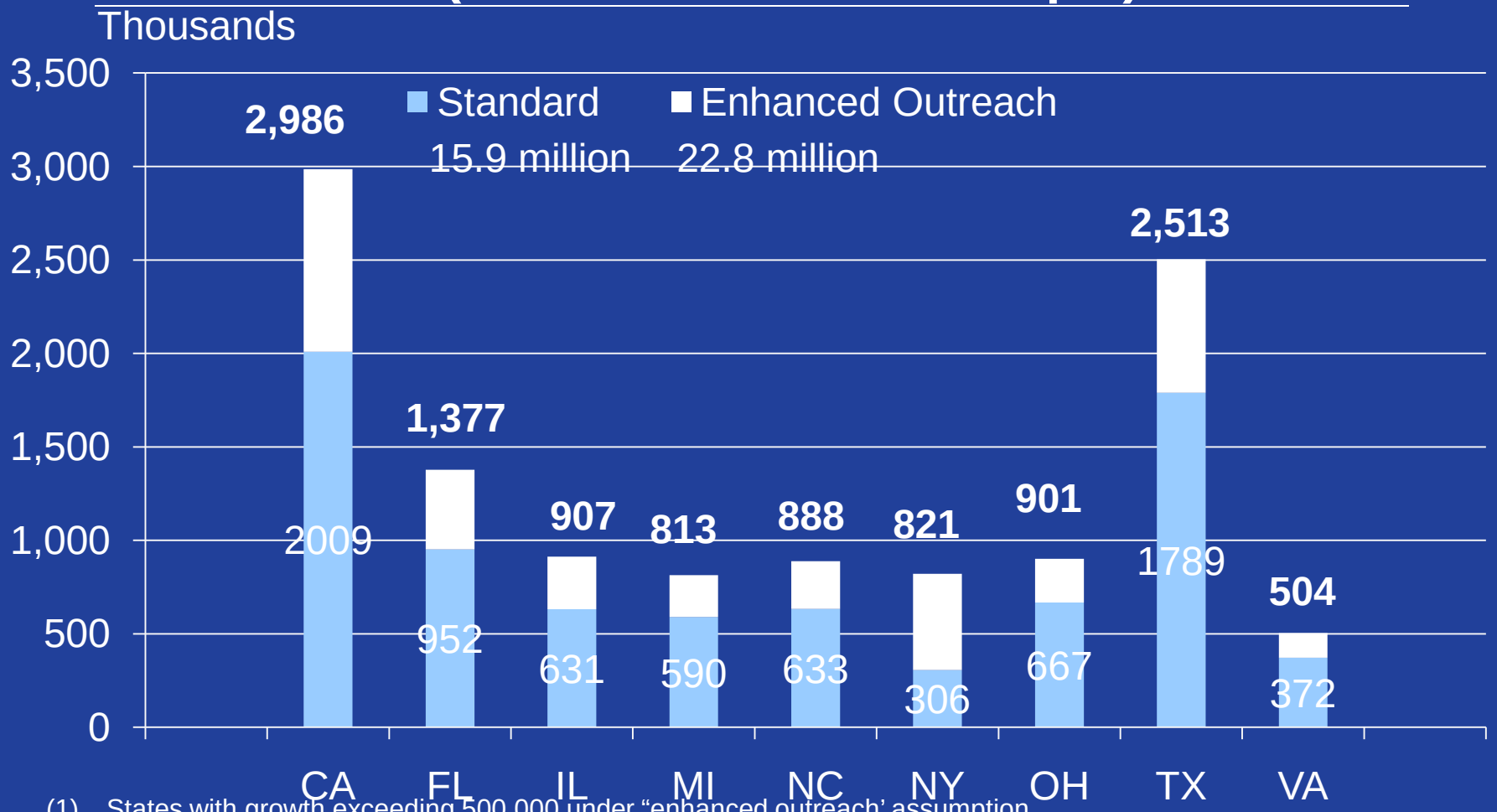
Source: HMA analysis of: John Holohan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," Kaiser Family Foundation, 2010.

% Medicaid Enrollment Growth, (2) Under Health Reform, Selected States



Source: HMA analysis of: John Holohan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," Kaiser Family Foundation, 2010.

Number of New Medicaid Enrollees Under Health Reform
(Selected States – Group 1)

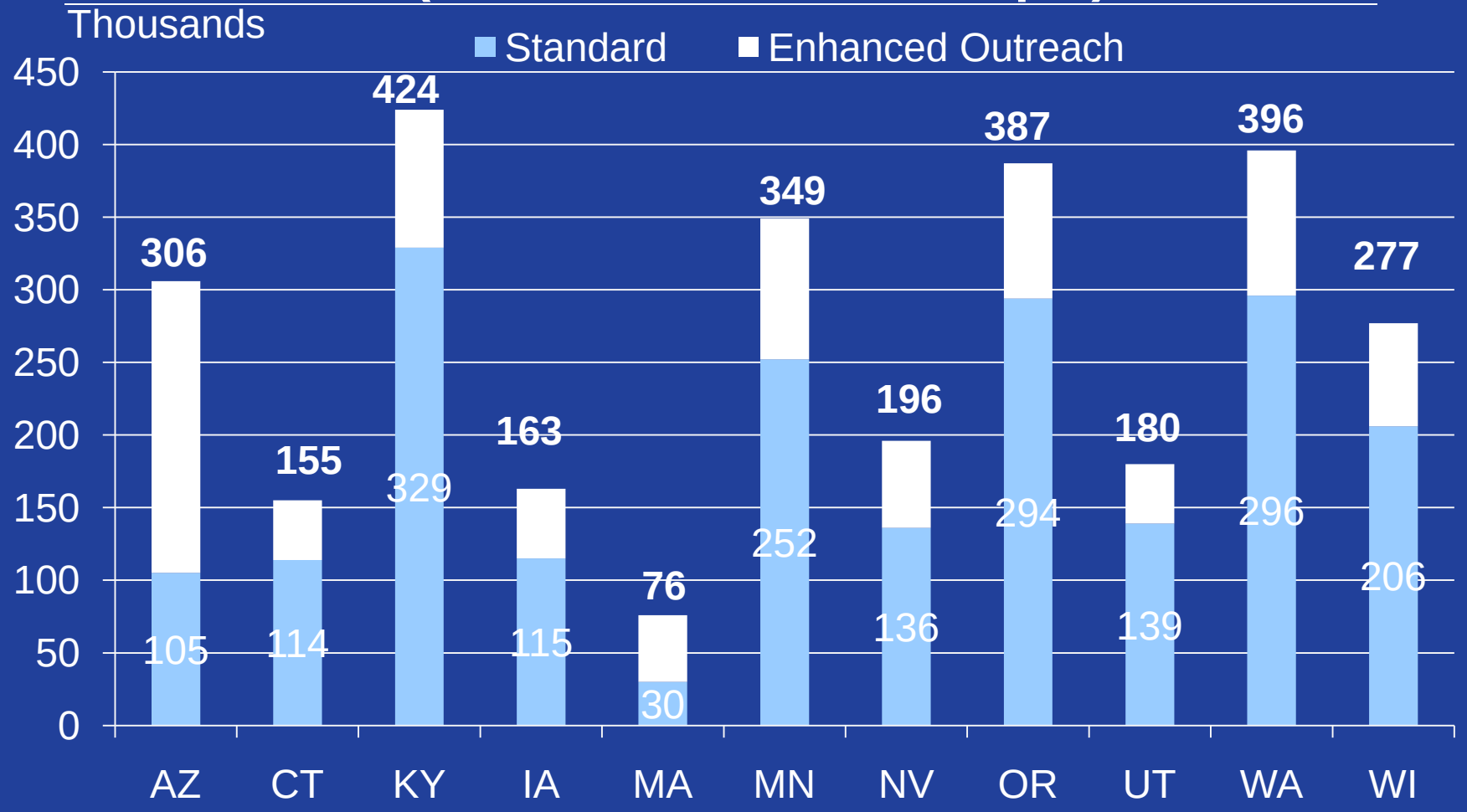


(1) States with growth exceeding 500,000 under "enhanced outreach' assumption.

Source: John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," Kaiser Family Foundation, 2010.

Number of New Medicaid Enrollees Under Health Reform

(Selected States – Group 2)

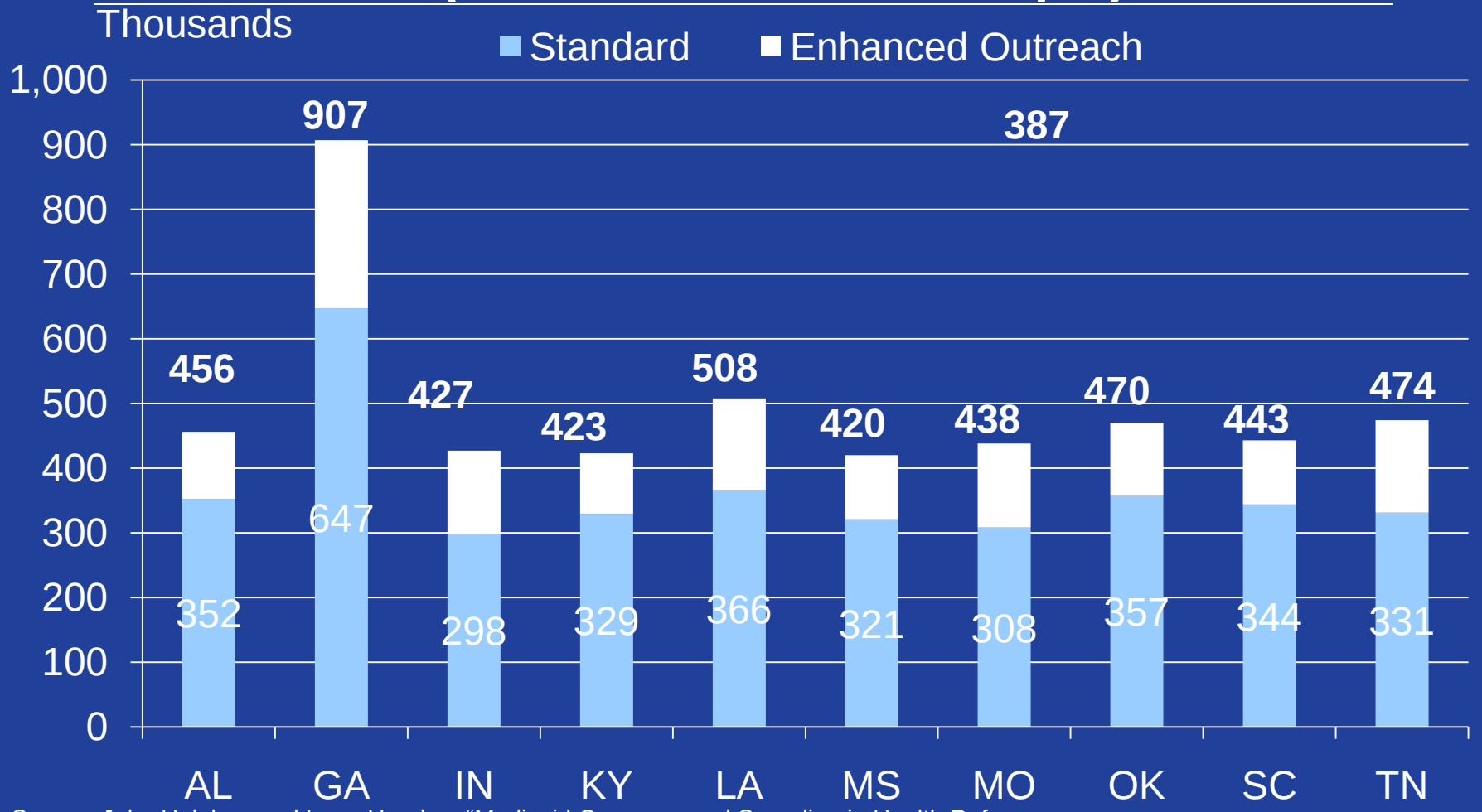


(2) States with growth less than 500,000 under "enhanced outreach' assumption.

Source: John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," Kaiser Family Foundation, 2010.

Number of New Medicaid Enrollees Under Health Reform

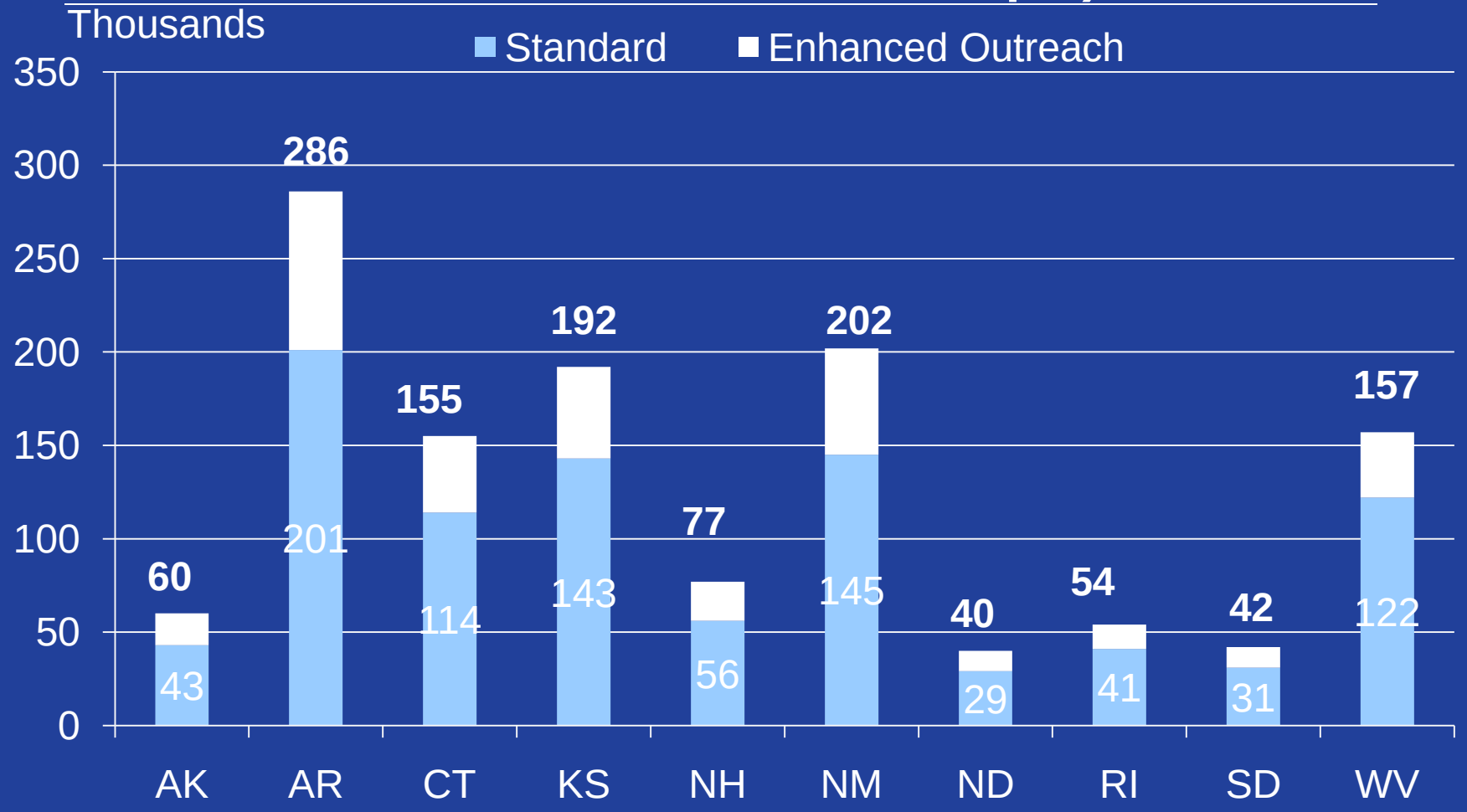
(Selected States – Group 3)



Source: John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," Kaiser Family Foundation, 2010.

Number of New Medicaid Enrollees Under Health Reform

Selected States – Group 4)



(2) States with growth less than 500,000 under "enhanced outreach' assumption.

Source: John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," Kaiser Family Foundation, 2010.

Most New Medicaid Enrollees Will Enroll in Medicaid MCOs

- Most states with Medicaid MCOs will require enrollment in a health plan
- Medicaid MCO enrollment, now 25 million in 35 states, will grow by 11 to 16 million
  - to 36 million – 41 million
  - 40% to 60% growth above current U.S. enrollment
  - New enrollees mainly will be adults without dependent children

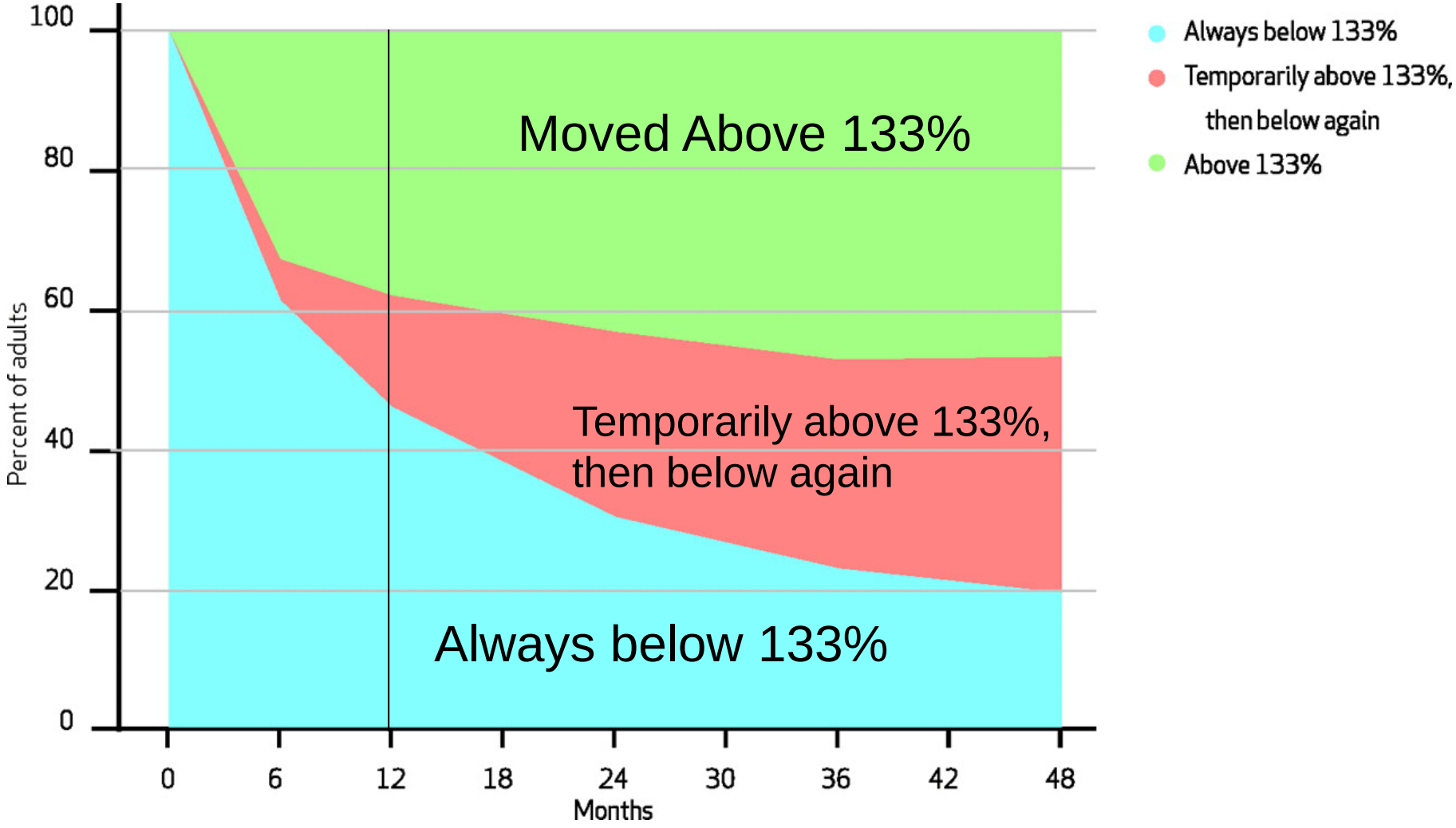
Source: Estimates prepared by Health Management Associates, 2011.

Churn: a Newly Appreciated Issue

- Medicaid eligibility is easily lost due to changes in income or family composition
- Churning is prevalent around 133% FPL
- Many will shift from Medicaid to Exchange, and Exchange to Medicaid
  - 35% within 6 months
  - 50% within 12 months
    - Risk of disruption of care, higher MCO costs, poorer health outcomes

Source: Sommers and Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," Health Affairs, February 2011.

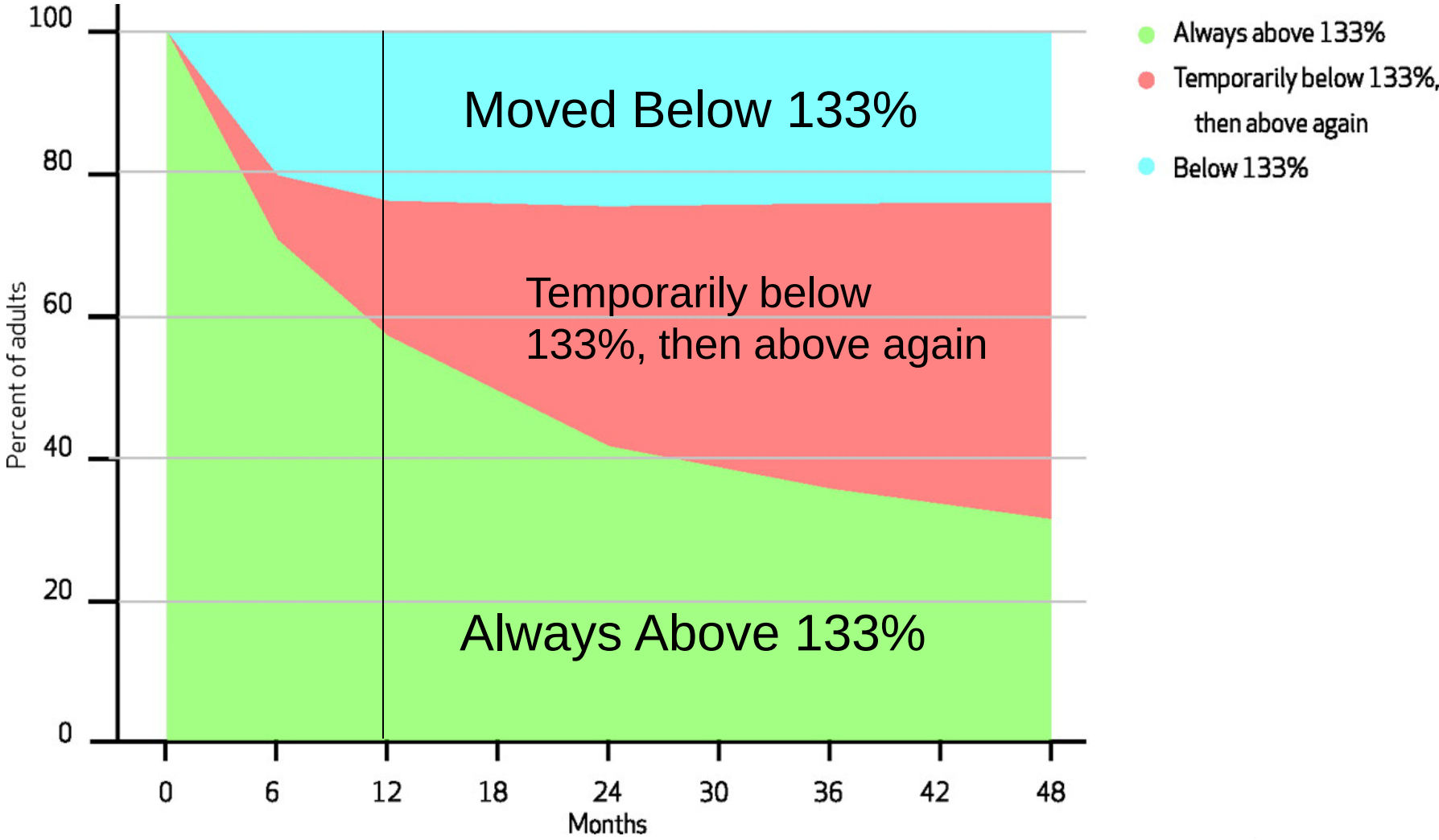
Income Changes Over Time: Adults Ages 19–60, Incomes Initially Under 133% Of Federal Poverty Level.



Source: HMA adapted from: Sommers B D , Rosenbaum S Health Aff 2011;30:228-236

HealthAffairs

Income Changes Over Time: Adults Ages 19–60, Incomes Initially Between 133% And 200% Of Federal Poverty Level



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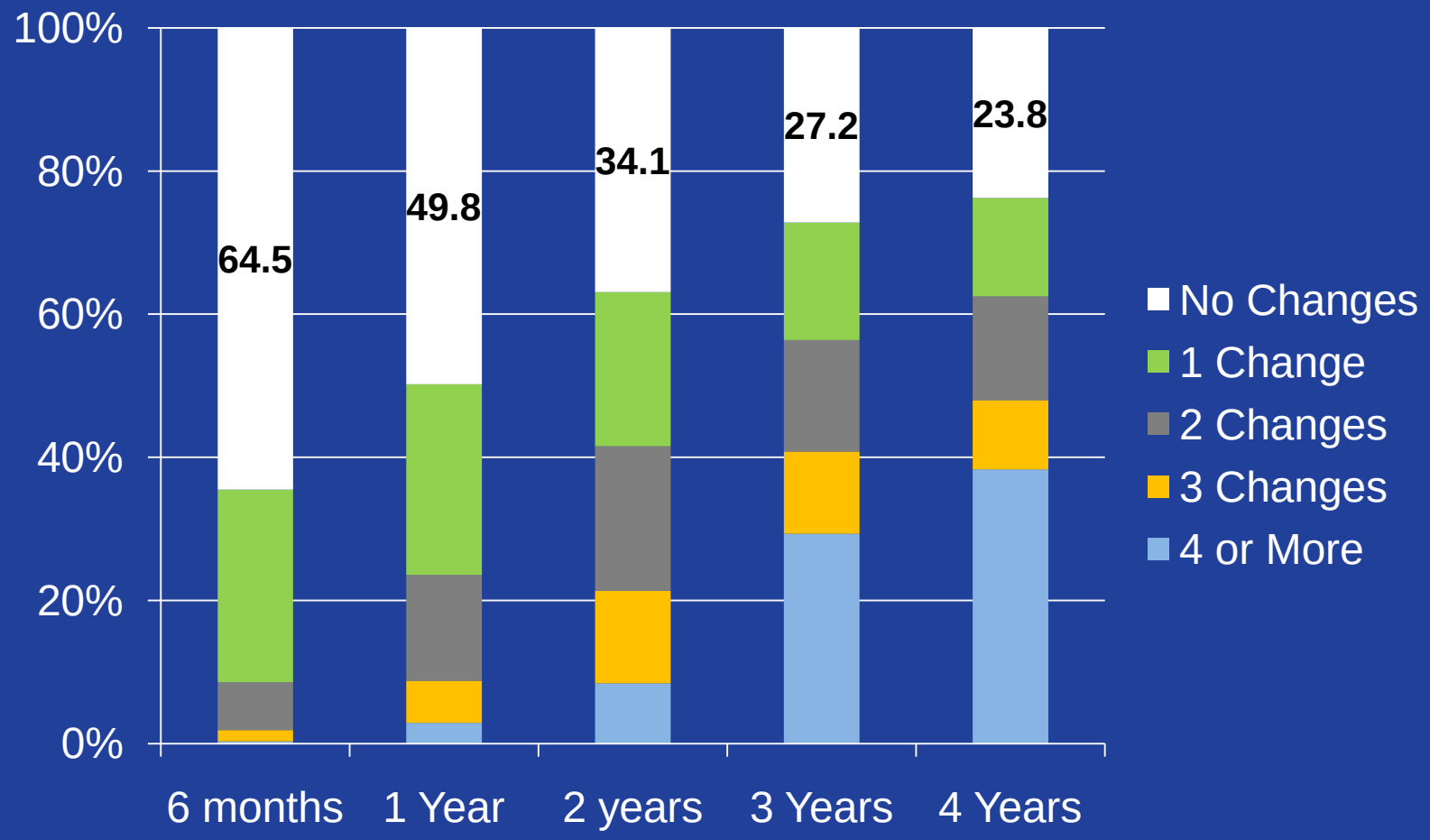
Frequency of Income Fluctuation Across 133% FPL, for Adults Initially Below 200%



Source: HMA, based on data from: Sommers B D , Rosenbaum S Health Aff 2011;30:228-236.

To Address Churn, States Could Adopt The New "Basic Health Plan" Option

- BHP option would cover adults with incomes below 200% FPL, and not eligible for Medicaid
- Coverage could be like Medicaid or CHIP
  - Through MCOs, but could vary in benefits, cost sharing, provider payments
- Federal payments to states set at 95% of federal subsidies in Exchange
  - Could exceed total PMPM, so States could realize savings in GF funds
- Could lessen churn around 133%FPL, but lessen role of Exchange

Source: Stan Dorn, "The Basic Health Program Option Under Federal Health Reform: Issues for Consumers and States," Urban Institute for State Coverage Initiatives, 2011.

Summary of Factors Impacting State Fiscal Impacts of Reform

- Medicaid eligibility to 133% FPL without categories, with MAGI, no asset test, enhanced FMAP
- Higher physician fees 2013-2014 & after
- New coordination for duals
- CHIP extended, with higher federal match
- Health insurance exchanges
- Less uncompensated care, DSH payments

Source: Bovbjerg, Ormand and Chen, "State Budgets Under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts," Kaiser Family Foundation, February 2011. http://www.kff.org/healthreform/8149.cfmpdf

Fiscal Impact of Reform on States: Estimates Vary Widely

FL	$ 5.7 cost
IN	$ 2.5 cost
KS	$ 0.2 savings
MD	$ 0.8 savings
TX	$27.0 cost

All states, by CBO	$ 20.0 cost
All states, by CMS	$ 33.0 savings
All states, by Dorn	$ 40.9 savings
All states, by Holahan	$ 21.1 savings
All states, by Lewin	$106.8 savings

Source: Bovbjerg, Ormand and Chen, "State Budgets Under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts," Kaiser Family Foundation, February 2011.

Why Do Estimates Vary?

"Expanding Medicaid naturally costs more in states where there are more uninsured residents with Medicaid income levels."

"Estimates use different methodologies in projecting costs of new enrollment and in including or omitting other costs, savings, or revenues."

Source: Bovbjerg, Ormand and Chen, "State Budgets Under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts," Kaiser Family Foundation, February 2011.

Other Factors in Variation

- Assumptions about Medicaid
  - “crowd-out” (employers to Medicaid)
  - Participation rates
  - Reductions in uncompensated care
  - Shifts from Medicaid to Exchange
  - Physician fees after 2014
- Time periods included
- Other cost and revenue offsets

Political Uncertainties

- Congressional attention to “repeal and replace” health reform will maintain uncertainty
  - Funds for implementation?
  - Changes to timelines, Medicaid expansion or Exchanges?
  - Allow demos and innovations?
  - Change Medicare payment reductions?
  - Change unpopular individual insurance mandate?
    - Supreme Court expected to rule on Constitutionality in 2012
- Reform issues will be kept alive through 2012 elections
- Leveraging sentiment to balance budget, reduce federal deficit
  - Congressional proposals for a Medicaid block grant,
  - Governors who want flexibility to cut Medicaid now

Summary: Amidst Political Uncertainty, Top Medicaid Issues Now For States

1) How to administer Medicaid in a way that is fiscally sustainable and assures value for taxpayers

- Significant decisions on how to slow spending growth
- End of enhanced federal matching on June 30, 2011 will force difficult funding decisions across state programs

2) How to prepare for health reform so it is advantageous for the state

- Designing the Exchange and integrating systems with Medicaid
- Using new options and demos to improve care and value, in primary and acute care, and in long term care
- Politics and uncertainty will influence each state's actions