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THE HENRY J. KAISER FAMILY FOUNDATION

Medicaid Today; Preparing for Tomorrow
A Look at State Medicaid Program Spending, Enrollment and Policy Trends

Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013

Executive Summary

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Executive Summary

After experiencing the impacts of the worst economic downturn since the Great Depression, state policy makers were finally beginning to see signs of economic recovery at the end of state fiscal year (FY) 2012 and heading into FY 2013. State revenue growth was positive and neither Medicaid spending nor enrollment was growing at the high rates seen only a few years before. Cost pressure and cost containment were still dominant themes, but states were also now able to consider positive program changes, payment and delivery system reforms and continue efforts to re-orient long-term care programs to community-based care models. Eligibility rules for Medicaid remained stable due to the maintenance of eligibility (MOE) protections that were part of health reform legislation, and a number of states adopted targeted eligibility expansions or simplified enrollment procedures.

States now are also preparing for the new role for Medicaid in the implementation of the Patient Protection and Affordable Care Act (ACA). As passed, the ACA would expand Medicaid beginning in January 2014 to nearly all adults with incomes up to 133 percent of the federal poverty level (FPL) ($14,856 per year for an individual in 2012). The Congressional Budget Office (CBO) estimated that across all states the ACA changes would add 17 million new enrollees to Medicaid by 2016. Under the June 2012 Supreme Court ruling, the Secretary's authority to enforce the ACA Medicaid expansion requirement is limited, and state policy makers will decide whether or when to implement the Medicaid expansion. Election year politics and looming discussions about federal deficit reduction serve as a backdrop and context for state decision making.

The findings in this report are drawn from the 12th 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. This survey reports on trends in Medicaid spending, enrollment and policy initiatives for FY 2012 and FY 2013. The report describes policy changes in reimbursement, eligibility, benefits, delivery systems and long-term care, as well as detailed appendices with state-by-state information, and a more in depth look through four state-specific case studies of the Medicaid budget and policy decisions in Massachusetts, Ohio, Oregon and Texas.

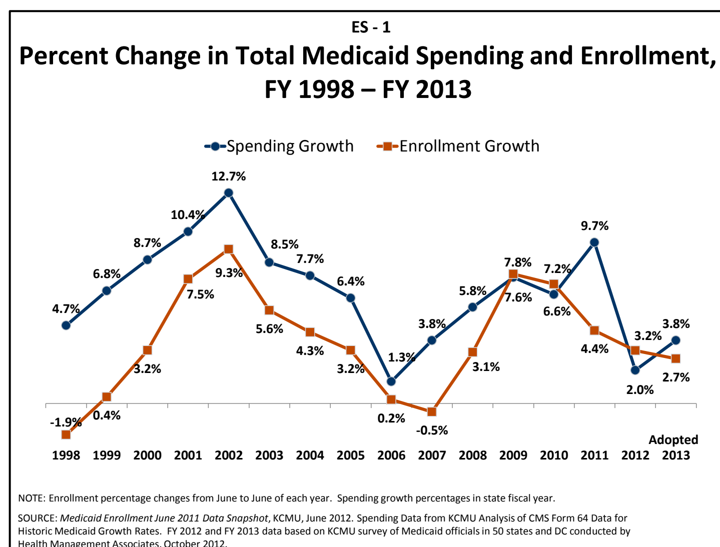
The top 5 key findings from the survey are highlighted below:

1. Medicaid spending slowed in FY 2012 to a near-record low as the economy began to improve and enrollment growth slowed. Slow program growth is expected to continue for FY 2013.
2. Cost containment remained a strong focus for Medicaid, but with small improvements in the economy, a number of states were able to make some targeted program improvements, including continued expansions of community-based long-term care options.
3. Medicaid eligibility levels remained stable in most states, as the ACA maintenance of eligibility (MOE) provisions limited states from restricting Medicaid eligibility standards, methodologies or procedures. Despite tight budgets, a number of states reported targeted eligibility expansions or enrollment simplifications.
4. Medicaid programs are engaged in a range of delivery system changes, including managed care reforms and care coordination strategies. Some of the most significant of these are initiatives to better deliver care for those dually eligible for Medicare and Medicaid.
5. Looking ahead, states are preparing for the implementation of the ACA and are making decisions about the Medicaid expansion in the context of upcoming elections as well as potential Medicaid implications from an intense national debate about the federal budget deficit.

1. **Medicaid spending slowed in FY 2012 to a near-record low as the economy began to improve and enrollment growth slowed. Slow program growth is expected to continue for FY 2013. (Figure ES-1)**

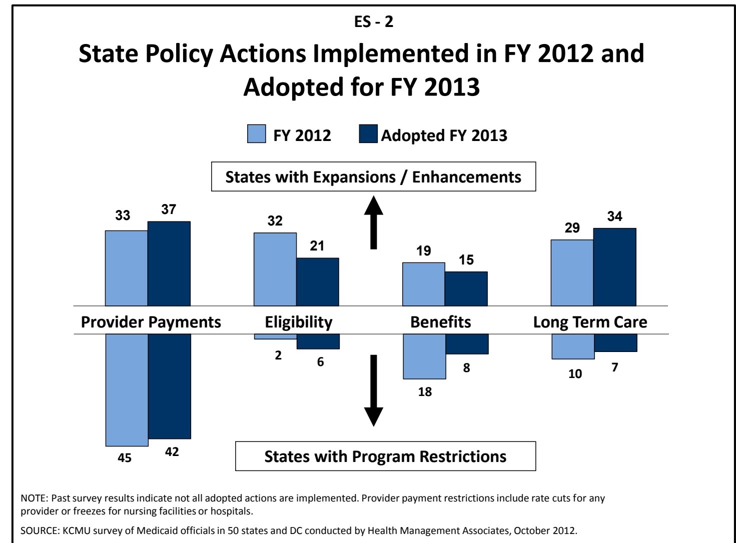
Total Medicaid spending growth hit a near record low in FY 2012, even as the state share of Medicaid spending spiked as states replaced expiring enhanced federal matching payments that were part of the American Recovery and Reinvestment Act (ARRA). FY 2012 total Medicaid spending increased by only 2.0 percent on average across all states. This was slightly less than original legislative appropriations of 2.2 percent set at the beginning of the fiscal year. Low spending growth was attributed to an improving economy which resulted in lower enrollment growth. The pace of Medicaid enrollment growth slowed in FY 2012 to 3.2 percent, the lowest rate of growth since 2008 at the beginning of the recent recession. Enrollment growth in FY 2012 was below initial projections for the second year in a row. Slow growth in FY 2012 was also attributed to intense state efforts to mitigate the increase in state spending driven by the expiration of enhanced federal matching payments on June 30, 2011. From October 2008 through June 2011, states received about $100 billion in federal fiscal relief from ARRA in the form of an enhanced federal match rate for Medicaid. The ARRA-enhanced federal matching rates (FMAP) reduced the state costs for Medicaid by increasing the federal share. This resulted in average declines in state spending for Medicaid of 10.9 percent in FY 2009 and 4.9 percent in FY 2010, the only declines in state spending for Medicaid in the program's history. Upon expiration of the enhanced federal Medicaid matching rate, the FMAP shifted back to statutory calculated levels and the state share of Medicaid spending increased by 27.5 percent in FY 2012 to make up for lost federal funds.

Headed into FY 2013, Medicaid spending and enrollment growth are much slower compared to rates during the height of the economic downturn. For FY 2013, legislatures authorized total spending growth on average of 3.8 percent across all states. While higher than for FY 2012, the 3.8 percent growth is one of the three lowest rates of growth in total Medicaid spending in the past 15 years. For FY 2013, states expected enrollment to continue to increase, but at an even slower pace than in FY 2012, with average growth across all states projected at 2.7 percent. Ten states budgeted for actual declines in Medicaid spending for FY 2013. Just over one-third of Medicaid officials reported a possible Medicaid budget shortfall, compared to more than half of states at the beginning of FY 2012. Growth among persons with disabilities and the elderly (groups with higher per capita costs) was cited as a group with significant growth in 15 states, largely driven by demographic trends.



2. Cost containment remained a strong focus for Medicaid, but with small improvements in the economy, a number of states were able to make some targeted program improvements, including continued expansions of community-based long-term care options. (Figure ES-2)

In FY 2012 and FY 2013, limits on provider payments, benefits and strategies to control prescription drug spending were the most reported cost savings strategies. In FY 2012, 48 states implemented at least one new policy to control Medicaid costs and 47 states planned to do so in FY 2013. As in previous years, provider rate restrictions were the most commonly reported cost containment strategy. A total of 45 states restricted provider rates in FY 2012 and 42 states reported plans to do so in FY 2013. Some states, however, increased or imposed new provider taxes that helped to mitigate provider cuts. Eighteen states in FY 2012 and eight states in FY 2013 reported eliminating, reducing or restricting benefits. Limits on dental and vision services, therapies, personal care services, and medical supplies were most frequently reported. Nearly all states continue to implement and refine an array of sophisticated pharmacy management tools including preferred drug lists (PDLs), supplemental rebates and prior authorization to control drug spending. New efforts for FY 2013 include plans to adopt the "Actual Acquisition Cost" reimbursement methodology for pharmacy ingredient costs, to "carve-in" prescription drugs to capitated managed care arrangements and to better control behavioral health drug utilization.



For FY 2013, budgets included more program improvements compared to FY 2012 for provider rates and benefits; rates for primary care physicians will also increase to Medicare levels as part of the ACA in 2013. These positive changes demonstrate some improvements in the economy relative to FY 2012. Overall restrictions outnumbered increases in provider payments in FY 2013, but more states increased, rather than cut, rates for certain providers such as physicians, MCOs and nursing facilities. In addition to other rate improvements, the ACA provides federal funding to increase rates for primary care services to Medicare levels for 2013 and 2014. This provision will increase primary care payment rates in nearly all states, with increases exceeding 80 percent expected in six states. More states also enhanced benefits than made restrictions. Benefit improvements included adding or expanding behavioral health services and some dental restorations in Idaho, Kansas, Massachusetts and Washington.

States continue long-standing efforts to re-orient the delivery of long-term care from institutions and into community settings through traditional programs and new options in the ACA. In FY 2012 and FY 2013, 29 and 34 states, respectively, took actions to expand long-term care (LTC) services (primarily through home and community-based service (HCBS) programs). The ACA included a number of new LTC options that are now in effect. Joining seven other states, three states (Connecticut, Idaho and Louisiana) implemented the HCBS state plan option in FY 2012, and two states (Delaware and Maryland) reported plans to implement in FY 2013. A number of states are using this option to target services to persons with mental illness or intellectual disabilities. Four states implemented the Balancing Incentive Program (BIP) in FY 2012 (Georgia, Iowa, Maryland and New Hampshire) and 10 states reported plans to implement the program in FY 2013. BIP increases Medicaid matching funds for states that meet requirements for expanding the percentage of LTC spending for HCBS relative to spending for institutional services. California was the only state to implement the Community First Choice (CFC) Option in FY 2012, but six more states (Arkansas, Louisiana, Minnesota, Montana, New York and Oregon) reported plans to implement the option in FY 2013. Under the CFC option, states that provide Medicaid-funded home and community-based attendant services and supports will receive an FMAP increase of six percentage points for CFC services.

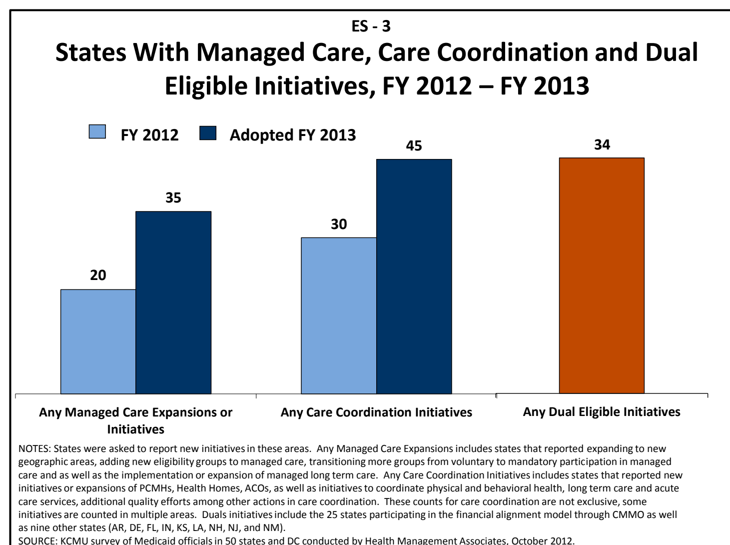
3. Medicaid eligibility levels remained stable in most states, as the ACA maintenance of eligibility (MOE) provisions limited states from restricting Medicaid eligibility standards or procedures. Despite tight budgets, a number of states reported targeted eligibility expansions or enrollment simplifications.

States continue to implement targeted eligibility expansions as well as simplifications to enrollment processes. Thirty-two states in FY 2012 and 21 states in FY 2013 reported moving forward with positive eligibility changes. For example, Minnesota, Colorado and New Mexico joined several other states in implementing Medicaid coverage for childless adults under a new option in the ACA or through a waiver. A waiver proposal has been submitted to expand coverage for adults in Cook County, Illinois. In addition to eligibility expansions, many states reported efforts to streamline their enrollment processes such as 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 few states are moving forward with restrictions to Medicaid eligibility that are exempt from the MOE provisions. Under the ACA, states must maintain eligibility and enrollment standards for Medicaid and CHIP that were in place at the time the ACA was enacted (March 23, 2010). These requirements apply until 2014 for adults and until 2019 for children in Medicaid and CHIP, with some limited exceptions. Under these exceptions related to expiring waivers and coverage for adults above 138 percent FPL in states certifying a budget deficit, a few states are implementing coverage restrictions. For example, Arizona froze enrollment for childless adults in their waiver program effective July 2011; Hawaii decreased the income limit to 133 percent of FPL for non-pregnant adults as of July 1, 2012; Illinois reduced the income limit for parents from 185 percent to 133 percent of FPL as of July 1, 2012, and Maine plans to eliminate coverage for non-disabled young adults ages 19 to 20 and reduce coverage for parents from 200 percent to 100 percent of FPL, effective October 1, 2012. Maine's plan is still pending at CMS.

4. Medicaid programs are engaged in a range of delivery system changes, including managed care reforms and care coordination strategies. Some of the most significant of these are initiatives to better deliver care for those dually eligible for Medicare and Medicaid. (ES-3)

States continue to adopt policies to expand managed care and enhance quality. In FY 2012, a third of states (20 states) reported expanded use of managed care, primarily by expanding managed care into new geographic areas or by adding eligibility groups. For FY 2013, over two-thirds of states (35 states) reported they were expanding managed care, including 10 states that indicated plans to implement managed long- term care. Over the 2012 to 2013 period, a total of 40 states are adopting new managed care policies. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. In FY 2012, a total of 14 states adopted new quality improvement strategies, and for FY 2013, a total of 23 states are planning to implement new strategies. These strategies include the use of new quality metrics, linking payment to plan performance on contractually specified measures, linking auto-enrollment to plan quality performance, and undertaking performance improvement projects targeted to priority areas.



NOTES: States were asked to report new initiatives in these areas. Any Managed Care Expansions includes states that reported expanding to new geographic areas, adding new eligibility groups to managed care, transitioning more groups from voluntary to mandatory participation in managed care and as well as the implementation or expansion of managed long term care. Any Care Coordination Initiatives includes states that reported new initiatives or expansions of PCMHs, Health Homes, ACOs, as well as initiatives to coordinate physical and behavioral health, long term care and acute care services, additional quality efforts among other actions in care coordination. These counts for care coordination are not exclusive, some initiatives are counted in multiple areas. Duals initiatives include the 25 states participating in the financial alignment model through CMMO as well as nine other states (AR, DE, FL, IN, KS, LA, NH, NJ, and NM).
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.

States are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care. All states except six reported that they have new care coordination efforts underway in FY 2012 or FY 2013. In FY 2013, health home initiatives were reported in 31 states, patient-centered medical homes in 32 states, and Accountable Care Organizations in 13 states, as well as initiatives to coordinate physical and behavioral health in 28 states, or to coordinate long-term care and acute care services also in 14 states.

New initiatives related to systems of integrated, coordinated care to serve dual eligible beneficiaries (individuals enrolled in both Medicaid and Medicare) were a top priority in FY 2012 and FY 2013. The ACA established the Medicare-Medicaid Coordination Office (MMCO) and the Center for Medicare and Medicaid Innovation. Together, these offices are working with states to develop new approaches to improve care for dual eligible beneficiaries. In this survey, 34 states reported that they will be developing new payment or delivery system options for dual eligible beneficiaries. This includes 25 states actively working with MMCO on financial alignment demonstration proposals, plus nine other states that are developing initiatives outside the financial alignment demonstrations to coordinate care for some or all dual eligible beneficiaries in their states. To date only one state, Massachusetts, has finalized a Memorandum of Understanding (MOU) with CMS to implement its capitated financial alignment demonstration. In the survey, states reported a number of challenges in moving forward with efforts for this population such as complexities in setting rates for providers, receiving and analyzing data from CMS on Medicare services for this population, how to avoid any gaps in care, especially during the transition to the financial alignment demonstration, and timelines. Despite the many challenges, states are actively working to implement these initiatives.

5. **Looking ahead, states are preparing for the implementation of the ACA and are making decisions about the Medicaid expansion in the context of upcoming elections as well as potential Medicaid implications from an intense national debate about the federal budget deficit.**

State policy makers are weighing the political, economic and health care consequences of their decisions related to Medicaid. With just over a year to go before the ACA health care coverage expansions go into effect in January 2014, most states are immersed in multiple planning and development efforts. States are deciding which insurance exchange model will operate in their state in 2014 and deciding how to proceed with the ACA Medicaid expansion. The June 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius* limited federal enforcement of the requirement to expand Medicaid giving states the ability to choose whether to implement the expansion. The vast majority of the Medicaid expansion is funded with federal dollars, so states that do not expand will forgo federal dollars and will leave many without coverage. Even without the expansion, states are still required to streamline and simplify the enrollment process for health coverage by 2014. Almost all states are moving forward with plans to take advantage of the 90/10 federal funding to upgrade or replace their Medicaid eligibility systems. States reported new opportunities to cover or improve coverage under the ACA but also highlighted challenges related to implementation timeframes, the need for additional federal guidance and additional administrative resources to implement the law.

Looking ahead, the outcome of the upcoming elections and the results of another round of federal deficit reduction negotiations are key areas of uncertainty for state Medicaid programs. While still a key priority, the singular focus on budget shortfalls and cost containment eased somewhat compared to prior years. However, decisions about moving forward with the Medicaid ACA expansion may hinge on state and national election outcomes for many states. In addition, states face some uncertainty about Medicaid changes that may be included in the upcoming federal deficit reduction debates. Despite these uncertainties, Medicaid directors and state policy makers are focused on the opportunities to improve care, enhance quality and control costs while at the same time preparing for the implementation of the ACA and its effect on Medicaid.