

# medicaid and the uninsured

JUNE 2012

## A Focus Group with Medicaid Directors: As FY 2012 Ends, Looking Toward FY 2013

### Executive Summary

This report is based on a focus group discussion in May 2012 with the Executive Board of the National Association of Medicaid Directors (NAMd) and other leading Medicaid directors. The group of nine directors reflected perspectives from various regions of the country. The discussion focused on state fiscal conditions, Medicaid spending and enrollment trends, key Medicaid policy changes and federal health care reform implementation. At the time of the meeting, most states were wrapping up FY 2012 and preparing for FY 2013.

**Most Medicaid directors in the focus group reported that the economic outlook continues to improve, but some were still facing ongoing fiscal challenges such as high unemployment and budget shortfalls.** Some of the Medicaid directors participating in the discussion reported that revenues were improving and in some cases higher than anticipated. Other directors reported fiscal challenges largely tied to the lingering effects of the recession.

**Medicaid enrollment and spending growth are moderating.** Most of the directors reported that enrollment (the primary driver of Medicaid spending) was continuing to grow, but at a significantly slower rate than in recent years. Overall improvements in the economy as well as a recent unexpected and unexplained moderation in utilization growth were contributing to slower enrollment and spending growth. While three directors reported the need to address FY 2012 Medicaid budget shortfalls, one state commented that FY 2012 Medicaid spending growth was lower than expected contributing to a current state surplus.

**FY 2013 policy changes are focused around delivery system reforms and managed care.** Improvement in state fiscal conditions appears to have alleviated pressure to enact severe Medicaid cuts in many states. Instead, directors most frequently mentioned delivery system reforms, managed care and care coordination initiatives as policy changes planned for FY 2013. Directors specifically mentioned efforts to address behavioral health service delivery issues and efforts to control increasing costs for specialty pharmacy drugs. Plans to cut provider rates were not as prevalent as in prior years among those in the focus group.

**Most of the states in the focus group were moving ahead with initiatives to integrate care and financing for the duals, but face obstacles.** Five of the nine states participating in the focus group discussion were working with the CMS Medicare-Medicaid Coordination Office on integrated care initiatives for persons eligible for both Medicare and Medicaid ("dual eligibles"). Several directors identified barriers to achieving full integration such as long-standing operational divisions between Medicare and Medicaid within CMS at the federal level, tight timelines and delays in accessing data.

**Directors in the focus group reported that efforts to implement the Affordable Care Act (ACA) continue, even with the Supreme Court decision pending.** Despite the uncertainty generated by the pending legal challenges, Medicaid directors report that ACA implementation efforts continue across the country, although the degree of readiness varies considerably from state to state. Directors were generally positive about the potential access improvements that could result from the ACA requirement to increase rates for primary care providers in 2013 and 2014, but were concerned about implementation challenges and complexities. Directors generally reported more progress in updating eligibility systems compared to progress establishing health insurance exchanges. Regarding benefits for the Medicaid expansion population, several directors agreed that it would be simplest to adopt the existing Medicaid benefits package as the required essential health benefits package. States represented in the focus group were mixed in terms of the net state fiscal impact of the ACA with some states anticipating new costs and others projecting net savings.

## Introduction

In May 2012, a group of leading state Medicaid Directors met in Arlington, Virginia to discuss the current challenges and opportunities facing state Medicaid programs. At the time of the meeting, most states were at the end of FY 2012 and about to start FY 2013. During FY 2012, states were still experiencing the effects of the recession and state budgets also had to account for the expiring federal Medicaid stimulus funds. From October 1, 2009 through June 30, 2011, the American Recovery and Reinvestment Act of 2009 (ARRA) provided an estimated \$103 billion in fiscal relief to states in the form of an enhanced federal matching rate (known as the federal medical assistance percentage, or FMAP).<sup>1</sup> To replace those funds, states were forced to increase FY 2012 state funds for Medicaid budgets, on average, by 28.7 percent.<sup>2</sup> As a result of the recession and the expiration of the ARRA funds, 42 states needed to take action to close FY 2012 state budget shortfalls.<sup>3</sup>

Heading into FY 2013, state revenue collections in most states had improved. Through the fourth quarter of CY 2011, total state tax collections (nationwide) had grown for eight consecutive quarters with collections in most states finally exceeding collections in the 4<sup>th</sup> quarter of 2007 when the recession began. In 17 states, however, revenues remained lower than they were four years earlier,<sup>4</sup> and in many states, unemployment remained high. On the national level, the unemployment rate was 8.2 percent in May 2012.<sup>5</sup> For FY 2013, 30 states have addressed or have projected shortfalls of \$54 billion, lower than FY 2012 but still high by historic standards.<sup>6</sup> Despite constrained budgets, states are forging ahead with planning, development and implementation of a number of very important and high profile initiatives including integrated care initiatives for dual eligibles, managed care expansions and health care reform-related activities. It was within this context that the focus group took place.

## Key Findings

***Most Medicaid directors in the focus group reported that the economic outlook continues to improve, but some were still facing ongoing fiscal challenges such as high unemployment and budget shortfalls.***

Half of the Medicaid directors participating in the focus group discussion reported that economic conditions in their states were improving. One director said that his state had seen 18 consecutive months of state revenue increases making FY 2013 the “easiest budget year in recent memory.” Another indicated his state had experienced better than expected revenue collections in the current fiscal year while another Medicaid director reported a budget surplus from higher than expected state revenues and lower than expected Medicaid expenditures. Other directors, however, reported ongoing state fiscal challenges. For example, one director reported a \$150 million unresolved Medicaid budget shortfall for FY 2012. At the time of the focus group, that state’s FY 2013 budget remained unresolved as well.

---

<sup>1</sup> ARRA included an additional 6.2 percentage point increase in all states’ FMAPs with additional targeted increases related to changes in the state’s unemployment rate through December 2010. This was extended at a reduced rate through June 2011. For more information, see “Impact of the Medicaid Fiscal Relief Provisions in the American Recovery and Reinvestment Act (ARRA),” Kaiser Commission on Medicaid and the Uninsured, October 2011. <http://www.kff.org/medicaid/8252.cfm>.

<sup>2</sup> Vernon Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, and Laura Snyder, “Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends,” Kaiser Commission on Medicaid and the Uninsured. October 2011. <http://www.kff.org/medicaid/8248.cfm>.

<sup>3</sup> Elizabeth McNichol, Phil Oliff and Nicholas Johnson, “States Continue to Feel Recession’s Impact”, Center on Budget and Policy Priorities, May 24, 2012. <http://www.cbpp.org/cms/index.cfm?fa=view&id=711>.

<sup>4</sup> Lucy Dadayan, “Tax Revenues Surpass Previous Peak But Growth Softens Once Again,” State Revenue Report No. 87, Rockefeller Institute of Government, April 2012. [http://www.rockinst.org/pdf/government\\_finance/state\\_revenue\\_report/2012-04-19-SRR\\_87.pdf](http://www.rockinst.org/pdf/government_finance/state_revenue_report/2012-04-19-SRR_87.pdf).

<sup>5</sup> Regional and State Employment and Unemployment — May 2012, Bureau of Labor Statistics, June 15, 2012.

<sup>6</sup> Elizabeth McNichol, Phil Oliff and Nicholas Johnson, “States Continue to Feel Recession’s Impact”, Center on Budget and Policy Priorities, May 24, 2012. <http://www.cbpp.org/cms/index.cfm?fa=view&id=711>.

### ***Medicaid enrollment and spending growth are moderating.***

In the 2011 annual Medicaid budget survey, states projected Medicaid enrollment to increase on average by 4.1 percent in FY 2012, lower than the 5.5 percent rate of growth in FY 2011 and much lower than the 7.2 percent growth rate in FY 2010. During the focus group discussion, most of the states reported that enrollment was continuing to grow, but at a significantly slower rate than in recent years. Both Tennessee and West Virginia, for example, reported that enrollment growth had slowed to an annual rate of less than 1 percent. The Nevada director also reported that a steep drop in state in-migration had contributed to a slowing enrollment growth rate in his state.

On the spending side, three states reported the need to address FY 2012 Medicaid budget shortfalls which indicates that Medicaid spending growth in those states exceeded the growth rates assumed in the original FY 2012 appropriated amounts. Two of these states, however, had predicted a likely shortfall in the 2011 annual Medicaid budget survey (suggesting that the actual FY 2012 Medicaid spending growth rate was not unexpected as of the beginning of the fiscal year). One state, however, commented that FY 2012 Medicaid spending growth was lower than expected contributing to a current state surplus. The directors identified slower enrollment growth and a recent unexpected and unexplained moderation in utilization growth as contributing factors to slower spending growth. There was also general agreement that accelerating growth in specialty pharmacy expenditures was an upward pressure on Medicaid spending. One director commented that spending growth for specialty pharmacy products in his state had grown from the 1-3 percent range to 8 percent in more recent quarters. He further noted that approximately 60 percent of the state's pharmacy trend was attributable to specialty drugs. Policy initiatives are emerging to address these cost trends.

### ***FY 2013 policy changes are focused around delivery system reforms and managed care.***

Improvement in state fiscal conditions appears to have alleviated pressure to enact severe Medicaid cuts in many states. When asked about Medicaid program and policy changes planned for FY 2013, the Medicaid directors attending the focus group discussion most frequently mentioned delivery system reforms, managed care and care management initiatives. Many of these initiatives were focused on complex, high-need and high-cost populations. Unlike previous years, provider rate cuts were not raised as a dominant policy to control costs. In fact, one director mentioned plans for targeted rate increases for specific services and another director reported that his state was actually planning to “buy back” some cuts previously made. The delivery system and managed care changes mentioned included the following:

- **Arkansas** is instituting a multi-payer payment initiative as a first wave of planned payment reforms.
- **Nevada** and **Oregon** reported plans for payment and delivery system reforms using Section 1115 demonstration waivers. Nevada's waiver was submitted to CMS in April. Oregon's waiver was recently approved and is based on the creation of Coordinated Care Organizations (CCOs) — a new legal entity created by the state legislature to improve the delivery of health care by coordinating care among a spectrum of providers, from primary care physicians and hospitals to dentists and behavioral health professionals.
- **Minnesota** and **West Virginia** are expanding their current managed care programs to additional populations and West Virginia is also carving in the prescription drug benefit.
- **North Carolina** reported plans for a managed care initiative that would integrate behavioral health and physical health care. The state also plans to employ new analytics to improve its program integrity efforts and make changes to its adult home health and personal care programs — changes that were needed but only possible because of the state's budget issues.

- **Massachusetts'** new Behavioral Health Organization contracts will require plans to provide care management and care coordination for physical health services. Massachusetts also reported working on an Accountable Care Organization (ACO) approach and provider level pilots that integrate behavioral health and physical health.

Several directors were also focused on initiatives to improve the delivery of behavioral health services in their states. Specific initiatives targeted over-utilization of behavioral health services for children and over-prescribing of atypical antipsychotics. Looking ahead to 2014, directors commented that behavioral health is likely to be an emerging issue as states move away from a grant-based system to individual coverage which will have implications for community-based mental health providers.

***Most of the states in the focus group were moving ahead with initiatives to integrate care and financing for the duals, but face obstacles.***

Most of the states in the focus group discussion were working with the CMS Medicare-Medicaid Coordination Office (the "Coordination Office") on integrated care initiatives for persons eligible for both Medicare and Medicaid ("dual eligibles"). To date, 26 states have submitted proposals to CMS, with 18 states seeking to test the capitated model, 5 states seeking to test the managed fee-for-service model, and 3 states seeking to test both models. The vast majority of these states are targeting all duals or all adult duals statewide. Nationwide, CMS expects that up to 2 million dual eligibles will be enrolled in a state demonstration. The demonstrations are proceeding on a relatively fast timeframe, with two states seeking to implement their proposals by late 2012, and another 13 states seeking implementation in 2013. Many important design and operational details remain to be determined in the memoranda of understanding that will be negotiated between CMS and the states.

During the focus group discussion, several directors noted barriers in achieving full integration under dual eligible demonstrations such as long-standing operational divisions between Medicare and Medicaid within CMS at the federal level, tight timelines and delays that are pushing demonstration implementation start dates from 2013 to 2014. For example, one director indicated delays in receiving Medicare rate information had made it impossible to know whether the state's demonstration would be financially viable. Lacking this information, the state has been unable to move forward despite buy-in from all levels of government.

***Directors in the focus group reported that efforts to implement the Affordable Care Act (ACA) continue, even with the Supreme Court decision pending.***

In November 2011, the U.S. Supreme Court agreed to hear federal court appeals challenging the constitutionality of the ACA including the constitutionality of the individual mandate and the Medicaid expansion. The court held oral arguments over three days in March 2012 and is expected to issue a decision by late June. Despite the uncertainty generated by the pending legal challenges, Medicaid directors report that ACA preparations and implementation efforts continue across the country, although the degree of readiness varies considerably from state to state.

***Proposed regulations implementing the primary care physician rate increase may present operational challenges to states.*** The directors were generally positive about the potential access improvements that could result from the ACA requirement to reimburse primary care services at no less than the Medicare rate in 2013 and 2014, but several directors in the focus group discussion identified operational challenges. For example, states with older claims payment systems may be unable to identify the provider specialties required in the proposed rule. A few directors noted issues related to implementing the fee increase for managed care. Another director commented that while the ACA provided 100 percent federal funding for the incremental Medicaid cost in 2013 and 2014 only, increases required in the Children's Health Insurance Programs (CHIP) are not fully federally funded and another director commented on the difficulty of sustaining the increases after 2014 when the enhanced federal funding expires.

**States are moving forward with eligibility system upgrades.** Medicaid eligibility systems in many states are very old and not able to meet the ACA requirements for 2014 to expand Medicaid eligibility, implement the new Medicaid income eligibility standard based on "Modified Adjusted Gross Income" (MAGI), and coordinate with new health insurance exchanges. In November 2010, the federal government approved a temporary funding opportunity, under which states can receive a 90 percent federal funding match for the design, development, and implementation of major upgrades or new Medicaid eligibility systems, up from the regular 50 percent administrative matching rate. As of January 1, 2012, 29 states had approved or submitted plans to overhaul or build new systems, and most of the remaining states had indicated interest in pursuing an upgrade during 2012.<sup>7</sup> One director commented that the enhanced federal funding was a "once in a lifetime" opportunity for investment in new systems. Despite the enormous challenge to achieve system readiness within a compressed timeline, most of the states at the focus group discussion expected their eligibility systems to be ready to support health care reform implementation in 2014. The focus group discussion highlighted some challenges in coordinating the eligibility determination processes for Medicaid with other social service programs such as TANF<sup>8</sup> and SNAP.<sup>9</sup> Other challenges cited were related to the potential impacts on eligibility caseworkers (including staff reductions) resulting from greater use of on-line, simplified application processes.

**State progress in developing health insurance exchanges is mixed.** Other than the ACA required Medicaid expansion, state-based health insurance exchanges are the principal mechanisms used by the ACA to extend health insurance to millions of uninsured Americans beginning in 2014. A number of states quickly initiated exchange planning activities soon after the passage of the ACA, and many states applied for and received federal Level 1 Exchange Establishment grants to support planning and development activities. Exchange planning in some states, however, has been slowed or halted by pending legal challenges to the ACA. As of May 2012, 12 states had halted exchange planning while awaiting the U.S. Supreme Court's ruling on the constitutionality of the ACA expected in late June and another five state continued to plan but were awaiting the Supreme Court decision before pursuing authorizing state legislation. Six states have never begun serious exchange planning activities.<sup>10</sup>

Among Medicaid directors participating in the focus group, two expressed concerns regarding their state's readiness to operate an exchange. In the absence of state readiness, the federal government will step in to run all or part of the exchanges in these states. One director opined that some states that are not currently moving forward with exchange planning publicly may nevertheless continue to work "behind the scenes" to avoid the possibility of a federally run exchange in their state.

Several directors also commented on their state's planning regarding the ACA required "essential health benefits package (EHB)." The EHB is the comprehensive package of items and services in 10 statutorily required categories that is mandatory for both the Medicaid expansion population and in private plans offered in the individual and small group markets, both inside and outside of the ACA exchanges. CMS has provided each state the flexibility to define the essential benefits plan for its state by using the traditional Medicaid benefits package or by selecting one of the benchmark plans that reflects the scope of services offered by a "typical employer plan."<sup>11</sup> Several directors agreed that for the Medicaid expansion population it would be simplest to adopt the existing Medicaid benefits package as the essential health benefits package.

---

<sup>7</sup> "How is the Affordable Care Act Leading to Changes in Medicaid Today? State Adoption of Five New Options," Kaiser Commission on Medicaid and the Uninsured. May, 2012. <http://www.kff.org/medicaid/8312.cfm>

<sup>8</sup> Temporary Assistance for Needy Families, formerly AFDC or "Welfare."

<sup>9</sup> Supplemental Nutrition Assistance Program, formerly "Food Stamps."

<sup>10</sup> "Timing Matters: States Waiting for a Supreme Court Decision to Plan an Exchange," Kaiser Family Foundation, May 25, 2012. [http://www.kff.org/healthreform/quicktake\\_SCOTUS\\_exchanges.cfm](http://www.kff.org/healthreform/quicktake_SCOTUS_exchanges.cfm).

<sup>11</sup> Benchmark reflects the scope of services offered by a "typical employer plan": one of the three largest small group plans in the state by enrollment; one of the three largest state employee health plans by enrollment; one of the three largest federal employee health plan options by enrollment, or the largest HMO plan offered in the state's commercial market by enrollment.



**States have mixed views on the net fiscal impact of the ACA.** In 2014, the ACA will expand Medicaid eligibility to nearly all low-income people under age 65 with incomes below 133 percent of the federal poverty level (FPL) and 100 percent federal funding for those newly eligible from 2014 to 2016. Thereafter, the federal contribution phases down to 90 percent by 2020. For those currently eligible for Medicaid, states will continue to receive their regular federal Medicaid matching rate. Some states are projecting increased state costs associated with higher enrollment of those previously eligible for Medicaid (who would be eligible for the lower traditional state matching rate). Two directors indicated that they believed that CMS and the Congressional Budget Office had underestimated likely take-up rates. Another director expressed concern about the potential CMS methodology for calculating blended federal matching rates for new eligibility categories that comprise those previously eligible and those newly eligible. Additional regulations on these methods will be forthcoming. Three other directors, however, said that their states were projecting overall net savings from health care reform.

## Outlook

A number of states are now seeing improvements in state revenue collections and moderating Medicaid enrollment trends that are tempering the intense fiscal pressure on state Medicaid programs. At the time of the focus group discussion, all but one of the participating directors reported that their states had resolved remaining FY 2012 budget shortfalls, and most had adopted budgets for FY 2013. After several years of intensive, widespread Medicaid cost containment efforts, state directors reported a greater focus on managed care and other payment and delivery system reforms to improve both the quality and cost of care. Dual eligible integrated care demonstrations currently under development in over half the states hold particular promise for states as the federal government is actively working with states to overcome integration barriers between the Medicare and Medicaid programs and has also agreed to share savings with the states. As states await the Supreme Court decision on the constitutional challenges to the ACA, they continue to move forward with efforts to implement the law.

### Methodology

The Kaiser Commission on Medicaid and the Uninsured convened a focus group discussion with Medicaid directors who serve on the Executive Board of the National Association of Medicaid Directors (NAMd) focused on state economies, Medicaid enrollment and budget trends; policy directions; and state progress and concerns about implementing the ACA. The discussion took place in May 2012. Six Medicaid directors from the Executive Board plus Medicaid Directors from three additional states and NAMd staff participated in the discussion. The following states were represented: Arkansas, Maryland, Massachusetts, Minnesota, Nevada, North Carolina, Oregon, Tennessee, and West Virginia.

*This report was prepared by Kathleen Gifford, Vernon Smith and Michael Nardone from Health Management Associates and Robin Rudowitz from the Kaiser Commission on Medicaid and the Uninsured.*

1330 G STREET NW, WASHINGTON, DC 20005  
PHONE: (202) 347-5270, FAX: (202) 347-5274  
WEBSITE: WWW.KFF.ORG/KCMU

This publication (#8331) is available on the Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org).



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 bi-partisan group of national leaders and experts in health care and public policy.