

# medicaid and the uninsured

March 2013

## A Mid-Year State Medicaid Budget Update for FY 2013

### 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 improving and Medicaid spending and enrollment growth was slowing. Medicaid spending growth at 2 percent (FY 2012) and 3.8 percent (authorized for FY 2013) are some of the lowest average rates of growth reported for Medicaid in the last 15 years. Cost containment remains a dominant theme in FY 2013, but states were able to avoid some of the deeper reductions of years past and focus on payment and delivery system reforms and preparing for the implementation of the Patient Protection and Affordable Care Act (ACA).

This report is based on structured discussions in late October 2012 with a cross-section of Medicaid Directors from across the country and survey questions e-mailed to all 50 states and DC in January 2013.<sup>1</sup> This report provides a mid-fiscal year 2013 update on state Medicaid issues, augmenting the findings from the most recent comprehensive Annual Survey of Medicaid Directors<sup>2</sup>.

Mid-way through FY 2013, more than 3 out of 4 states reported Medicaid spending and enrollment growth at or below original projections.

- A total of 40 states reported that the most recent enrollment growth trend for FY 2013 was about the same or lower than that which was projected at the beginning of FY 2013.
- Consistent with trends in enrollment growth, a total of 39 states reported that their spending trend for FY 2013 was about the same or lower than was projected at the beginning of the fiscal year.
- Only 3 states reported mid-year Medicaid cuts and 4 states reported mid-year policy improvements or program expansions.

Focus group discussions with Medicaid directors show that states are moving ahead on a number of fronts to implement delivery system and payment reforms and develop initiatives to coordinate care for beneficiaries with high health needs. For example, Oregon is moving ahead with Coordinated Care Organizations to better serve Medicaid enrollees and reduce costs and other states are developing similar models. Other key reforms include working across payers to improve delivery of care and reduce costs, implementing new payment reforms, developing initiatives for dual eligible beneficiaries, expanding community based long-term care, integrating physical and behavior health services. The Medicaid director discussion took place in October prior to the elections. However, states were actively engaged in planning related to major provisions in the ACA. At the same time, the major concern expressed by states related to how Medicaid might be affected by the discussions at the federal level on how to reduce the deficit and address the fiscal cliff.

<sup>1</sup> Medicaid Directors from Arizona, Arkansas, Georgia, Indiana, Illinois, Maryland, Oregon, South Carolina, and Virginia participated in the structured discussion. All but two states (AK and WI) provided responses to the survey.

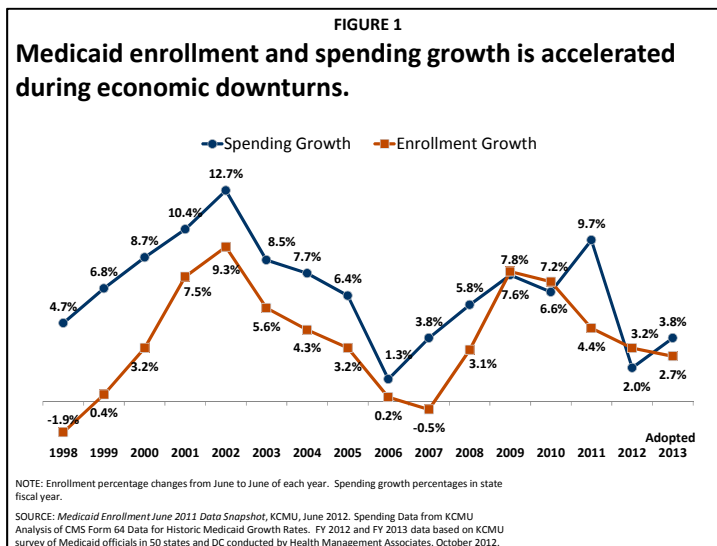
<sup>2</sup> Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder, "Medicaid Today; Preparing for Tomorrow, A Look at State Medicaid Program Spending, Enrollment and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013," The Kaiser Commission on Medicaid and the Uninsured, October 2012.

<http://www.kff.org/medicaid/8380.cfm>

## Introduction and Background

Medicaid is the primary public health program providing health coverage and long-term services and supports to more than 60 million low-income Americans. States administer Medicaid within broad federal rules and the program is jointly financed by states and the federal government. Medicaid plays a major role in our country's health care delivery system, accounting for about one-sixth of all U.S. health care spending, 41 percent of long-term care expenditures, and providing critical funding for a range of safety-net providers. Total spending on Medicaid in FY 2010 was \$389 billion.<sup>3</sup>

Medicaid enrollment increases during economic downturns when unemployment rises and incomes fall resulting in more individuals qualifying for coverage. High enrollment growth was the largest contributor to Medicaid spending growth during the recent economic downturn. 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 improving and Medicaid spending and enrollment growth was slowing.<sup>4</sup> In FY 2012, total Medicaid spending across all states increased two percent, one of the lowest annual rates on record. Growth for FY 2013 was authorized at only slightly higher rate of 3.8 percent. (Figure 1)



Despite the improving outlook, pressure to control Medicaid costs remains a dominant theme. Nearly all (48) states implemented at least one new policy to control Medicaid costs in 2012 and 47 states planned to do so in 2013. However, states were able to avoid some of the deeper reductions of years past, and make some restorations, program improvements and focus on payment and delivery system reforms.

States are preparing for 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 138 percent of the federal poverty level (FPL) (\$15,415 per year for an individual in 2012).<sup>5</sup> Under the June 2012 Supreme Court ruling, the Secretary's authority to enforce the ACA Medicaid expansion requirement is limited and state policy makers are now deciding whether or when to implement the Medicaid expansion. Analysis prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured shows that an additional 21.3 million could be added to Medicaid in 2022 if all states

<sup>3</sup> Urban Institute estimates based on data from CMS (Form 64) (as of 12/21/11). Available at: <http://www.statehealthfacts.org/comparemaptable.jsp?ind=177&cat=4>.

<sup>4</sup> State tax revenues have grown for eleven consecutive quarters, but overall tax collections are still comparatively weak by recent historical standards. Dadayan, Lucy and Donald J. Boyd. "State Tax Revenues Continue Slow Rebound." The Rockefeller Institute of Government, State Revenue Report No. 90, February 2013. [http://www.rockinst.org/pdf/government\\_finance/state\\_revenue\\_report/SSR-90.pdf](http://www.rockinst.org/pdf/government_finance/state_revenue_report/SSR-90.pdf).

<sup>5</sup> The ACA expands coverage to 133% of FPL, but includes a disregard of 5 percentage points of the FPL which raises the effective threshold to 138% FPL.

implemented the Medicaid expansion.<sup>6</sup> Pursuant to the ACA, states are also preparing to implement major changes to simplify and streamline enrollment and to coordinate enrollment with other health coverage in the newly established exchanges. These changes are required even if states do not move forward with the Medicaid expansion.

States are making Medicaid policy decisions facing some uncertainty about how federal deficit reduction efforts will affect states and Medicaid. Recently, officials in the Administration have said they would not propose or support reductions to Medicaid.<sup>7</sup>

This report is based on structured discussions in late October 2012 with a cross-section of Medicaid Directors from across the country (Arizona, Arkansas, Georgia, Indiana, Illinois, Maryland, Oregon, South Carolina, and Virginia), including members of the Executive Board of the National Association of Medicaid Directors (NAMD), and survey questions e-mailed to all 50 states and DC in January 2013. This report provides a mid-fiscal year 2013 update on state Medicaid issues, augmenting the findings from the most recent comprehensive Annual Survey of Medicaid Directors.<sup>8</sup>

## Key Findings

### **Mid-way through FY 2013, more than 3 out of 4 states reported Medicaid enrollment and spending growth at or below original projections.**

In the Annual Survey of Medicaid Directors states reported that they expected enrollment to continue to increase at an average growth rate across all states of 2.7 percent, lower than the 3.2 percent growth rate experienced in FY 2012. A rate of 2.7 percent would mark the fourth year in a row that growth in the number of persons on Medicaid was less than in the previous year and would also be slower than the pre-recession growth rate of 3.1 percent recorded in 2008. At the start of FY 2013 states reported projected increases in authorized Medicaid spending levels that averaged 3.8 percent for 2013. Though higher than the 2012 Medicaid spending increase of 2 percent in 2012 – this is still one of the lowest increases in Medicaid spending ever recorded – it is well below the recessionary high of 9.7 percent in FY 2011. Ten states budgeted for actual declines in Medicaid spending for FY 2013.

In the Annual Survey of Medicaid Directors, state officials expressed more confidence than in prior years that state Medicaid budgets adopted for FY 2013 would be adequate to fully fund Medicaid spending obligations for the coming year. In just a third of the states did Medicaid officials express concern of a possible Medicaid budget shortfall (compared to over half of states at the start of FY 2012 and almost two-thirds of states in FY 2011.)

According to the mid-FY 2013 survey results, enrollment and spending growth for state Medicaid programs generally continues to track or beat state projections for 2013, indicating that fiscal pressure on state Medicaid programs continues to moderate in the aftermath of the Great Recession. (Figure 2) Of the 48 states<sup>9</sup> (and DC) that participated:

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<sup>6</sup> Holahan, John, et al. *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*. Prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, November 2012.

<http://www.kff.org/medicaid/8384.cfm>.

<sup>7</sup> Baker, Sam. "White House advisor: Obama willing to cut Medicare, but not Medicaid." *The Hill*, January 31, 2013.

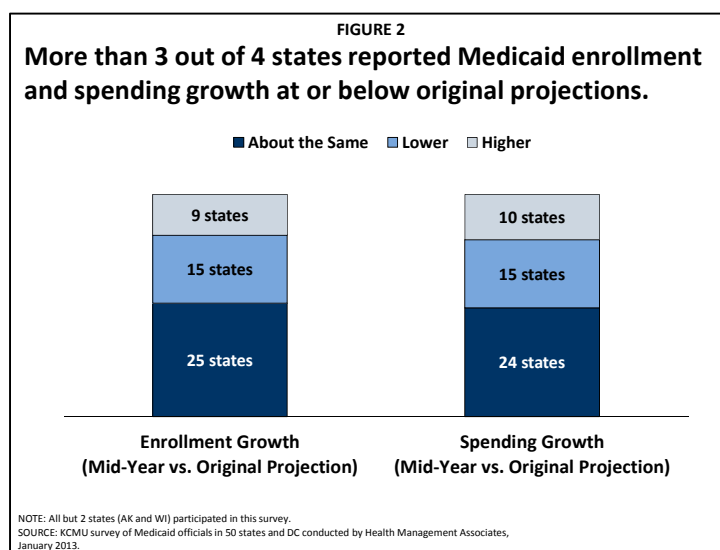
<http://thehill.com/blogs/healthwatch/medicaid/280401-white-house-adviser-obama-willing-to-cut-medicare-but-not-medicaid>.

<sup>8</sup> Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder, "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," The Kaiser Commission on Medicaid and the Uninsured, October 2012.

<http://www.kff.org/medicaid/8380.cfm>

<sup>9</sup> The two states that did not participate in the mid-fiscal year survey were AK and WI.

- A total of 40 states reported that the most recent enrollment growth trend for FY 2013 was about the same or lower than that which was projected at the beginning of FY 2013, including 25 states reporting growth about the same and 15 states reporting the most recent trend was lower.
- Consistent with trends in enrollment growth rates, a total of 39 states reported that their spending trend for FY 2013 was about the same or lower than was projected at the beginning of the fiscal year, including 24 states where the spending trend for 2013 was about the same and 15 states where the most recent trend was lower.
- The improved fiscal picture is also not equally shared by all states, as unemployment rates in 5 states still remained at 9 percent or higher in December 2012<sup>10</sup>, more than a percentage point above the national rate. The mid-year survey results also indicate that roughly one-fifth of the states were experiencing spending and enrollment growth above the levels predicted for 2013.



In the structured discussion with Medicaid Directors, several states also pointed out that implementation of significant cost containment in prior years has contributed to lower Medicaid spending trends and the improved budget outlook. As reported in the Annual Survey of Medicaid Directors nearly all of the states have implemented some form of cost containment in the past year or two.

The structured discussion with Medicaid Directors reinforced the notion that despite the recent improvement in the fiscal outlook, the focus on cost containment in Medicaid is likely to continue for the foreseeable future. Although enrollment growth and spending trends have ameliorated, state directors mentioned a number of factors that will keep budgets tight, including barriers to implementation of particular cost containment strategies requiring alternative budget actions; potential increased costs under the Affordable Care Act due to increased enrollment of individuals currently eligible but not enrolled; and the need to ensure that Medicaid spending does not crowd out state investments in other important areas, such as education, as state revenues continue to slowly rebound among other factors. As a result of these continuing budget challenges now and in the future, the state Medicaid directors in our discussion agreed that although the fiscal outlook is improving, cost containment will continue to be a major focus across all states in the upcoming fiscal years.

<sup>10</sup> Table 3, *Regional and State Unemployment: December 2012*. Bureau of Labor Statistics. Figures are preliminary.

**Only a handful of states are reporting additional mid-year Medicaid cuts and several states indicated they were pursuing new mid-year policy improvements or program expansions.**

An improving economy, lower unemployment, and slower enrollment growth appear to be stabilizing and improving state Medicaid budgets, limiting the need for mid-year budget reductions, and in some instances, allowing for program enhancements. The mid-year budget survey indicates that additional Medicaid spending reductions, beyond the cost containment included in the original state spending plan, have generally not been required in 2013. The overwhelming majority of states – 43 – indicated that there were no additional cuts or policy changes being implemented in their 2013 budget beyond those previously reported. Only three states (compared to ten states in last year’s mid-year survey) indicated they were implementing additional spending restrictions in mid-fiscal year. They included the following states:

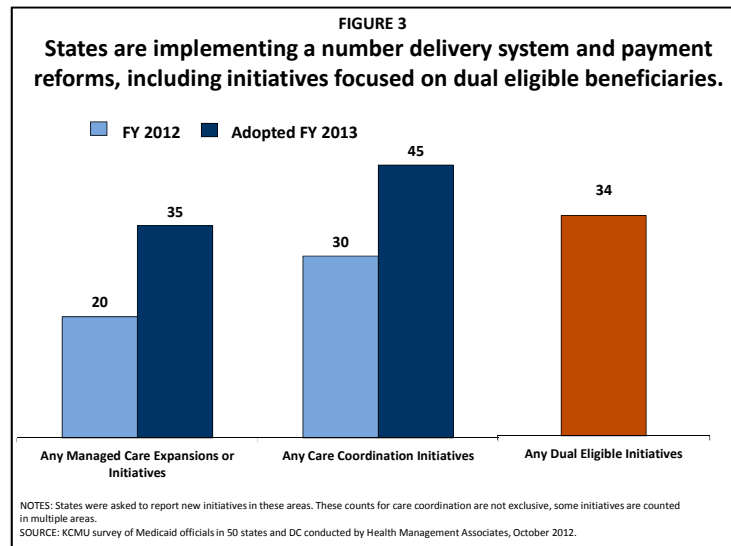
- Connecticut reported efforts to strengthen certain prior authorization requirements for various services, e.g. customized wheelchairs, home health, devices that support individuals with sleep apnea.
- Louisiana reported a series of new reductions, including elimination of dental services for pregnant women, elimination of rehabilitation services, a one percent reduction in physician rates (not including primary care services eligible for the ACA rate bump), and a one percent reduction in inpatient and outpatient hospital rates.
- Massachusetts implemented \$155.5 million in FY 2013 midyear budget reductions through a number of measures including: MCO contract adjustments; rate reductions for nursing facilities and hospitals; reduced pay for performance allocation for nursing facilities; reduced Infrastructure Capacity Building (ICB) Grants to community health centers and hospitals, and additional drug rebates.

In a departure from the recent past, four states indicated that they were pursuing mid-year program expansions or policy improvements, including one state (Connecticut) that was also proposing mid-year restrictions. These include:

- Connecticut reported implementation of an HCBS waiver for specified children and adults with autism spectrum disorders and implementation of a 1915(i) state plan amendment for older adults who were financially but not functionally eligible for the HCBS elder waiver.
- Hawaii plans to expand eligibility to former foster youth up to age 26 prior to January 2014 requirement and to restore a 3 percent reimbursement reduction to acute care hospitals.
- New Mexico is increasing reimbursement rates to ICF-MR facilities by the market basket index and increasing MCO rates for physical health and long term services in the second half of 2013 to reflect higher cost trends and new benefits (i.e. non-emergency transportation to substance abuse clinics).
- In January 2013, Oklahoma increased the cap on the amount beneficiaries can have in their Medicaid Income Pension Trust (or Miller Trust) to the average nursing home rate. This change affects financial eligibility rules for all long term care programs, including the 1915(c) waiver programs for Home and Community Based Services.

**States are moving ahead on a number of fronts to implement delivery system and payment reforms including initiatives to coordinate care for dual eligible beneficiaries.**

In the Annual Survey of Medicaid Directors, the majority of states reported that they were implementing a range of initiatives to better coordinate and integrate care in FY 2012 and 2013. (Figure 3) Similarly, during the structured discussion with Medicaid Directors payment and system delivery reforms with a particular emphasis on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for the delivery of high quality care, were consistently mentioned as among their top priorities. Several directors stressed the significance of these initiatives in driving change at the practice level and bending the cost curve. One Medicaid Director stated, “Every time you see fragmentation, you see poor care and opportunities to improve care.” Some specific initiatives highlighted were:



- Care Coordination.** Oregon discussed the formation of Coordinated Care Organizations (CCOs) designed to better serve Medicaid enrollees and reduce costs. CCOs represent a hybrid MCO-Accountable Care Organization (ACO) model, utilizing a full network of health care providers (physical health, behavioral health, dental providers) at the local level to provide services in an integrated and coordinated way. The state will be using a series of 16 metrics, including health outcome measures, to track performance of CCOs and Medicaid dollars will be tied to CCO performance. Other states including Illinois and Indiana were exploring development of similar delivery system models. Many states also stressed the importance of more effectively using quality and health outcome metrics to enhance program success like the CCO initiative. Georgia described its plans to explore an enhanced case management, patient-centered health home model to tackle increasing expenditures for the aged, blind and disabled population. Virginia is exploring ways to work through MCOs to implement health homes or other payment/delivery reforms through its contracts with the plans.
- Working with Other Payers.** Maryland is working with other third-party payers on patient-centered medical homes, a health information exchange, and focus on high cost cases and is also considering modifications of its all-payer hospital waiver as part of its effort to drive change. South Carolina also noted its efforts to work with its state Blue Cross plan to implement payment strategies to reduce elective deliveries and NICU costs. In discussing their rationale for an all-payer strategy, several of the States acknowledged the limits of Medicaid’s ability, acting alone, to impact delivery reform and practice change given lower Medicaid reimbursement rates, limited state Medicaid resources overall and, in many instances, low market share. At the same time, others voiced skepticism that the private sector could drive such change on its own and that public sector partnership and leadership was definitely required. As a result, states see the need to take the lead in bringing other payers to the table to improve the delivery of care and reduce system costs.

- **Payment Reform.** Arkansas reported on the implementation of a retrospective episodic or bundled payment system that covers multiple services provided during an episode of care. The initial phase involves implementing five “episodes” (upper respiratory infections (URI), total hip and knee replacements, congestive heart failure (CHF), attention deficit/hyperactivity disorder (ADHD), and perinatal care). The plan is to introduce an additional set of bundled payments each year. Providers will be held accountable for meeting quality standards and are eligible to receive bonuses or penalties based on costs of care across the episode. Arkansas is also looking to foster patient-centered medical homes employing a risk-based approach that initially provides opportunities for positive gain-sharing.
- **Initiatives for Dual Eligible Beneficiaries.** Medicaid Directors in our structured discussion all agreed that states are placing a major emphasis on care coordination for dual eligible beneficiaries. The discussion confirmed findings contained in the Annual Survey of Medicaid Directors indicating that dual eligible beneficiaries were at the top of the priority agenda of Medicaid Directors. Dual eligible beneficiaries represent 15 percent of all Medicaid beneficiaries but account for 38 percent of Medicaid program expenditures. Nearly half of all states have been working with the Medicare-Medicaid Coordination Office (MMCO) and the Center for Medicare and Medicaid Innovation (CMMI) to develop demonstrations to better integrate care and financing for this population. The Centers for Medicare and Medicaid Services (CMS) has signed memoranda of understanding for demonstrations for dual eligible beneficiaries in four states: Illinois, Massachusetts, Ohio and Washington. Arizona noted that they are pursuing two tracks on dual eligible beneficiaries: a CMS financial alignment demonstration as well as an approach aligning Special Needs Medicare Plans for duals eligible beneficiaries (D-SNPs) with Medicaid managed care to ensure they have an approach in place targeted at these high need individuals.
- **Expanding Community Based Long-Term Care.** In addition to the focus on dual eligible beneficiaries, several states in the structured discussion mentioned steps they are taking to balance the long term care system more generally. Maryland reported that long-term care rebalancing is a priority and, toward that end, the state is pursuing the Community Choice option authorized by the Affordable Care Act. Indiana mentioned it is looking at moving to a 50/50 balance between home and community based services and institutional services for its developmental disabilities population through its Money Follows the Person initiative. South Carolina reported it had eliminated the waiting list for home and community based services and stressed the need to get stakeholders more engaged in decision making, particularly for dual eligible beneficiaries and families with disabled children.
- **Integration and Management of Behavioral Health Services.** During the structured discussion session, Oregon, Arizona, Maryland and Arkansas all discussed behavioral health initiatives that their state was either currently implementing or planned to pursue. Oregon’s CCO model places significant emphasis on behavioral health metrics as part of its payment and accountability framework. Arizona is likewise focusing on behavioral health and physical health integration. Its current performance improvement projects (PIPs) under managed care focus on behavioral health. The state also will provide behavioral and physical health services in its largest county, Maricopa, through a selected contractor who will manage all BH and PH services for individuals with serious mental illness (SMI), effective October 2013. The selected plan must be a Medicare Special Needs Plan as well to foster better care coordination for the dual eligible SMI members. Maryland is exploring options on how best to manage its state’s behavioral health services and Arkansas reported this is an area where they will be seeking ways to improve accountability and outcomes.

## **States are actively engaged in planning related to implementation of multiple provisions in the ACA.**

The ACA expands Medicaid to a national eligibility floor of 138% of the federal poverty level (FPL). The Supreme Court upheld the ACA but limited the federal government's ability to enforce the Medicaid expansion to low-income adults, effectively making implementation of the Medicaid expansion a state choice. Many states are making these decisions as part of developing their budgets for FY 2014. Even if states do not move forward with the Medicaid expansion, the ACA includes new requirements for web-based, paperless, real-time eligibility and enrollment processes that will need to be in place by October 1, 2013 for existing and new coverage options beginning in 2014. For many states, this will be a huge transformation from their current systems. States have been actively engaged in moving forward with these system changes.

The structured discussion with Medicaid directors was just before the November elections so some states were waiting for the elections to make decisions about the Medicaid expansion. That said, Maryland noted it was fully committed to the ACA and that successful implementation was among the Medicaid agency's top priorities. South Carolina noted that they were not planning to implement the Medicaid expansion, but they anticipated up to 200,000 people currently eligible for Medicaid but not enrolled would sign up for coverage. In an effort to reduce the amount of children churning on and off of Medicaid coverage, South Carolina implemented express lane eligibility (ELE) for its Medicaid redeterminations and plans to implement ELE for new enrollees. It is estimated that these efforts will bring an additional 65,000 currently eligible children onto the program and connect them to a medical home.

## **Medicaid Directors expressed significant concerns about the effect of federal deficit reduction efforts on Medicaid and state budgets.**

When the structured discussion was held late last year, Medicaid Directors expressed significant concerns about the potential impact of automatic federal budget cuts (sequestration) and/or a Federal White House Congressional budget deal to avoid the impending "fiscal cliff" on their Medicaid programs. Even though Medicaid is exempt from the sequestration, directors noted that the reductions would impact other programs serving low-income individuals, such as public health, and behavioral health programs and Medicaid would be called on to fill in the gaps created by the across-the-board reductions. Similarly, any cuts in Medicare reimbursement to providers under sequestration would have ripple effects on Medicaid as providers, such as nursing homes, seek additional funds from Medicaid to help ameliorate these cuts. Directors also noted that plans to avert the sequestration could more directly affect Medicaid. Provider taxes were seen as an area that might be targeted by Congress for cutbacks and any changes here would have a big impact on states.

## **Conclusion**

At the mid-point of state fiscal year 2013, an improving economy is reflected in slowing rates of growth in Medicaid spending and enrollment. Across the country, states are focused now on payment and delivery system reform as their primary strategies to improve their programs, improve care, improve the health of the Medicaid populations and to save costs. Preparation for Medicaid's significant role in health reform in 2014 is well underway. Medicaid directors see several threats to the program, particularly from strategies to address fiscal issues at the federal level, but the focus now is clearly on program improvements that will restructure the program for the future.

This brief was prepared by Mike Nardone, Vernon Smith and Kathy Gifford of Health Management Associates and Robin Rudowitz and Laura Snyder of the Kaiser Commission on Medicaid and the Uninsured.

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