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If states opt to ignore Medicaid expansion, are feds' hands tied?

If a state doesn't institute the Medicaid expansion included in the Patient Protection and Affordable Care Act (PPACA), that state would no longer be eligible for federal Medicaid funds, just as it would not be eligible if it didn't cover children up to the current mandatory levels, says **Edwin Park**, vice president for health policy at the Center on Budget and Policy Priorities in Washington, DC.

"That is why a few of the states, like Texas, that discussed withdrawing from the Medicaid program entirely, realized the fiscal implications and backed away from it," he says.

Stan Rosenstein, MPA, principal advisor at Health Management Associates in Sacramento, CA, and former California Medicaid director, notes that while the federal government can't make a state comply, it can take away federal funds. "If they are willing to take away all your federal funds, it can be very, very expensive to the state," he says.

MOE very broad

There was a maintenance of effort (MOE) requirement when Medicaid programs began receiving federal funding for Intermediate Care Facilities for the Mentally

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Minnesota opts for early expansion of Medicaid

Minnesota faces a projected state budget deficit of \$5 billion for the next biennium and increased program enrollment and health care costs in Medical Assistance, Minnesota's Medicaid program, reports **David Godfrey**, Minnesota state Medicaid director.

Beginning in 2009, payments for specialists and non-primary care providers were reduced by 12%, payments to managed care organizations were reduced by 3%, inpatient hospital rates were reduced by 3%, and pharmacy rates were reduced by 1%, Mr. Godfrey says. Dental

services for adults except for pregnant women have been reduced, he adds, and a number of services now require prior authorization.

"The governor has proposed Medicaid surcharges for providers, and payment reduction and reforms, to help balance the state budget," Mr. Godfrey says. "We are examining ways to improve the health care delivery system and payment reform to help contain costs and improve the quality of care."

**Fiscal Fitness:
How States Cope**

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Cover story

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Retarded back in the 1970s, but it was very limited in scope, says Leslie Hendrickson, PhD, principal of Hendrickson Development, an East Windsor, NJ-based consulting group that helps to develop and strengthen long-term care programs, and former assistant commissioner in the New Jersey Department of Health and Social Services.

States were required to keep the same level of funding for this program that they had in place before they got federal funds, explains Dr. Hendrickson. "It was a limited MOE that spoke just to the particular service or program that the federal money was supporting," he says. "Now, 40 years later, the MOE is basically just a huge hammer. Under the terms of the PPACA, it is very broad."

If a state changes its eligibility standards, methodologies or procedures, says Dr. Hendrickson, the penalty is a complete denial of all federal funds for the entire Medicaid program. If a state uses federal funds from the American Recovery and Reinvestment Act for hospitals, and changes eligibility methods, for instance, "all its Medicaid money can be lost, not just the money that went to the hospitals," says Dr. Hendrickson.

This means that states are locked into the current configuration that they have in their Medicaid programs, says Dr. Hendrickson, with the possible exception of expansion populations that were covered above 133% of FPL.

De facto noncompliance

With over half of states having launched lawsuits challenging the PPACA's constitutionality, says Dr. Hendrickson, "You start to get a critical mass of opposition. You could well end up with a situation where you have de facto noncom-

pliance from about 10 or 15 states, with the other 30 or 35 states going along to some degree."

It is difficult for federal agencies to deal with situations where there is widespread noncompliance and numerous extension or waiver requests by states, says Dr. Hendrickson. How many fights can CMS [the Centers for Medicare & Medicaid] get into?" he asks.

It doesn't have to be a majority of states, says Dr. Hendrickson, "but once you get a critical mass of states opposed to something, governors have more conversations with the president and Congress. That starts to influence legislation, or the ability of HHS [the Department of Health and Human Services] to do something about those states."

Dr. Hendrickson notes that South Carolina's request to CMS to email notices to Medicaid clients for a projected \$6 million savings was denied, via email. After the state's governor talked with President Obama, he says, CMS granted the request.

Political downside

If a state's Medicaid funds were taken away completely, adds Dr. Hendrickson, "the political downside would be enormous."

"What would [Representative Henry A.] Waxman do to Utah or Idaho, who doesn't want to go along with the PPACA?" asks Dr. Hendrickson. "Is he, as a Democrat who moved heaven and earth to expand Medicaid programs, going to say, 'We're going to take away all your Medicaid money?'"

If this occurred, says Dr. Hendrickson, congressional offices would be flooded with complaints from constituents. Medicaid provides funding for about 60 million people, he notes, and if the federal agencies cut the Medicaid funds of ten or fifteen states, it could impact more than 10 million people.

"Every state would point a finger

at HHS and say, “They made us do it. They took the money away from us. State officials, advocates, providers and recipients would come unglued,” he says.

When an individual state tries to cut programs, notes Dr. Hendrickson, individual recipients of those services are very vocal with complaints. “Multiply that by the hundreds of thousands and see what impact that has on Congress,” he says.

Dr. Hendrickson asks, “What congressman is going to get up there and say, ‘CMS was absolutely correct in cutting 200,000 people with developmentally or physical disabilities off the Medicaid rolls in our state, and those 10,000 poor 90-year-old women in our nursing

homes didn’t really need Medicaid support anyway?”

For this reason, says Dr. Hendrickson, “I don’t think CMS has much in the way of leverage in situations where multiple states don’t go along with new legislation. The feds have the hammer, but they can’t use it.”

Subject to contempt charges

If the state doesn’t follow the PPACA, says Mr. Rosenstein, it is subject to litigation by beneficiary advocates or providers. If you don’t follow the eligibility rules and improperly denied somebody coverage, he says, the state can be sued and the court can compel the state to act.

Mr. Rosenstein points to his own

experience as California’s Medicaid director, when advocates disagreed with the interpretation of the law requiring certain steps to transfer individuals from Supplemental Security Income to Medi-Cal, and sued the department.

“A judge found us out of compliance. We didn’t have any choice but to follow the law,” says Mr. Rosenstein. “If you don’t comply, then you subject both your department and yourself to contempt charges.”

Repercussions for not complying with federal law can be enforced upon you thorough the courts as a result of third-party action, explains Mr. Rosenstein. “It can go as far as the court appointing a receiver

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Fiscal Fitness

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10,000 uninsured covered

The 2010 Legislature authorized the governor to allow the expansion of Medical Assistance, an option under federal health reform, to adults without children at home with incomes under 75% of the Federal Poverty Level, says Mr. Godfrey.

“The expansion allows the state to provide more comprehensive health care coverage to an estimated 95,000 Minnesotans, and protect 20,000 health care jobs across the state,” he says.

The expansion is expected to have a neutral impact on the state budget through state fiscal year 2015, says Mr. Godfrey. The state costs of early expansion are equivalent to the current state cost of providing coverage under two state-funded programs — General Assistance Medical Care and MinnesotaCare, he explains, whose enrollees will shift to Medical Assistance.

“The expansion provides federal matching funds of \$1.1 billion for the next biennium,” says Mr. Godfrey. It also generates cost savings for the state, by reducing the projected shortfall in the Health Care Access Fund by \$500 million, he adds.

Mr. Godfrey estimates that 85,000 people covered by the expansion were covered under state-funded programs, and will now receive more comprehensive care with lower co-pays. An estimated 10,000 who will now be covered under Medical Assistance were uninsured, notes Mr. Godfrey.

“The expansion is expected to benefit the state overall, by reducing the number of people who do not have health care coverage and uncompensated care costs,” he explains.

Rapid timetable

Governor Mark Dayton, who took office January 1 of this year, signed the executive order implementing Minnesota’s early Medicaid enrollment on January

5 for implementation by March 1, reports Mr. Godfrey. “The rapid timetable to implement the expansion in two months has been a challenge,” he says.

The implementation involved policy development, system changes, worker training and communications with clients, workers, providers, and other stakeholders, he says, as well as securing federal approval. State and county workers, health care providers, and other stakeholders worked to quickly implement the expansion, he adds.

“The expansion was the department’s number-one priority,” says Mr. Godfrey. “That work was done first and resources were supplied.”

Minnesota’s Department of Human Services did some preliminary planning prior to the executive order, says Mr. Godfrey, then established a departmentwide team that worked on all of the various areas. “The implementation began on schedule,” he reports. “We are on track with case conversions.” ■

Cover story

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to basically run your program,” he says. “I’ve never seen that in Medicaid, but if you don’t comply, you risk having the courts take over your program.”

Expansion is the issue

“For a number of states, the Medicaid expansion is the issue,” says **Mark Trail**, managing principal at Health Management Associates in Atlanta, particularly those that have been more conservative with their eligibility requirements around adults. He notes that a December 2010 analysis done by the Texas Health and Human Services Commission concluded that the state would lose \$15 billion in federal funding and increase its uninsured by 2.6 million if it opted out of Medicaid.

“Obviously, then, their conclu-

sion was that opting out is not the way to go,” says Mr. Trail. “I think that was instructive to a lot of states that were also thinking that way. I am not hearing about states talking about opting out now, while there was that kind of discussion going on before.”

If a state doesn’t comply with the Medicaid expansion, Mr. Trail says that the federal government is likely to use whatever weight of authority it has to make the states comply. “Based on my experience with the feds, if you are noncompliant with something and they know about it, then they have the right to come in and perform audits and take exception to things that you’re doing,” he says.

Mr. Trail says that regarding withholding of all federal funds, “I believe it would be in their purview to do that. Obviously that would be a huge political move for them to make.”

Another possibility, says Mr. Trail,

is that CMS could go through the courts to compel the state to act. “I don’t know that CMS by themselves would have the authority to come in and take over,” he says. “But CMS aside, there is another issue, and that is the member issue.”

If a state didn’t act, says Mr. Trail, various advocacy/legal rights attorneys would quickly locate individuals who couldn’t get onto the program despite being entitled by federal law to coverage.

“There are quite a few ways that a state could be compelled to act,” says Mr. Trail. “I can’t imagine that nothing would happen. I just don’t see that as a possibility.”

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States will be looking for relief, help with Medicaid

While opting out of Medicaid altogether doesn’t seem to be a realistic option for states currently, **Stan Rosenstein**, MPA, principal advisor at Health Management Associates in Sacramento, CA, and former California Medicaid director, doesn’t think the issue has gone away.

“States are going to be confronted with very bad budget situations that are likely not to be resolved in the short term,” he says. This means that out of necessity, says Mr. Rosenstein, states are going to have to look at every option.

“I think states will wrestle with their Medicaid budgets for a number of years,” he says. “Things are going to be in turmoil for awhile. States have the hurdle of the loss of the enhanced [Federal Medical Assistance Percentages].”

States will be looking to the

Department of Health & Human Services (HHS) for various kinds of relief and assistance, says Mr. Rosenstein, and will likely challenge maintenance of effort requirements for their Medicaid programs.

States are under tremendous stress, says Mr. Rosenstein, because they have to balance their budgets when the economy has not yet recovered. “And Medicaid has to be part of any budget solution. It’s too big not to be,” he says. “There are no really great answers here.”

What states can do, he says, is go to the federal government and ask for waivers to address their fiscal concerns. While the Patient Protection and Affordable Care Act (PPACA) is the law, Mr. Rosenstein says, “states can certainly challenge the law, and there are vehicles to do that. The federal government does have flexibility to waive the law with

an 1115 waiver.”

More flexibility

States are looking to get additional flexibility in their Medicaid programs, says Mr. Rosenstein, as California is doing by seeking a waiver for greater cost-sharing of copays. “The secretary of HHS has waiver authority. That is the way I see states doing this,” he says.

Other than that, says Mr. Rosenstein, options for the short term are very limited. “If you save money for next year, that’s good and it needs to be done. But it doesn’t solve this year’s budget problems,” he says. “There are a limited number of areas that you can make changes.”

For this reason, says Mr. Rosenstein, states may seek greater flexibility on cost sharing, limiting benefits, the requirement to provide Early Periodic Screening Diagnosis

& Treatment services for children, or reimbursement rates. States may also seek to put limits or greater utilization controls on Medicaid benefits.

“States may seek a waiver to charge premiums, or reward good behavior and punish bad behavior,” adds Mr. Rosenstein. “There are multiple variables that people can come up with to try to reduce state expenditures.”

Making a point

Arizona was recently allowed to suspend Medicaid coverage for about 250,000 childless adults, notes **Mark Trail**, managing principal at Health Management Associates in Atlanta. However, this particular situation is unique, says Mr. Trail, and most

states are not in the same position.

“The only reason Arizona is able to do that is because the group is above the federally mandated threshold,” says Mr. Trail. “It wasn’t done with a state plan amendment; it was done with a waiver. The waiver is expiring, and they are not compelled to have to redo that waiver exactly like it was.”

For Georgia, the expansion will mean an additional 600,000 to 900,000 individuals on Medicaid, says Mr. Trail, depending on how many people actually enroll. “Most states were already pretty low in their thresholds,” he explains. Georgia’s Medicaid program covers families at about 50% of the Federal Poverty Level (FPL), he adds, and doesn’t

provide any coverage for single childless adults who are not disabled.

“As far as the minimum requirements are concerned, you have to either comply with them or get a waiver from the feds,” says Mr. Trail. “But there are lots of things that feds can’t waive. You don’t get to waive the basic eligibility requirements.”

Waivers are only possible in cases where states are asking not to cover expansion groups that were beyond the 133% of FPL, says Mr. Trail. “That doesn’t mean a state wouldn’t try to waive those basic requirements. Politics is a funny thing. They could try just to make a point,” he says. “But I don’t think they’d get very far.” ■

Do some states want federal takeover of Medicaid program?

There are probably some states that wouldn’t mind if their Medicaid program was taken over by the federal government, according to **Leslie Hendrickson**, PhD, principal of Hendrickson Development, an East Windsor, NJ-based consulting group which helps to develop and strengthen long-term care programs

“Medicaid is widely described as a state/federal partnership, but the feds own 51% of the partnership. If you don’t believe it, look at the [maintenance of effort requirements] that came with the PPACA [Patient Protection and Affordable Care Act],” he says. “As long as the feds want to run the Medicaid program, then why not let them?”

Dr. Hendrickson points to Idaho and Utah as examples of states that could potentially benefit by giving a block grant to the federal government. “They could say, ‘Here’s how much state money we spent on Medicaid in the last year. We will give you that money and you

can run our Medicaid program.’ This puts the risk of Medicaid onto the federal government and not the state,” he says.

There is a lot of discussion currently about the possibility of the federal government giving a block grant to the states, notes Dr. Hendrickson. “Why not reverse the process and let states give a block grant to the feds?” he asks.

Dr. Hendrickson notes that the PPACA gives the federal government the right to step in if states do not create their Health Insurance Exchanges. “I don’t think the feds have evolved a strategy yet for dealing with states that don’t comply,” he says. “I think it’s highly likely that the feds could end up running health exchanges for 10 or 15 states.”

Problem of uninsured

Just because 26 states have joined the lawsuit challenging the constitutionality of some provision in the PPACA, he says, doesn’t necessarily mean those states won’t ultimately

cooperate. “It doesn’t mean that all or most of them aren’t going to do anything,” Dr. Hendrickson says. “The chances are that the majority of states will in fact be enacting some kind of insurance expansions.”

One reason for this, says Dr. Hendrickson, is that publicly elected officials know it’s not good to have hundreds of thousands of uninsured individuals in the state. “People with insurance get better health care. Having large numbers of uninsured drives the margins of your hospitals down to basically zero, pushing them into consolidation and bankruptcy,” he says. “It puts constant pressure on your charity care allocations.”

Dr. Hendrickson gives the example of Colorado as a state that has done excellent health planning in dealing with the problem of its uninsured, but nonetheless still joined the lawsuit against the PPACA. “Before the PPACA came along, Colorado had spent years working on its uninsured problems and was developing

ways to expand health care coverage,” he says. One idea Colorado came up with was using a hospital provider tax, says Dr. Hendrickson, and the state is substantially expanding health care coverage of uninsured individuals.

“That is a state that is pushing ahead and making practical accomplishments, even though in joining the lawsuit you might think they were opposed to the health care expansion principles in the PPACA,” Dr.

Hendrickson says.

Both providers and health plans would rather have an insured population that can pay for its health care, adds Dr. Hendrickson. “There is an enormous impetus for states to go along with at least the fundamental idea of the PPACA, which is to lower the number of uninsured,” he says. “The sweeteners that the feds threw in will allay some of the cost fears about being

in the program.”

For example, states also have two years of the federal government paying to raise primary care rates up to Medicare levels, Dr. Hendrickson notes. “Granted, federal funds for the expansions phases out a little bit by 2020,” he says. “But almost all the funds needed for the expansion, administrative expenses excepted, will be provided by the feds at 90% of better.” ■

Will challenge to individual mandate actually succeed?

Efforts to eliminate the individual mandate requiring individuals to purchase health care insurance, included in the Patient Protection and Affordable Care Act (PPACA), “have a probability of success,” according to **Leslie Hendrickson**, PhD, principal of Hendrickson Development, an East Windsor, NJ-based consulting group which helps to develop and strengthen long-term care programs.

“It seems to me what we are looking at right now in the country is a re-emergence of the concept of nullification,” he says. This is a states’ rights doctrine dating back to 1798, says Dr. Hendrickson, which holds that states don’t have to comply with a requirement of the federal government if they don’t agree with it.

This legal doctrine, explains Dr. Hendrickson, “usually gets shot down by the Supreme Court when it invokes the supremacy clause of the federal government.” However, he says, legal challenges to the individual mandate appear to be on firmer ground.

He notes that U.S. District Judge Roger Vinson’s January 2011 ruling that the health law is unconstitutional reviewed the history of the Commerce Clause. “This is the justification for the federal government’s authority to direct individu-

als to purchase health insurance,” he says. Administration lawyers argued in the Florida case that the government can tax individuals for not buying health insurance, says Dr. Hendrickson, because individuals are not buying health insurance in an activity involving interstate commerce. “The district courts are split on it,” he says. “I am not a lawyer, but I think it’s a stretch to argue that the Commerce Clause can be used to compel persons to buy health insurance.”

In addition, the individual mandate goes against a deeply held principle of individual choice in Medicare, says Dr. Hendrickson. “Unlike Medicaid, if you are a Medicare beneficiary you cannot be forced to go into a managed care plan. And if you choose to go into the managed care plan, you have freedom of choice of plans,” he says.

Recent precedent

Dr. Hendrickson points to the Real ID Act of 2005 as an example of states not cooperating with a federal law en masse. This was a homeland security measure that had the practical effect of creating a national identity card, he explains.

“Nobody went along with it,” says Dr. Hendrickson. “The opposition extended from the Northeast

states that opposed it because of a classic liberal Democratic viewpoint to the Rocky Mountain states that were opposed because of a classic Republican libertarian viewpoint.”

The end result, says Dr. Hendrickson, was that not a single state did anything to comply with the federally passed law. Similarly, he says, states may choose not to create the Health Insurance Exchanges required in the PPACA, and let the federal government create them.

If it a single state fails to comply, says Dr. Hendrickson, then the federal government has more leverage in “corralling that state and cajoling that state into taking action — lots of audits, denials of state plan amendments, Department of Justice investigations, and withholding funds. But I can easily see 10 states basically dragging their feet and doing nothing about this. I don’t think there is much the feds can do about that.”

There are still many implementation regulations that have yet to be promulgated, notes Dr. Hendrickson. “Over the next couple of years, there could well be thousands of pages of regulations issued implementing this,” he says. “It is a large, complicated, multi-year process.”

However, Dr. Hendrickson says that looking forward, he expects

that millions of currently uninsured Americans will have health insurance as a result of the PPACA.

“States will not all cooperate and there will be a lot of issues, but I think they will be negotiated and worked out,” he says. “There will be large numbers of states that seize on the federal funds as an opportunity to provide health insurance.”

“Wait and see” approach

Georgia is one of the states that joined in the lawsuit against the PPACA, notes **Mark Trail**, managing principal at Health Management Associates in Atlanta, but at the same time, the executive branch is preparing for the law’s implementation.

“They’re going to seek to get some improvements in some of the requirements if it doesn’t run off the tracks,” he says. “But I don’t think it’s going to be sitting back, folding your arms and saying, ‘Make me.’”

Mr. Trail adds that some states

are holding off on taking specific steps to implement the law. “You’ve got those in the legislature that say ‘Don’t do anything to make this easier,’” he says. “However, that is not the approach that the executive branch is taking. They are saying, ‘This is the law. We don’t like it, but in the meantime we’re going to get prepared.’”

Those with the “wait and see” attitude, says Mr. Trail, are waiting for the Supreme Court consideration of the lower court’s decision. “That is what I think they are hanging their hat on,” he says. “As for whether that turns out to be a good or bad idea, I guess time will tell.”

Mr. Trail notes that even the Florida decision acknowledged that the federal government has the right to compel a state to expand its Medicaid eligibility. “I don’t think there are any states that are hanging their hats on that particular point,” he says. “I am not aware of any state thinking that somehow that they

are going to win a battle to prevent that from happening through the courts.”

The individual mandate is another matter altogether, adds Mr. Trail. “Maybe they are hoping that the individual mandate will not occur, if in fact there is severability in the law and they can just throw out part of it,” he says.

There is some discussion about allowing states to offer a less expensive basic health plan to newly eligible individuals, adds Mr. Trail. “But from what I’ve seen, that doesn’t apply to anything below 133% FPL. It applies to a narrow margin from 133% up to 200%,” he says. For this reason, Mr. Trail explains, states realize they are not going to get relief in moving to the basic plan, at least not in how the law exists today.

“That doesn’t mean, however, that they are not trying to pursue that through their own congressional delegation or something along those lines,” he adds. ■

Is Medicaid going to be ready for a “culture of coverage?”

Medicaid and the Children’s Health Insurance Program (CHIP) will have roughly 16 million additional enrollees as a result of the Patient Protection and Affordable Care Act (PPACA), according to the Congressional Budget Office in Washington, DC, but how quickly will these individuals enroll? According to **Jocelyn Guyer**, co-executive director of Georgetown University’s Center for Children and Families in Washington, DC, “If there is an expectation of people having coverage, that will happen more quickly and be more widespread.”

A January 2011 survey shows that while improvements have been made for low-income children, eligibility for low-income adults lags behind.¹ According to the survey, 49

states held steady or made targeted improvements in their Medicaid and CHIP eligibility rules and enrollment procedures.

In addition, a total of 13 states expanded eligibility, mostly for children, and 14 states improved enrollment and renewal processes to reduce burdens on families and streamline administrative processes.

“We found that only two states had rolled back coverage. A major reason is the maintenance of effort requirements,” says Ms. Guyer, one of the study’s authors. “What was surprising to us was the 14 states that took affirmative steps to improve enrollment systems.”

According to Ms. Guyer, states are doing surprisingly well with eligibility and enrollment simplifications. “Despite the serious budget situa-

tions, a number of them have made improvements over the last several years,” she says. “They’ve been able to hold onto those improvements, even during the downturn.”

While many states have made significant progress, says Ms. Guyer, “it continues to be a tough budget time, so we’ll see what happens in the years ahead. But it has been surprising that states have been quite stable in their enrollment simplifications.”

Seamless system

Operating a seamless enrollment system between Medicaid and the health insurance exchanges, says Ms. Guyer, “will require a lot of work for virtually every state between now and 2014.”

Ms. Guyer notes that only a couple of states have implemented online enrollment, and most have a significant amount of work to do. “It’s easier to get your technology up and running if you have a very simple enrollment process,” she adds. “If you can streamline how much paperwork you are asking families to provide, it makes it easier to offer an efficient enrollment system.”

However, says Ms. Guyer, no matter how good a state’s online enrollment system is, there will always be some families who need assistance from a community-based expert. “We’ve heard from both Massachusetts and Wisconsin that the technology is too daunting for some individuals,” she says. “So it’s important to keep those doors open.”

Ms. Guyer notes that it took

Wisconsin about five years to implement online enrollment for its Medicaid program. “When renovating a house, no matter how long the contractor tells you it will take, you should probably double it,” she says. “I think that it’s probably similar with online enrollment.”

Outreach needed

States need to send a clear message that if individuals apply for the program, they will likely be found eligible, says Ms. Guyer. When Massachusetts launched its health reform campaign, she notes, a massive outreach campaign was launched.

“It involved everything from the Red Sox to the governor. So something similar will probably be necessary,” says Ms. Guyer. “But because this will be taking place across the

country, there will presumably be a much higher level of awareness than when a state does it on its own.”

One potential obstacle involves health reform’s reliance on the income tax system to determine the extra help that people need to buy coverage, says Ms. Guyer. “A lot of people who are very low-income don’t file tax returns. So one of the major doors through which people will obtain coverage won’t be as relevant to them,” she explains.

Contact Ms. Guyer at (202) 784-4077 or jag99@georgetown.edu.

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Expert recommends states push for high-volume enrollment for 2014

States should implement a one-time, high-volume enrollment push at the launch of health reform, recommends **Beth Morrow**, director of health information technology initiatives for The Children’s Partnership, a child advocacy organization with offices in Washington, DC, and Santa Monica, CA. To streamline the enrollment process, she says, states can build on the innovative efforts undertaken by Louisiana and Alabama.

“States could use Express Lane Eligibility principles to achieve high-leverage enrollment in 2014,” she says. Since the Patient Protection and Affordable Care Act (PPACA) specifically identifies Express Lane Eligibility as an exception to the use of Modified Adjusted Gross Income (MAGI), Ms. Morrow explains, states can build it into their PPACA imple-

mentation strategy.

“As such, they should consider using full, statutory Express Lane Eligibility — borrowing and relying on another public agency’s eligibility findings — to automatically enroll children under 133% of the Federal Poverty Level who are being transferred from the Children’s Health Insurance Program to Medicaid, pursuant to PPACA.”

States can also consider broader data-driven enrollment, says Ms. Morrow, by borrowing eligibility information provided to another public program. For instance, she says, the Supplemental Nutrition Assistance Program can be used to identify and enroll uninsured individuals, both adults and children. Similarly, individuals currently enrolled in public limited coverage programs who will become eligible for comprehensive coverage can be

pre-enrolled, says Ms. Morrow.

Data-driven procedures can also be used, says Ms. Morrow, to “simplify the enrollment process for individuals who cannot avail themselves of all the simplifications offered by the PPACA, such as those who don’t file federal taxes, and for those whose circumstances have changed.”

States should be encouraged to deploy routine, data-driven procedures that use updated eligibility information to automatically renew coverage, says Ms. Morrow, unless the individual opts out of such data sharing. “Processes will also be needed to build bridges to hard-to-reach individuals who participate in other public programs but remain uninsured after 2014,” she adds.

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Efforts under way to roll back MOE requirements

The Centers for Medicare & Medicaid Services (CMS) and Congress will be under significant political pressure to roll back the maintenance of effort (MOE) requirements included in the Patient Protection and Affordable Care Act (PPACA), according to **Michael Miller**, director of policy at Community Catalyst in Boston, “either wholesale, or via individual waiver applications such as that filed by Arizona.”

First, says Mr. Miller, CMS and Congress need to consider the harm that a change in the MOE requirements would do to beneficiaries. “Then, they need to look at the extent to which states have availed themselves of less harmful alternatives,” he says.

Political vs. fiscal

CMS should consider whether, in some cases, a state’s claim of inability to sustain its Medicaid program represents merely a political preference of the state leadership rather than a true inability to afford the program, argues Mr. Miller. “It’s important for CMS to at least distinguish ‘can’t’ from ‘don’t want to,’” he says.

The PPACA established both a new national eligibility policy for

Medicaid and a set of interim rules, notes Mr. Miller, ensuring that Medicaid will cover up to 133% of the Federal Poverty Level, and states can’t go backward.

“The MOE is just as much a part of the PPACA as the 2014 coverage expansion. It is integral to it,” says Mr. Miller. Since MOE requirements don’t stop states from eliminating optional benefits, Mr. Miller says he expects to see additional cuts in services such as adult dental, therapies, and even prescription drugs.

In addition, says Mr. Miller, states are likely to consider expanding managed care to new populations such as people with disabilities, and implementing provider rate freezes or cuts.

As all governors, CMS, and Congress are aware, and as a Feb. 3, 2011, letter from HHS Secretary Kathleen Sebelius makes clear, says Mr. Miller, efforts to roll back the MOE are not primarily about giving states the tools to better afford their Medicaid program.

“States already have multiple tools at their disposal,” says Mr. Miller. “These efforts are about re-litigating and trying to overturn the coverage expansion in the PPACA, and in so doing, undermine the entire law.”

Secretary Sebelius’ letter was an effort to address many of the recent

questions posed by states, says Mr. Miller. “It would, I think, be enormously helpful to states to have HHS further clarify their willingness to entertain waiver requests relating to care coordination for Medicare and Medicaid dual eligibles,” he says.

This would allow states to share Medicare as well as Medicaid savings, Mr. Miller explains. “There are other areas where additional clarification or further policy development would help states,” he adds. “For example, in light of better information and tools to control drug spending, will CMS recalculate Part D ‘clawback’ payments?”

Going forward, Mr. Miller says we are likely to see more states come in with requests for MOE waivers. “We are virtually certain to see congressional hearings on the MOE,” he says. “We will very likely see legislation to eliminate the MOE.”

This could come either as stand-alone legislation or it may be connected to another bill, says Mr. Miller. “Unfortunately, we are all too likely to see many states taking the well-worn, but ultimately dead-end path of cuts to benefits, instead of putting their Medicaid programs on the path of sustained improvements in cost effectiveness,” he says.

Contact Mr. Miller at miller@communitycatalyst.org. ■

Medicaid programs are facing “mismatch” with primary care

The states with the largest expected Medicaid enrollment growth are the very ones that have the fewest number of primary care physicians, according to a March 2011 report.¹ Temporary increases in Medicaid reimbursement are unlikely to make much of a difference in states facing the biggest enrollment increases, says study author **Peter Cunningham**, PhD, a

senior fellow and director of quantitative research at the Center for Studying Health System Change in Washington, DC.

This is because states that currently have the lowest primary care physician capacity tend to already have Medicaid reimbursement rates that are close to Medicare rates, or in some cases exceed Medicare rates, explains Dr. Cunningham.

“That was a bit of a surprise,” he says. “That means they are not going to benefit as much by the two-year increase in rates that is part of health care reform.”

While states with the smallest number of primary care physicians per capita overall will see the largest percentage increases in Medicaid enrollment, states with the largest number of primary care physicians

per capita will see more modest increases in Medicaid enrollment, the researchers found. “It doesn’t mean that they don’t have to increase their reimbursement,” says Dr. Cunningham. “It’s just that the impact won’t be as great.”

Reasons for shortage

The overall shortage of primary care physicians is a larger problem than the Medicaid reimbursement rates, adds Dr. Cunningham. “There is only so much that states can do,” he says.

Increasing the role of nurse practitioners is one possible approach to addressing the primary care shortage in the short term, says Dr. Cunningham. “Obviously, it becomes a big political issue. The medical groups are generally opposed to that,” he adds.

States that tend to have low primary care physician supply tend to have more stringent rules for what nurse practitioners can do without the supervision of a physician, says Dr. Cunningham. “But for the short term, a lot of people believe it is crucial to more fully utilize nurse practitioners and other non-MDs, in order to address the primary care shortages,” he says.

Dr. Cunningham notes that

some states are building new medical schools. “That could potentially increase the supply of physicians in those states, to the extent that they can keep them,” he says. “The other thing that people need to keep in mind is why there is a shortage of physicians in these states to begin with.”

States with large numbers of uninsured individuals aren’t viewed by physicians as an attractive place to practice, explains Dr. Cunningham.

While some people may view the study’s findings as an indication that health care reform is fundamentally flawed, says Dr. Cunningham, there is another way to look at it. “To address the geographical distribution of providers, you really need to address the coverage issues,” he says. “The only way to attract more physicians in the long term is to reduce the number of uninsured.”

Rates aren’t silver bullet

There is no question, says Dr. Cunningham, that reimbursement in some states is so low that it just is not worthwhile for many physicians to take on Medicaid patients. The Medicaid population is more likely to have complex health problems, he adds, and some physicians perceive they are not good with following up

on treatment and prescriptions.

Regarding efforts to reduce administrative burdens for providers, Dr. Cunningham says there is a “delicate balance” to maintain. “Paperwork issues can’t be completely eliminated without increasing the potential for fraud, which is a big issue in Medicaid,” he explains.

As of 2008, about 41% of all primary care physicians were accepting all or most new Medicaid patients, notes Dr. Cunningham. If the whole nation went to 100% Medicare rates for Medicaid patients, he says, that percentage would probably increase to about half of primary care physicians.

“So reimbursement *does* have an impact, but it is not necessarily the silver bullet,” says Dr. Cunningham. “Physicians complain about Medicare rates, which are lower than private pay rates. For a lot of physicians, 100% of Medicare for just two years may not be enough of an inducement.”

Contact Dr. Cunningham at (202) 484-4242 or PCunningham@hschange.org.

REFERENCE

1. Cunningham, PJ. State variation in primary care physician supply: Implications for health reform Medicaid expansions. Research Brief No. 19. Center for Studying Health System Change, Washington, D.C. (March 2011). ■

Influx of Medicaid providers needed for newly eligible

The Medicaid expansion will pose a major challenge in terms of where the newly insured will be able to receive care in 2014, according to **Daniel R. Hawkins**, senior vice president for public policy and research at the National Association of Community Health Centers in Washington, DC.

“To the credit of Congress, they anticipated that problem, and responded with a major expansion

of the Community Health Centers program,” says Mr. Hawkins.

The \$11 billion provided in the Patient Protection and Affordable Care Act (PPACA) will enable health centers to expand to serve another 20 million people by 2015, in addition to the over 20 million individuals they serve today, notes Mr. Hawkins.

Health centers are principally primary care medical, dental, and

behavioral health homes, says Mr. Hawkins, which provide care to the country’s underserved. “They will locate and expand in exactly the same communities where the estimated 16 million new Medicaid recipients live and work,” he says. “That will be vitally important.”

Clinical workforce

The single biggest challenge for

the new and expanding health centers, says Mr. Hawkins, will be where to recruit the new clinical workforce needed to staff them. "This is where the National Health Service Corps comes in," he says.

Congress provided an additional \$1.5 billion to the National Health Service Corps over the next five years, notes Mr. Hawkins. "That is enough to assist and place some 17,000 clinicians in underserved areas," he says.

The biggest strength of the

National Health Service Corps, according to Mr. Hawkins, is that it assists only medical, dental, and behavioral health students who are focused on primary health care. "It only places them in underserved areas, exactly where they are most needed," he says.

Mr. Hawkins says that by partnering with a major academic institution, National Association of Community Health Centers helped to create one of the nation's newest dental schools and then one of its

newest medical schools.

The A. T. Still School of Medicine in Mesa, AZ, takes in 100 students each year, he notes, and trains them in community health centers. "We are also partnering with schools to train more nurse practitioners and physician assistants," reports Mr. Hawkins. "This is another strategy being deployed by health centers — that of 'training our own.'"

Contact Mr. Hawkins at (202) 296-0131 or dhawkins@nachc.org. ■

Primary care practices will need extra help to transform

When **Craig Thiele**, MD, chief medical officer of Dayton, OH-based CareSource, the state's largest Medicaid managed care plan, thinks of 2014, he remembers the need to "be sure, from the sheer aspect of supply and demand, that we don't get into trouble."

To be ready for the influx of millions of Americans onto the Medicaid rolls, he says, there is no question that the number of primary care providers must increase significantly.

"We have been working on this for a good long while with our networks, but this took it up a couple of notches," says Dr. Thiele. "You can't wait until you have a flood of people moving into the market."

One challenge is that many of the newly insured will be in the health insurance exchanges, says Dr. Thiele, which will probably have a higher pay rate than Medicaid. "We are getting very serious about finding ways to make it easier for our providers," he says. "Making it easier' is our mantra."

Providers are not only paid less to care for Medicaid patients, says Dr. Thiele, but they also have more administrative burdens to contend with. For this reason, he says,

CareSource is implementing a "first call" resolution process and an easier appeals process.

"We are looking at anything and everything that we can do to remove those hassles, to the point where that isn't what they think about with a Medicaid managed care plan," says Dr. Thiele.

Partner with providers

Another key, says Dr. Thiele, is partnering with providers in helping them to manage Medicaid patients more easily. As part of a patient-centered medical home pilot, a case manager was assigned to help pro-

viders with practice transformation, he reports.

It was discovered that practices needed a great deal of help to implement open access scheduling, disease registries, and other approaches to better manage patients with complex health needs, says Dr. Thiele. Depending on the size of the practice, he adds, onsite case managers were sometimes needed.

Providers now use CareSource's Clinical Practice Registry to keep track of which members are overdue for diagnostic tests, says Dr. Thiele. "We reward them for improving on those same measures for which we provide the tools," he says. "We are

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now part of the solution, and not just a payer.”

Notably, says Dr. Thiele, the medical home pilot consists mostly of “mainstream” practices varying in size from 200 to 5000 members. “We didn’t just want the early adopters,” he explains. “We have to help them get there. It’s certainly not a cookie-cutter approach.”

The payer’s approach is to make it easier for the practice to do better on the measures, explains Dr. Thiele, then reward them for it financially. “If we get that practice to do everything better, *and* they are being rewarded for it, now they will say, ‘I want more of your patients in my practice,’” he says.

Providers are notified if a member goes to the ER or the hospital or fills a prescription, adds Dr. Thiele, and a 24-hour nurse advice line is made available to patients. “That drives quality, but it also reduces some of the workload off the provider,” he says. “It makes their lives easier.”

A single model

Each of the state’s six other Medicaid managed care plans agreed to use the same medical home model, reports Dr. Thiele. “We went to the Ohio Department of Jobs and Family Services and shared that with them,” he says. “That shows that we can work together on certain things that are very important.”

If a given physician in the community is presented with the medical home option, says Dr. Thiele, he or she will consider the fact that CareSource comprises only a small percentage of their practice. However, he explains, if all of the Medicaid managed care plans are using the same medical home model, that percentage might increase to 20% or even 40%.

“That provider won’t be as excited about the medical home option, if different plans are giving them different models,” says Dr. Thiele. “If we bring them the one model, and say, ‘All the Medicaid managed care plans are behind this,’ that simplifies things for them.”

CareSource is currently working to make the pharmacy benefit simpler for providers, says Dr. Thiele, given the fact that the seven plans each manage the state’s formulary a little differently. “That is something we are discussing with the state now,” he says. “They have been very open to working with us on solving some of these barriers.”

Some providers will not accept any patients outside commercial payers or Medicare, notes Dr. Thiele. “By allowing more dollars to flow through programs that improve outcomes, that will allow more growth to occur in the safety net system,” he says. “I think it will encourage even providers who aren’t in the safety net system to be curious.”

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