State Health Watch
Vol. 18 No. 10
The Newsletter on State Health Care Reform
October 2011

AHC Media

In This Issue

New evidence supports value of Medicaid coverage

Individuals with Medicaid coverage were 70% more likely to have a regular medical office to obtain basic care, 55% more likely to have a personal doctor, and obtained more preventive care than an uninsured group, according to a new study.[1]

"Our study shows that Medicaid substantially improves the well-being of enrollees, putting to rest any arguments that Medicaid doesn't matter to beneficiaries," says **Katherine Baicker**, PhD, one of the study's authors and a professor of Health Economics at the Department of Health Policy and Management at the Harvard School of Public Health in Boston.

Researchers compared 10,000 Oregonians who won a state-sponsored lottery for Medicaid in 2008 with a group who applied for Medicaid but remained uninsured. Those who obtained Medicaid coverage were 40% less likely to borrow money or skip paying other bills because of medical expenses, and were 25% more likely to perceive their health as being good to excellent, the researchers found.

"We found that Medicaid coverage increased health care use, including inpatient care and outpatient care, such as doctor's

*See **Cover Story** on page 2*

RI's global waiver changes administration of Medicaid

The global waiver that was granted to Rhode Island in 2009 allows the state to operate its Medicaid program in a way that is different than otherwise required under statute and still receive federal matching funds, according to **Elena Nicolella**, the state's Medicaid director.

The Global Consumer Choice Compact waiver will expire on Dec. 31, 2013, unless the state decides to request a renewal, she reports. "Under the waiver — and I want to emphasize that it is not a block grant — the state seeks to demonstrate changes to the Medicaid program in the long-term care and primary and acute care arenas," says Ms. Nicolella.

Fiscal Fitness: How States Cope

Utilization of long-term care community-based services is being increased in lieu of institutional services such as nursing homes, says Ms. Nicolella, and the number of Medicaid eligible beneficiaries who participate in coordinated care is being increased.

"In the two years that the Rhode

*See **Fiscal Fitness** on page 3*

State Health Watch
The Newsletter on State Health Care Reform

On-line access / Index

Back issues of ***State Health Watch*** may be searched on-line for a fee at **www.newslettersonline.com/ahc/shw.** Issues may be searched by keyword and date of publication.

State Health Watch (ISSN# 1074-4754) is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to *State Health Watch,* P.O. Box 105109, Atlanta, GA 30348.

Subscriber Information:
Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m. - 6 p.m. Monday-Thursday; 8:30 a.m. - 4:30 p.m. Friday ET.

E-mail: customerservice@ahcmedia.com. Web site: www.ahcmedia.com.

Subscription rates: $399 per year. Add $17.95 for shipping & handling. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Back issues, when available, are $67 each.

Government subscription rates: Call customer service at (800) 688-2421 for current rate. For information on multiple subscription rates, call Steve Vance at (404) 262-5511.

(GST registration number R128870672.)

Editor: **Stacey Kusterbeck**, (631) 425-9760, staceykusterbeck@aol.com.
Executive Editor:
Russ Underwood, (404) 262-5521, russ.underwood@ahcmedia.com.
Associate Managing Editor:
Jill Von Wedel, (404) 262-5508, jill.vonwedel@ahcmedia.com.

AHC Media

Cover story

Continued from page 1

office visits, prescriptions, and preventive care," says Dr. Baicker. "Policymakers need to weigh those benefits against the cost of the program."

First study of its kind

The study's findings "really do lay to rest the question of whether insurance coverage, and Medicaid coverage in particular, is of value," says **Sara R. Collins**, PhD, vice president for affordable health insurance at the Commonwealth Fund's office in Washington, DC.

One major difference between this study and prior research, says Dr. Collins, is that the possibility of differences between people who enroll in Medicaid, and those who are eligible but don't enroll, was eliminated. "In this case, it was a population with similar characteristics," says Dr. Collins. "The state had to make a decision about who they could let into Medicaid. Everyone in the group wanted to enroll. Some were randomly selected, and others didn't make it in."

In addition, says Dr. Collins, the strength of the findings, the large sample size, and the quality of the research team, which includes health policy experts who served in both the Bush and Clinton administrations, "lends the study an enormous amount of credibility."

The fact that people who did not get into the Medicaid program were significantly worse off than those who did, says Dr. Collins, "is an incredibly encouraging finding. People should be heartened by it."

This is the first study to evaluate the effects of Medicaid using a randomized control group, notes Dr. Baicker. Without such a control group, it is very difficult to isolate the effects of insurance itself, she explains, since the insured and the uninsured differ in many ways, such as income, employment, or initial health, that may also affect their health outcomes.

For example, people in ill health may be more likely to enroll in Medicaid when given the opportunity, says Dr. Baicker. "A naive comparison of those who are enrolled to a group of uninsured people might incorrectly conclude that Medicaid harmed health, because enrollees might have worse health outcomes, but it's not that Medicaid caused worse health outcomes," says Dr. Baicker. "Rather, those in poor health were more likely to be enrolled in the first place."

Joseph Newhouse, PhD, one of the study's authors and John D. MacArthur Professor of Health Policy and Management at Harvard University, says that because there had never been a randomized experiment with an uninsured group, he had no strong expectations about the health status results.

"How to interpret them will be clearer when we are able to analyze the physiologic measures of health we are collecting," says Dr. Newhouse. "The work certainly suggests Medicaid has value among the group we enrolled. Whether that value exceeded the cost is still an open issue."

More utilization

"There has been a great deal of debate about how Medicaid affects access to care," says Dr. Baicker. Some have postulated that people on Medicaid don't have much access to care because providers may not accept Medicaid patients, she explains, while others have postulated that the uninsured already consume care through

uncompensated care, emergency departments, and clinics.

Prior research suggested that there would be an increase in utilization in response to Medicaid coverage, which the researchers also found, according to Dr. Newhouse. "It was also not surprising, though good to see documented since there had been no prior work, that Medicaid lessened financial strain," he adds.

The study shows that having access to community health centers or ERs is not the same as having health insurance coverage, says Dr. Collins. "It really does underscore the importance of the coverage expansions under the health reform law, which should bring the numbers of uninsured way down," she says.

The fact that people with Medicaid coverage got more preventive care also has fiscal implications for states, says Dr. Collins. "While it may increase public health costs in the short run, it's probably going to save the system costs over the longer term because of a healthier population," she says.

The study's findings demonstrate that Medicaid is a critically important health insurance program, according to **Deborah Bachrach,** special counsel at Manatt, Phelps & Phillips, a health law and consulting firm in New York City, and former New York Medicaid director.

"To suggest that low-income families, the elderly and the disabled would be better off without Medicaid flies in the face of the facts," says Ms. Bachrach. "This is not to say that Medicaid is without its flaws."

That is why Medicaid directors around the country are focused on strategies to ensure that Medicaid is a sound purchaser, says Ms. Bachrach, using many of the same tools as Medicare and private insurers.

"The Oregon study is a welcome endorsement of Medicaid's role in providing coverage and care," says Ms. Bachrach. "One can hope it will also provide an incentive to ensure eligible Americans are able to access quality, cost-effective care — now and in 2014."

Contact Ms. Bachrach at (212) 790-4594 or DBachrach@manatt.com, Dr. Baicker at (617) 432-1029 or kbaicker@hsph.harvard.edu, Dr. Collins at (212) 606-3838 or src@cmwf.org, and Dr. Newhouse at (617) 432-1325 or newhouse@hcp.med.harvard.edu.

REFERENCE

1. Finklestein A, Taubman S, Wright B, et al. The Oregon health insurance experiment: Evidence from the first year. National Bureau of Economic Research Working Paper No. 17190. July 2011, Cambridge, MA. ■

Fiscal Fitness

Continued from page 1

Island Medicaid program has been operating under the waiver, major changes in the way we administer the program have been undertaken," says Ms. Nicolella. Here are some examples:

• **A new process was implemented for determining a person's clinical eligibility for long-term care services.**

Under the waiver, the state no longer applies institutional level of care criteria to long-term care eligibility, explains Ms. Nicolella, adding that the state now uses functional criteria to limit who can access nursing home services.

"The level of care criteria also includes the development of a preventive level of care," says Ms. Nicolella. "This allows the state to provide a minimal amount of home care to people not yet clinically eligible for the full scope of long-term care services."

• **Mandatory enrollment into Medicaid managed care was implemented for Medicaid-only adults with disabilities.**

Currently, 12,000 people are enrolled in Rhody Health Partners Program, administered by Medicaid managed care organizations, says Ms. Nicolella, and 2,000 people are enrolled in Connect Care Choice, the primary care case management program.

• **Aggressive outreach and assistance to individuals interested in transitioning from a nursing home to a community has resulted in more than 100 people successfully transitioning to the community.**

"This effort, as well as a concerted effort to divert people who are at risk for institutionalization, has resulted in a modest but promising downward trend on the utilization rate of nursing homes," reports Ms. Nicolella.

Controversial aspect

"One of the more controversial aspects of the global waiver is that the state operates under a budget cap," says Ms. Nicolella. This cap represents the maximum expenditure amount for which the federal government will provide financial participation, she explains, and the five-year cap for the demonstration is $12.075 billion.

If the overall cost of the Medicaid program for the five-year demonstration period exceeds that amount, the state will need to fund the excess spending with state-only dollars, says Ms. Nicolella.

"While the cap puts the state at risk for caseload and utilization, this risk factor has been essentially neutralized by the experience to date," she says. "Through the end of the second full year of the waiver, our experience is more than $1.3 billion below the budget neutrality cap for that period." This figure,

which does not represent a savings to the state, is projected to grow through the remainder of state fiscal year 2011 and into state fiscal year 2012, adds Ms. Nicolella.

The advantage of the cap is that it provides the state a certain degree of flexibility in deciding how to finance the larger publicly funded health care system, says Ms. Nicolella. "The Costs Not Otherwise Matchable authority is very closely tied to the cap limit," she says. "The notion is that without the waiver, the state would spend a certain amount."

The program changes pursued under the waiver are intended to decrease the growth rate of Medicaid costs, notes Ms. Nicolella. "If the state can curb that growth rate, there is authority to claim federal match on non-Medicaid eligible populations," she says. "In Rhode Island, we have used that additional funding authority to match expenditures for services that were funded with state-only dollars."

Those populations include individuals enrolled in the state's General Public Assistance Program and adults with behavioral health needs who are not eligible for Medicaid, says Ms. Nicolella.

ACA goals complemented

Ms. Nicolella says that the major fiscal challenge she sees is the amount of available state funding in the current budget. While enrollment of the aged, blind, and disabled population has remained relatively constant at 50,000, the number of eligible families and children has increased by 3,834 over the past 12 months, she reports.

However, Ms. Nicolella says that fiscal opportunities exist in many of the initiatives offered through the federal government, including the Health Home Model, the Community First Choice Option, the Money Follows the Person Grant, and the Re-Balancing Initiative.

"The state's economic challenges have resulted in the need to increase cost sharing and decrease provider reimbursement rates," says Ms. Nicolella.

The global waiver complements the goals of the Affordable Care Act, according to Ms. Nicolella, and has enabled the state to be better prepared for its implementation. "Through the Costs Not Otherwise Matchable initiative, we have access today to many of the childless adults who will be Medicaid eligible on January 2014," she says.

The efforts in the long-term care system enabled the state to request and receive a $24 million Money Follows the Person grant to accelerate its re-balancing efforts, says Ms. Nicolella. "Our work with the Medicaid managed care organizations and Connect Care Choice practices has prepared us to begin to adopt new payment methodologies and care models, such as the patient-centered medical home and the health home," she adds.

Contact Ms. Nicolella at (401) 462-3575 or enicolella@dhs.ri.gov. ■

RI waiver meant more federal funds for state

Some states are contemplating asking the federal government for a "waiver" of the standard Medicaid requirements modeled after Rhode Island's, which was implemented in 2009, says **Jesse Cross-Call**, a policy associate on the Health Policy team at the Center on Budget and Policy Priorities in Washington, DC.

However, according to a March 2011 report from the Center on Budget and Policy Priorities (CBPP), *Rhode Island's Global Waiver Not a Model For How States Would Fare Under a Medicaid Block Grant*, proponents of converting Medicaid into a block grant have exaggerated the savings.

Rhode Island's global waiver, called the Global Consumer Choice Compact, merged new waiver initiatives with a number of waivers the state already had received from the federal government, says the report, including waivers for helping Medicaid-eligible people enroll in employer-based coverage and expanding the use of home- and community-based services for people needing long-term care.

A key component of the Rhode Island waiver, though, was that it allowed the state to receive federal Medicaid funds for services the state previously paid for entirely on its own — meaning the state got *more* federal money, not less, says Mr. Cross-Call, one of the report's authors. "New Jersey and Texas are two states that have made it explicit that they too hope to use a waiver to increase the federal contribution to their Medicaid programs," he says.

Some states are also using waivers as a means to prepare their Medicaid programs and their larger health care markets for the expansion of coverage that will occur in 2014 when health reform is fully implemented, says Mr. Cross-Call, noting that California's Bridge to Reform waiver was approved by the Centers for Medicare & Medicaid Services (CMS) in November 2010.

Under this waiver, he explains,

California will receive a federal match to extend Medicaid coverage to some individuals earning less than 133% of poverty, provide new revenue to public hospitals to upgrade their infrastructure and delivery systems in anticipation of the greater demand for care in 2014, and move Medicaid-eligible seniors and persons with disabilities into managed care.

Lower federal contributions

Texas submitted a waiver proposal to CMS that incorporates some of the features of California's waiver, says Mr. Cross-Call, and seeks to expand Medicaid managed care in the state and use the anticipated savings to help cover hospitals' uncompensated care costs and expand their capacity in advance of 2014. "Importantly, the Texas proposal does not seek a cap on Medicaid spending, and would not cut beneficiaries from the program," he adds.

Mr. Cross-Call notes that although Medicaid was a focus as many states confronted large budget gaps during the most recent legislative sessions, no state has submitted a proposal that would change the structure of their Medicaid program to a block grant.

"This is not surprising, because a block grant would decrease the *federal* contribution to state Medicaid programs over time, as a way to bring down federal spending," says Mr. Cross-Call. Under a block grant, he explains, states would receive significantly less federal funding than they would under the current Medicaid system, shifting significant costs to the states.

This cost shift would force states to cut eligibility for seniors, children, pregnant women, and persons with disabilities, reduce payments to health providers in their states, contribute more state funds to their Medicaid programs, or some combination of these options, says Mr. Cross-Call.

The House-passed budget crafted by Budget Committee Chairman Paul Ryan contains a concrete example of a block grant, says Mr. Cross-Call, and would reduce federal funding for state Medicaid programs by 35% in 2022 and cut it nearly in half in 2030. As a result, between 14 million and 27 million people would lose coverage and hospitals would have to deal with a 31% decline in revenue from Medicaid, according to a May 2011 analysis.[1]

"In addition to millions losing insurance coverage, many health providers would find it difficult to stay in business," says Mr. Cross-Call.

Contact Mr. Cross-Call at (202) 408-1080 or cross-call@cbpp.org.

REFERENCE

1. Holahan J. Buettgens M, Chen V, et al. House Republican budget plan: State-by-state impact of changes in Medicaid financing. May 2011. Kaiser Commission on Medicaid and the Uninsured, Washington, DC. ■

Washington Medicaid eyes moving costly SSI population to managed care

Washington Medicaid first tried moving its high-cost Supplemental Security Income (SSI) population into managed care back in the 1990s, but that effort was a failure, according to **Doug Porter**, the state's Medicaid director.

Currently, 693,539 individuals are enrolled in Medicaid managed care, says Mr. Porter, and 561,238 of them are children.

"The attempt to move the SSI population into our Healthy Options plan lasted for a year or less," says Mr. Porter. "The reasons for that are as varied as the number of people you ask about it who were here at the time, but for whatever reason, it was not a success."

The failure put policymakers in a "don't even think about it" mode for a number of years, according to Mr. Porter, but then economic conditions worsened. "The fee-for-service program grew so robustly and became very unpredictable," he says. "More and more folks started pushing us back to the drawing board to figure out how to manage the care of the people who cost the most money."

While the Temporary Assistance for Needy Families (TANF) population of mothers and children is relatively inexpensive to cover, says Mr. Porter, about 5% of clients drive half of the expenses in the Medicaid program, mostly elderly and disabled individuals.

"That is why we are re-procuring our managed care contracts right now. We have an RFP out on the street that people are looking at and responding to," says Mr. Porter. "We fully intend to undergo a major shift from the fee-for-service world into the managed care world."

Preston Cody, director of Washington state's Division of Healthcare Services, says that about 100,000 to 120,000 individuals in the aged, blind and disabled population will likely be moved into Medicaid managed care, but not dual eligibles.

"There wouldn't be much advantage to managing the care of those individuals, except to Medicare," he explains. "We will need to come up with a shared savings strategy

with Medicare before we move the dual eligible population into managed care in Medicaid."

More obligations for plans

Back in the 1990s, says Mr. Porter, policymakers were "a little naive" in thinking that the Healthy Options plans could simply absorb the SSI population with their existing contracts, without taking the unique needs of this group into account.

"That was one problem," says Mr. Porter. "We didn't fully anticipate how the plans' obligations to this population would be greater than the existing TANF population."

In fact, plans were obliged to do a great deal more for the SSI population than was being done in the fee-for-service world, says Mr. Porter, and people were skeptical that clients would really be able to access all the services they needed.

At the time, Mr. Porter was director of California's Medi-Cal program, and was involved with the debate over expanding managed care to the 12 largest counties in the state on a mandatory basis.

"The advocates were certainly concerned about the motivation plans would have to deny or delay services to achieve a better margin," Mr. Porter says. In Washington state, stakeholders set out to make sure that managed care plans would really provide all the necessary services to clients, he explains, which quickly became unaffordable.

The managed care organizations (MCOs) are now more mature in their development, says Mr. Porter, and over time, the state has gotten better at measuring the care they provide. "We have lived with this model for some time," he says.

Washington Medicaid has worked with the MCOs on various quality improvement efforts, explains Mr. Porter, such as improving immunization rates and well-child visits.

"This has positioned us, at this point in time, to go back and revisit the SSI population," says Mr. Porter.

The state's budget includes an estimated first-year savings of $16.2 million due to the switch to managed care, says Mr. Porter. "This may be an unreasonable expectation, in their desperation to close a $5 billion shortfall," he adds. "We don't know how reasonable it is. We're going to find out when we go to the market and see what our actuaries come up with, and what plans are willing to go at risk for."

However, Mr. Porter says he is not willing to jeopardize the move to managed care if that estimated savings amount turns out to be unrealistic. "If we can't realize it, we can't realize it. That's not a reason not to move this population to managed care," he says.

The state has done a three-year look at the fiscal impact of managed care, says Mr. Cody, and expects to see some savings in the first year. The state won't necessarily go with the lowest bidder when selecting MCOs, he adds, but rather, the ones who can achieve the desired outcomes.

The MCOs that are contracted with will provide care through January 2014, says Mr. Cody, at which point an additional 400,000 to 500,000 individuals are expected to come onto the Medicaid program. Therefore, he says, "Plans have a lot of incentive to bid lower. We want the best carrier to provide the service at the lowest cost."

Duals may be next

As one of 15 states awarded a $1 million planning grant for dual eligibles, Washington is working to identify how to manage not only the Medicaid expenditures for the dual eligibles, but also the Medicare expenditures, Mr. Porter says.

"There are things that we could do in Medicaid that would likely save Medicare money, but it would cost Medicaid more," he explains. "Until we can control not just the Medicaid side but also the Medicare side, it's not worth it to any state to do that."

The goal is to have Medicare share those savings with Medicaid, says Mr. Porter, which would probably result in a more aggressive move into managed care for dual eligibles.

For instance, nursing homes which are paid for by Medicaid don't have trained staff available to medically manage a patient around the clock, says Mr. Porter. A patient with an impacted bowel or indigestion is therefore rushed by ambulance to the nearest ED, he explains, where diagnostic tests are done and the patient may be admitted, all of which Medicare pays for.

If Medicaid reimbursed nursing facilities to have better medical management on site, it could save the cost of an ambulance trip or a hospital admission, and would be better care for the patient, says Mr. Porter. "But it would cost Medicaid more to do that, and save Medicare the extra expense. That is the sad state of affairs," he says.

In the current delivery system, says Mr. Porter, providers do exactly what they are paid to do, and no more. "We've got to figure out how to change that," he says. "That is really part of the appeal of managed care."

Managed care offers a lot more flexibility for how you buy services than fee-for-service, says Mr. Porter, which is designed to pay for each pill dispensed or each admission. "You buy widgets, not outcomes," he says. "We have to move toward buying outcomes."

Contact Mr. Cody at (360) 923-2765 and Mr. Porter at (360) 725-1040 or portejd@dshs.wa.gov. ■

Approved bridge waiver gives "preview" of Medicaid expansion

The approval of a Bridge waiver in January 2011 "rescued" Washington state's Basic Health plan, according to **Doug Porter**, the state's Medicaid director, and should give the state a preview of Medicaid expansion. "We're now drawing down federal matching funds for a program that was previously all state funded," he says.

By going the waiver route, says Mr. Porter, Washington was able to avoid changing its state plan to cover more people, which other states have had to do in order to expand Medicaid coverage.

Mr. Porter gives the example of Connecticut, which increased eligibility for people previously not categorically eligible for Medicaid, but without any limit on how many people can enroll in the program. "We were able to negotiate a capped enrollment in our program," he says. "We don't have to add anybody else to the rolls, even if they meet the same eligibility requirements."

The state doesn't intend to add anyone onto the program until the expansion of Medicaid in 2014, adds Mr. Porter, unless the legislature provides funds to add additional people. "As we look at our revenue forecast, that does not look likely between now and 2014," he says.

Washington's governor had proposed eliminating the Basic Health program in her budget, notes Mr. Porter, even after the waiver was approved.

Ultimately, the decision was made to sustain the Basic Health program at its current level, he says, and instead reduce the rates paid to hospitals, long-term care facilities, and Federally Qualified Health Centers.

"The legislature adopted an approach of 'don't eliminate services to people, cut the rates paid to providers instead,' to save an equivalent amount of money," says Mr. Porter. "The bad news is we're getting sued by the hospital association, protesting that rate cut. It remains to see how that's going to play out."

The most difficult part of negotiating the bridge waiver with the Centers for Medicare & Medicaid Services (CMS) involved the cost sharing provisions that already existed in the Basic Health program, says Mr. Porter, which comprise about 7% of the client's household income. CMS has long held that cost-sharing should not exceed 2% of the client's household income, he adds.

"They approved it for 30,000 clients in Basic Health, but now we are asking them to approve it for ten times that number of adults coming on the program," says Mr. Porter. "I think that will be a major source of negotiation." ■

Many uninsured in ERs don't know they're eligible for Medicaid

Nearly 80% of 13,069 uninsured patients in the ERs of four San Diego hospitals over an 11-month period were eligible for some form of government insurance, yet weren't enrolled, according to a Point-of-Service ER Survey conducted by the San Jose, CA-based Foundation for Health Coverage Education (FHCE).

Researchers also analyzed data from the FHCE's National Eligibility Survey, which found 61.7% of 180,250 CoverageForAll.org visitors seeking information on their health care options were also unaware of their eligibility government coverage.

These results were "startling," according to **Phil Lebherz**, FHCE's executive director.

"To realize that 80% of the patients who received care at these four busy ERs were actually qualified for government programs, but not enrolled, indicates that the enrollment system is not working," he says.

Mr. Lebherz also notes while the hospitals will make an effort to get reimbursement for their "treat and admit" patients, it is often very difficult to get payment for the care provided to patients discharged from the ER.

Given that the nation's health care reform act mandates moving millions more Americans into the Medicaid program, Medicaid directors are seemingly being placed in a "no-win situation," says Mr. Lebherz.

"The Medicaid program has created a situation where it's providing care to a large segment of its qualified members at the highest cost venue possible — the emergency department," he says. "In the process, the government is avoiding its responsibility to provide needed reimbursement to hospitals and doctors giving care."

Hospitals nationwide reported that they incurred $36.5 billion

in uncompensated care losses in 2009, according to the American Hospital Association. Mr. Lebherz hypothesizes that "much of the responsibility for that figure is the result of the Medicaid enrollment inefficiencies across the nation."

Mr. Lebherz says his hope is that the government will someday see Medicaid as a health care program, not a health insurance program. "The principle behind insurance is to protect oneself against loss of assets in case of a financial disaster," he says. "People with few assets don't need an insurance program. They need health care."

For this reason, says Mr. Lebherz, a "point of care" eligibility and provider reimbursement system is needed. Since a person's annual income and current year quarterly estimates can be identified through the Internal Revenue Service, a patient could theoretically qualify on the spot for Medicaid, he explains.

"This is important, because each state's budgetary spending for qualifying and monitoring Medicaid recipients has grown exponentially, reducing the amount used for direct health care," says Mr. Lebherz.

Within the 2010 budget, the California Department of Health Services included employment of a staff of 27,300 to enroll the state's Medicaid, food stamp and welfare recipients with total costs exceeding $3 billion, notes Mr. Lebherz.

"This money did not provide care or funds to those in need, just administrative expenses," he says. "Through technology, we can improve access for all Medicaid eligible recipients at the point of care."

The fact that uninsured but eligible individuals continue to be identified in the ER points out the value of doing outreach and enrollment assistance in the ER, says **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.

"While in the ER, families often sit and wait for long periods of time," she says. "They are well aware of their health needs at that time. Thus, they are highly motivated to figure out their insurance options."

Furthermore, says Ms. Morrow, hospital staff can assist families in completing the application and obtain immediate, presumptive eligibility for Medicaid and the Children's Health Insurance Program, where state law allows.

"As we move forward with health reform, all available channels of entry should be explored to reach uninsured individuals, including emergency rooms," says Ms. Morrow.

Contact Mr. Lebherz at (800) 234-1317 or ả ceinfo@coverageforall.org and Ms. Morrow at (718) 832-6061 or bmorrow@childrenspartnership.org. ■

Medicaid spending becoming bigger share of state budgets

Although governors' proposed budgets for fiscal 2012 showed a 2.9% decline in Medicaid spending, state funds going to the program are predicted to increase by 18.6%, according to a spring 2011 report from the National Governors Association and the National Association of State Budget Officers.[1]

"Clearly, the current Medicaid path is not sustainable," says **Matthew Mitchell**, PhD, a research fellow at the Mercatus Center at George Mason University in Arlington, VA. "In the last two decades, it has doubled as a share of state spending. It's crowding out all sorts of things that everyone cares about, both conservatives and progressives."

Real inflation adjusted per capita cash assistance is down over the last 20 years ago, adds Dr. Mitchell, which can be attributed in large part to Medicaid spending. "Cash assistance that is not tied to a particular product is actually considered the most effective way to help poor people," adds Dr. Mitchell.

Dr. Mitchell notes that Utah recently passed a Medicaid reform plan which is asking for waivers to modify delivery and reimbursement methods. "Apparently, they did some analysis of what would need to happen if Medicaid continued on its present course," he says. "They looked at what would happen to other state programs — how many teachers would have to be laid off, how many universities would have to be closed."

Various stakeholders were involved early in the process, says Dr. Mitchell, including advocates of the Medicaid program. "They passed the reform, apparently with 100% support," he says. "The state is in a dire situation. They made good use of that, by recognizing there are even more difficult choices ahead if they don't change course."

Contact Dr. Mitchell at (703) 993-8940 or mmitche3@gmu.edu.

REFERENCE

1. The National Governors Association and the National Association of State Budget officers. The fiscal survey of states: An update of state fiscal conditions. Spring 2011, Washington, DC. ■

CMS eligibility systems guidance: "Good news" for Medicaid directors

Medicaid directors have been concerned that they would have to set up duplicative or "shadow" eligibility systems to distinguish between current eligibles and new eligibles under the Affordable Care Act (ACA), according to **Tricia Brooks**, a senior fellow at the Georgetown University Center for Children and Families in Washington, DC.

"A new CMS [Centers for Medicare & Medicaid Services] guidance solidly squashed speculation and fears," she says. "This is good news for state Medicaid directors."

The May 2011 CMS Exchange and Medicaid Information Technology Guidance 2.0 contains information for guiding development of the technology to be used for the exchanges, Medicaid and Children's Health Insurance Program (CHIP) coverage under the ACA, notes Ms. Brooks.

The ACA promises to transform public health coverage programs, including Medicaid, CHIP and subsidized coverage through the Exchange, into a consumer-focused, simplified, coordinated system of coverage options, she explains.

"The central player in this transformation is a state's information technology (IT) infrastructure," says Ms. Brooks. "The vision for these systems is to create a streamlined, paperless and real-time process whereby individuals apply on their own, or receive assistance from navigators, for coverage."

Despite the ability to deliver real-time eligibility decisions accessing trusted electronic sources of data such as the Internal Revenue Service and Homeland Security, says Ms. Brooks, some critical challenges remain.

CMS is investing significant federal funding to support the development of new Exchange IT systems and to upgrade or enhance Medicaid eligibility systems, she notes.

"This critical federal support — 100% for Exchange IT systems and 90% for Medicaid/CHIP systems is essential to delivering on the promise of health reform, particularly given the current state fiscal climate," says Ms. Brooks.

Additional guidance temporarily waives some requirements to allocate costs to other programs, such as the Supplemental Nutritional Assistance Program, for states that have integrated eligibility systems, says Ms. Brooks.

"This is a golden moment for states to seize an extraordinary funding opportunity to advance their aging systems," she says.

Many challenges remain

There are still certain challenges in converting to Modified Adjusted Gross Income (MAGI) and implementing other eligibility changes, says Ms. Brooks, such as eliminating the asset test for most people in Medicaid.

There must be a mechanism to distinguish between people who are newly eligible through the ACA, such as parents who meet current income guidelines but are not eligible due to a state asset test, and those who have been eligible but not enrolled, she explains.

Consistent, simplified eligibility decisions must be made in real-time, says Ms. Brooks, adding that the ACA aligns the rules for counting income and household size for subsidized premiums and reduced cost-sharing in the Exchange, as well as CHIP and most people in Medicaid.

The change to MAGI must ensure that children who are currently eligible and protected by the maintenance of effort provisions of the ACA remain eligible, says Ms. Brooks. "Thus, states will need to establish new effective gross income eligibility levels," she says. "These need to take into consideration that certain income disregards and expense deductions that states employ now will no longer be used in 2014."

CMS is working to address these changes, says Ms. Brooks, and issued a solicitation in June 2011 for a contract to help come up with a straightforward method of calculating newly eligibles for Federal Medical Assistance Percentages purposes and in determining effective eligibility levels.

"This will help states get beyond the concept of using 'shadow systems' to determine eligibility first one way, under the new rules, and then another under the old rules," she says.

Coming up with a methodology to address the challenges in converting to MAGI and simplifying the rules, is just part of the agency's effort to propel states forward, says Ms. Brooks. States will receive explicit guidance in how to use consistent standards in accessing data sources to verify eligibility, for instance, says Ms. Brooks.

"In the end, this will relieve states of the burden of re-inventing the wheel over and over again," she says. With a largely real-time, paperless system, individuals and families will be able to access coverage faster, says Ms. Brooks.

Even with the advanced state of technology, simplified and aligned rules, the ability to tap trusted

sources of eligibility data, and strong technical assistance from CMS, she says, "the goals are ambitious and the clock is ticking."

Many states stand to save administrative costs dedicated to their current paper-driven, manual processes, adds Ms. Brooks. "This is not to say that everything will be smooth sailing ahead. These are complex systems that require much lead time to design, develop, test and deploy," she says. "I am optimistic that we'll get there, but probably not with a lot of time to spare."

Contact Ms. Brooks at (202) 365-9148 or pab62@georgetown.edu. ■

Discrepancies in what reports say Medicaid expansion will cost states

The Affordable Care Act (ACA) will cost states $118 billion through 2023, according to the March 2011 Joint Congressional Committee report, *Medicaid Expansion in the New Health Law: Costs to the States*, while a March 2011 analysis from the Congressional Budget Office (CBO) estimated a cost of $60 billion through 2021.

The reason for this discrepancy is that "you're sampling in an incomplete universe over different periods of time," according to **Thomas P. Miller**, JD, a resident fellow at the American Enterprise Institute and former senior health economist for the Joint Economic Committee, both in Washington, DC.

There are basically three sources for what the expansion will cost states, he says, referring to the CBO's March 2010 estimate, which estimated new state spending on Medicaid at $20 billion between 2017 and 2019, the CBO's March 2011 estimate, and the Joint Congressional Committee's report.

"CBO's first estimate was on the low side. It probably wasn't their singular focus, considering everything else they were doing at the time," says Mr. Miller. "They did an update to a period of 2021, which brought it up to a little over $60 billion."

Unlike the CBO report, the Joint Congressional Committee's report didn't independently create an estimate, notes Mr. Miller. "It's almost the difference between a top-down and a bottom-up approach," he says. "CBO's estimates are partly literature-based, and part of it is black box models. My general view is that they will tend to have more of a national overview of what this is going to mean."

Timeframe is key

CBO's "top down" approach, says Mr. Miller, is to "make some assumptions and go formulate a number, which is what Congress wants. They want a number that looks like it is more precise than it is."

In contrast, says Mr. Miller, the Joint Congressional Committee report took more of a "bottom up" approach. "They took whatever good information there was, but it wasn't all from the same methodology. Some reports are more elegant and defined than others," he says.

Another key difference is that the Congressional report is based on a longer timeframe, says Mr. Miller. "With all of these spending projections, the further you go in the out years, the higher the number you will get," he adds. "By adding two years, you will get a lot of money. That doesn't account for the entire gap between the $60 billion and the $118 billion, but it can account for some of it."

In addition, says Mr. Miller, the Congressional report filled in additional out years, to 2023, for which it did not already have full estimates from various other sources, by taking the last year for which there was an estimate and increasing it each year by the assumed average annual rate of increase in Medicaid spending in general.

The Joint Congressional report was based in part on estimates from state agencies, adds Mr. Miller, which were mostly done some

time after the ACA was passed. "By that time, some of the cement was beginning to harden," he says. "People may have been beginning to express a little bit of over projection of their worst fears in a tough climate."

Estimates coming from states, says Mr. Miller, tend to be "a little more nervous or pessimistic about how this is all going to work in practice. They're going to load in some cost elements for hidden administrative costs that sometimes get airbrushed away," he says.

Most of the early estimates from the CBO focused on the costs to states for new eligibles, who wouldn't be fully subsidized in the out years, notes Mr. Miller. "But you have some other costs coming in, if you believe there might be a little game playing between the feds and the state," he says. "If the feds are running the exchange, they may call people previously eligible instead of newly eligible," he says.

A more negative forecast of those cost effects by state officials could account for some of the increased costs in the Joint Congressional Committee report, says Mr. Miller, adding that all of the existing estimates are inexact.

"No one has a great read on this," he says. "Folks at the state level, who can't afford what they currently have and are still belly up for a while, are going to think it will work out a lot more negatively for them, with them getting caught short."

In contrast, says Mr. Miller, "folks from Washington are saying, 'What a good deal. We are paying almost all of your bills. What's the problem?'"

The number of individuals eligible for Medicaid coverage, as opposed to coverage through the exchanges, is another uncertainty, adds Mr. Miller. "It's hard to know what will ultimately be tagged as Medicaid, as opposed to lower income exchange coverage, with people moving back and forth," he says. "It's a very volatile and unpredictable environment. When you haven't actually done it in the real world, you can't make those things as finely calculated as presumed on paper."

Concerns are valid

Spending projections are guesswork to a large degree, says Mr. Miller, but they do pinpoint some valid concerns.

"There are some warning flags from people who are closer to the ground," he says. "A lot of people in the states do think this is a problem, that it's not all been taken care of. That should be listened to, regardless of whether the calculations are exactly precise."

Here are other key variables that are still uncertain regarding the cost of the Medicaid expansion to states, says **Stan Rosenstein**, MPA, principal advisor at Health Management Associates in Sacramento, CA and former California Medicaid director:

- **Take-up rates.**

California's analysis of the cost of the Medicaid expansion included 50%, 75%, and 100% take-up rates, notes Mr. Rosenstein. "You can debate that, and states will make their best estimates of what those will be, but nobody knows until you get there," he says. "There is no science to those kind of projections."

- **Requirements for maintaining eligibility.**

"One thing the ACA didn't really address is the requirements for maintaining eligibility — both how easy it is to get enrolled, and also maintenance and status reporting," says Mr. Rosenstein.

States have a fair amount of flexibility on status reporting under the ACA, adds Mr. Rosenstein, and will have to decide what level of reporting they will require. "There are a whole range of options. That is another big variable that states will have to address," he says. "By requiring more status reporting, you can keep your caseloads down."

- **Enrollment levels.**

All of the spending projections are based on enrollment levels as of 2011, but there could be dramatic changes in levels by 2014, says Mr. Rosenstein. "Medicaid has grown dramatically in the past two years because of the recession," he says. "Things could turn around and enrollment could drop because unemployment is going down, or it could be the other way around."

Contact Mr. Miller at (202) 862-5886 or tmiller@aei.org and Mr. Rosenstein at (916) 792-3740 or srosenstein@healthmanagement.com. ■

Can states come out ahead under health care reform?

Most states can come out ahead financially under health care reform, according to **Stan Dorn**, a senior fellow at the Urban Institute in Washington, DC, noting that a December 2010 Urban Institute study found that states would see net budget savings of between $40.6 billion and $131.9 billion from 2014 to 2019 because of the Affordable Care Act (ACA).[1]

"Increased state Medicaid costs will be outweighed, in all likelihood, by state Medicaid savings," he says. Rejecting the ACA's Medicaid expansion could wind up being self-destructive fiscally for many, if not most, states, adds Mr. Dorn.

"Somewhat higher-income adults will be moved into the exchange," says Mr. Dorn. "Federal Medicaid dollars will substitute for current state and local spending on uncompensated care, mental health services, and social services for low-income parents."

Medicaid is a major source of coverage for children, pregnant women, seniors and people with disabilities in every state, notes **Gina E. Wood**, deputy director of the Health Policy Institute's Joint Center for Political and Economic Studies in Washington, DC.

"It has a unique role in our health care system, covering a diverse group of beneficiaries, including some of the most frail and vulnerable Americans," she says. "It is the nation's primary payer for long-term care in nursing homes and outside institutions."

Medicaid is a federal/state health partnership, adds Ms. Wood, and "to ignore the expansion requirements would be irresponsible and violate basic human rights of those individuals eligible under the new law."

Legal ramifications

If a state chose not to comply with the Medicaid expansion, says Ms. Wood, the legal ramifications are unclear, giving the pending lawsuits filed in federal courts, and would most likely be decided by the U.S. Supreme Court. "Those states who are complaining should realize that the new law will bring down the charity care needed for those that are now ineligible for Medicaid," she adds.

Between 2014 and 2019, says Ms. Wood, the federal government should pay $443.5 billion dollars, or 95.4% of the total cost of the Medicaid expansion. "The new health care law will result in an additional $15.9 million people receiving Medicaid," she says. "The amount of uninsured Americans should fall by a whopping 11 million people."

The expansion is needed because current income levels are "dismally low already," says Ms. Wood, adding that right now, the Medicaid law leaves dependents without children ineligible for Medicaid in at least 43 out of the 50 states, even if they don't have income.

Effect on budget

Failing to expand Medicaid eligibility won't solve the state budget crisis, adds Ms. Wood. "It would only be a short-term, stopgap measure that would reverse the gains we have made as a nation to cover all Americans living below 133% of the federal poverty level," she says.

That means that every American living alone who makes $14,000 in 2010 will be required to get Medicaid, says Ms. Wood, adding that states already have substantial flexibility to design benefits, service delivery systems, and payment strategies, without a federal waiver.

In 2008, roughly 40% of Medicaid spending — $100 billion — was spent on optional benefits for all enrollees, with nearly 60% of this spending for long-term care services, notes Ms. Wood.

"Efforts are under way to step up federal support to help identify cost drivers in the Medicaid program," she says. "New tools and resources will be provided to achieve both short-term savings and longer-term sustainability."

Contact Mr. Dorn at (202) 261-5561 or sdorn@urban.org and Ms. Wood at (202) 789-3517 or gwood@jointcenter.org.

REFERENCE

1. Dorn S, Buettgens M. Net effects of the Affordable Care Act on state budgets. The Urban Institute, Washington, DC, December 2010. ■