THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

ISSUE BRIEF

A Discussion with Leading Medicaid Directors:

July 2013

As FY 2013 Ends, Looking toward Health Care Reform Implementation in 2014

Executive Summary

In May 2013, a group of leading state Medicaid directors met outside Denver, Colorado to discuss the current opportunities and challenges facing state Medicaid programs as they prepare to implement the Affordable Care Act (ACA) coverage expansions and enrollment simplifications that will take effect in January 2014. Medicaid directors described a time of focused attention on their preparation for the implementation of significant and complex system and policy changes.

Key findings include:

States participating in the discussion varied with regard to their decisions on the ACA Medicaid expansion. Debate over the decision included a number of factors beyond just the fiscal impact.

The discussion clearly illustrated how widely divergent state decisions and approaches are on expanding Medicaid. Directors indicated that the debate on whether to move forward with the Medicaid expansion included a number of factors, many of which were specific to state circumstances. Beyond the fiscal impact of the decision, other factors mentioned as part of the debate included: how the expansion would be implemented, past experiences with coverage expansions, as well as potential action to reduce the federal deficit, and the funding commitment to Medicaid, in the future.

Regardless of where states stood on the Medicaid expansion, all the directors reported that they were actively working to have new streamlined eligibility and enrollment processes ready for 2014.

As part of health care reform implementation, all states are preparing to implement major changes to simplify and streamline eligibility and enrollment processes. By January 1, 2014, state Medicaid programs are required to use Modified Adjusted Gross Income (MAGI) to determine eligibility for most non-elderly Medicaid applicants and to have simplified enrollment policies and updated eligibility systems in place that interface with the new marketplaces. However, because the new marketplace will begin enrollment on October 1, 2013, there is an additional push to have

Medicaid enrollment systems ready earlier. These changes are significant and complex, and they are required even if states do not adopt the ACA Medicaid expansion. Overall, there was broad consensus among the participants that they were working hard to be ready for open enrollment, but that eligibility and enrollment-related issues would inevitably occur at the start despite the best efforts of states and the federal government. As such, they stressed the importance of setting realistic expectations for January 2014.

In addition to implementation of the ACA, states continue to improve their existing Medicaid programs, by continuing to pursue payment and delivery reforms and by building on previous successes.

States are continuing to pursue significant payment and delivery system reforms to better coordinate care for complex and high need populations. Discussion group participants cited a number of new and ongoing initiatives in their states, which illustrated their commitment to improving health outcomes and controlling costs.

Directors also noted the importance of recognizing the successes of Medicaid, particularly at a time when there are many misperceptions about the program. There was consensus that as the Medicaid expansion is implemented and states continue to make delivery and payment reforms to the program, it will be important to both share the program's achievements, innovations, and impact, and to communicate its effectiveness in connecting people to the care they need.

Introduction and Background

In May 2013, a group of leading state Medicaid Directors met outside Denver, Colorado to discuss the current opportunities and challenges facing state Medicaid programs as they prepare to implement the ACA coverage expansions and enrollment simplifications that will take effect in January 2014. At that time, affordable health coverage will become available to millions of Americans in every state either through new state-based marketplaces (also known as "exchanges") or through the new federally operated marketplace. Millions more will become newly eligible for Medicaid in states that implement the ACA Medicaid expansion.[1]

The Medicaid expansion extends Medicaid eligibility to nearly all adults with incomes up to 138 percent of the federal poverty level (FPL), ($15,856 for a household of one or $32,499 for a household of four in 2013), including adults without dependent children who historically have been excluded from Medicaid coverage in most states. The ACA provides 100 percent federal financing for those newly eligible for Medicaid from 2014 through 2016, phasing down to 90 percent by 2020 and beyond.

The fiscal impact of the decision varies across states, though states are likely to see net savings from the expansion. A report prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured estimates that if all states expanded Medicaid, the total cost of the expansion would be about $1 trillion over the 2013-2022 period, with the federal government paying $952 billion (93%) and the states paying up to $76 billion.[2] State costs are related to increased participation among those currently eligible for coverage (reimbursed at the traditional Medicaid match rate) and a small share for those newly eligible (up to 10% by 2020). Increased participation in Medicaid is likely to occur even if a state chooses not to implement the ACA Medicaid expansion due to national outreach and enrollment activities as well as requirements to simplify and streamline the enrollment process and to coordinate enrollment for the Marketplace, Medicaid and CHIP.

States are also likely to see savings or offsets to costs from the Medicaid coverage expansion from: reduced state spending for uncompensated care; the transition of current Medicaid coverage for specific groups to the "newly eligible" category at the higher match rates; the transition of those with incomes above 138% FPL currently covered by Medicaid to coverage in the Marketplace; or reduced spending for programs that serve indigent populations (such as state funded mental health or substance abuse programs.) States could also see increased revenue from broader economic effects such as increased jobs, income and state tax revenues within the health care sector and beyond. As of July 2013, 24 states are moving forward with Medicaid expansion; 21 states are not moving forward at this time and 6 states remain undecided or continue to debate the expansion.[3]

Regardless of whether a state chooses to implement the Medicaid expansion, new requirements for web-based, paperless, real-time Medicaid eligibility and enrollment processes will need to be in place by January 1, 2014. States also will need to shift to a uniform income eligibility standard (Modified Adjusted Gross Income or MAGI) for most coverage groups and coordinate closely with the new marketplaces to establish a "no wrong door" enrollment approach, so that, regardless of a person's point of entry (i.e., a marketplace or state Medicaid agency), eligibility is determined for all insurance affordability programs. For states, these changes will represent a huge transformation of their current systems.

Concurrent with implementation of the eligibility and enrollment changes under the ACA, states must continue to administer their existing Medicaid programs. At the time of the discussion in May 2013, most states were at the end of fiscal year (FY) 2013 and about to start FY 2014. On the whole, state revenues were continuing to grow, having improved after several years of record level declines during the Great Recession, but revenues were growing at a modest rate compared to recoveries from previous recessions. On average across all states, state revenues have returned to pre-recession levels but are still far from full recovery.[4] States continue to actively pursue payment and delivery reforms to better coordinate care for Medicaid beneficiaries, particularly those with chronic conditions.

It was within this context that a cross-section of Medicaid directors from across the country met for a structured discussion including members of the Board and staff of the National Association of Medicaid Directors (NAMD). This report is based on that discussion.

Key Findings

States participating in the discussion varied with regard to their decisions on the ACA Medicaid expansion. Debate over the decision included a number of factors beyond just the fiscal impact.

The discussion clearly illustrated how widely divergent state decisions and approaches are on expanding Medicaid. (Box 1) Directors indicated that the debate on whether to move forward with the Medicaid expansion included a number of factors, many of which were specific to state circumstances. Beyond the fiscal impact of the decision, other factors mentioned as part of the debate included: how the expansion would be implemented, past experiences with coverage expansions, as well as concerns over future federal action to reduce the federal deficit.

The fiscal impact of the Medicaid expansion was a part of the debate in all states, though its weight varied. Three of the Medicaid directors participating in the discussion group commented that their states (Michigan, Washington and West Virginia) had one or more fiscal analyses showing a net savings to the state from the ACA Medicaid expansion. For Washington and West Virginia, these analyses supported state decisions to implement the expansion and, in Washington, the expansion helped to partially offset a projected budget deficit. The Medicaid directors from Georgia, South Carolina and Tennessee – states not currently moving forward with the expansion or still debating the issue– indicated that their analyses showed overall net direct costs from implementing the expansion.

However, directors also indicated that the fiscal impact was not the only factor driving expansion decisions. In the state of Michigan, for example, implementation of the expansion remained in doubt at the time of the discussion despite legislative fiscal agency estimates of over $1 billion in net savings over ten years (including $200 million in mental health-related savings). Larger annual savings are expected in the first six years of implementation, which would more than offset small annual costs that would begin in year seven.[5] Despite the overall savings estimates and generally improving state revenue collections, at the time of the focus group, the Michigan legislature had not provided the needed budget authority for the expansion.

Box 1: Status of State Decisions on the Medicaid Expansion from the Directors' Discussion

Moving Forward at this Time: Medicaid directors from **California**, **Washington** and **West Virginia** indicated that their states were actively moving forward with implementing the ACA Medicaid expansion. Since the discussion, legislation has been signed into law by the Governor of **Arizona**.

Not Moving Forward at this Time: Medicaid directors from **Georgia** and **South Carolina** indicated that their states were not moving forward with the Medicaid expansion at this time. The Medicaid director from **Virginia** indicated that legislation precluded her state from moving forward at this time until a number of Medicaid reforms had been implemented, as determined by a bicameral legislative committee.

Debate Ongoing: Directors in two states, **Indiana** and **Tennessee**, indicated that although their Governors remain undecided, they are working with CMS to pursue alternative models for the Medicaid expansion. Indiana's Governor has proposed using its current Section 1115 Demonstration program, the "Healthy Indiana Plan," as the benefit model for the expansion. Tennessee's Governor has been in discussions with CMS officials about the potential use of a premium assistance model for the expansion population. Unlike in Indiana, the Medicaid director in Tennessee indicated that additional legislative authority may be needed. The Medicaid director from **Michigan** described continuing legislative resistance, despite gubernatorial support for expansion. At the time of the discussion, the Michigan Governor was continuing to seek the legislative budget authority required to expand. Since the discussion, legislation authorizing the expansion through a waiver has been passed by the state House in Michigan and is pending in the state Senate.

Debate on the Medicaid expansion in some states focused on how the Medicaid expansion would be implemented. Medicaid directors from Indiana and Tennessee, for example, noted that although their governors remain undecided, they are pursuing alternative methods of expanding Medicaid. Indiana's Governor has proposed using the state's current Section 1115 Demonstration program, the "Healthy Indiana Plan," as the benefit model for the expansion. Tennessee's Governor had been discussing with CMS the potential use of a premium assistance model for the expansion population. Unlike in Indiana, additional legislative authority may be needed in Tennessee

depending on the changes negotiated. In Virginia, expansion is predicated on a number of Medicaid reforms being implemented as determined by a bicameral legislative committee, including the successful negotiation of a Memorandum of Understanding with the federal government to implement their Financial Alignment Demonstration for those eligible for Medicare and Medicaid as well as expanding the use of managed care.

Past experiences with coverage expansion also played a role in how the debate for the Medicaid expansion was framed in some states. In Arizona, for example, the Medicaid expansion is viewed by the Governor and her supporters as a "restoration" rather than as an "expansion" given that the state had a previous coverage expansion to adults up to the poverty level that was reduced due to budgetary pressures in the recent recession. In Tennessee, the state's experience with its Medicaid managed care expansion in the mid-1990s has, in part, influenced the Governor's decision to pursue negotiations with CMS to use a premium assistance model for the expansion.

Concerns over possible future action to reduce the federal deficit, and the funding commitment to Medicaid, also factored into the expansion decision. Some states, such as Arizona, have included language in authorizing legislation that specifies if the federal share for the newly eligible drops below that which is specified in federal statue or some other specified level, the state will terminate the Medicaid expansion. Others have pointed to the long history of the program, during which the formula that determines the federal share of Medicaid spending has remained steady since the start of the program.[6] Congress has only amended the formula to provide more federal funding, not less.[7]

Regardless of where states stood on the Medicaid expansion, all the directors reported that they were actively working to have new streamlined eligibility and enrollment processes ready for 2014.

As part of health care reform implementation, all states are preparing to implement major changes to simplify and streamline eligibility and enrollment processes. By January 1, 2014, state Medicaid programs are required to use Modified Adjusted Gross Income (MAGI) to determine eligibility for most non-elderly Medicaid applicants and to have simplified enrollment policies and updated eligibility systems in place that interface with the new marketplaces. However, because the new marketplace will begin enrollment on October 1, 2013, there is an additional push to have Medicaid enrollment systems ready earlier. These changes are required whether or not states decide to adopt the ACA Medicaid expansion.

All the participating directors stressed that their states are working hard to prepare for implementation of these changes and that they will be ready by 2014, though there will be differing degrees of readiness. Some directors noted that there will likely be a significant number of manual and paper "workarounds" at initial implementation. Some directors also noted that staffing levels may not be fully adequate for the initial influx of applications expected due to the ACA. Some states noted that they were adding shifts and will be increasing the amount of teleworking to try to address potential staff issues. In addition, a few directors commented that some rural areas of their states lacked broadband internet access and that this potential limitation needs to be better understood by all states and by the federal government as electronic access to the exchange application process (by both staff and consumers) is developed. While states will be in different places at the start, they will continue to improve processes over time after initial implementation.

Directors wanted more detailed information about the federal government's projected timelines for system development and implementation to help inform state operations and planning efforts. Directors in the group pointed to the significant federal implementation challenges, including the creation of the federal data hub (that will link to various federal agencies to verify income and other information provided by applicants). There were also concerns expressed about the adequacy of staffing for the federal call center and several noted that many consumers will likely want enrollment assistance. States operating their own marketplaces, as well as some of those where the federal government will be operating the marketplace, are developing contingency plans with the intention of ensuring rapid response to problems that may arise with eligibility and enrollment issues. The directors noted that states have significant incentives to minimize implementation problems as state residents will likely turn to state officials if they experience enrollment difficulties, regardless of whether their marketplace is operated by the state or the federal government.

States represented by the directors in the discussion group varied widely in their plans and preparations to provide outreach and marketing for the new coverage expansions. Outreach and enrollment efforts in 2014 will likely vary across states. In addition to broad campaigns launched by the federal government and states, private entities, including advocacy groups, provider organizations and health plans, may launch their own outreach and enrollment efforts. The directors from Washington and West Virginia, for example, reported that their states were planning aggressive outreach efforts. In Washington, state staff is developing marketing and outreach plans and is also working to develop a brand identity for Medicaid. West Virginia has started working with Enroll America to form grass-roots educational partnerships ("Enroll West Virginia"). The director from South Carolina—which is not currently planning to implement the Medicaid expansion—indicated that the state is still planning aggressive efforts to enroll people currently eligible for Medicaid but not enrolled and those who will be eligible for coverage through the new marketplace.

Other directors commented that outreach was not currently a high priority in their states, as they remained primarily focused on systems implementation. In addition, concerns were raised that aggressive outreach may not be advisable at initial implementation since it would drive higher volumes of applications to systems when they are first coming online as states and CMS are still working through implementation issues. Some also noted that outreach campaigns would need to target messaging to account for coverage options that may be available in one state but not in the next, particularly in light of some states not moving forward with the Medicaid expansion at this time.

States continue to improve their existing programs, by continuing to pursue payment and delivery reforms and By building on previous successes.

In addition to implementation of the ACA, states continue to pursue significant payment and delivery system reforms to better coordinate care for complex and high need populations. Discussion group participants cited a number of new and ongoing initiatives in their states. For example, California and Tennessee mentioned plans to pursue bundled or episodic payments. Further expansion of managed care was also mentioned by several states; South Carolina, for example, discussed converting its Medical Home Network to a capitated payment arrangement. Additionally, Washington noted efforts to coordinate performance measures between Medicaid and mental health.

A number of other states mentioned ongoing efforts to better coordinate care for dual eligible beneficiaries, either as part of the financial alignment demonstrations offered by CMS or outside of these demonstrations. States are particularly focused on better coordinating care for this population because of both the potential to improve care for

this population, which is served by both Medicare and Medicaid, as well as the potential for savings. Participants in the discussion indicated that as work has continued, expectations have strengthened that such initiatives would improve the delivery of care for this population and deliver some savings for states, though states are moderating their original projections on the amount of state savings that may be achieved.

Directors highlighted the importance of recognizing the Medicaid program's successes in connecting people to needed care and improving their health. The focus group discussion closed with discussion about the importance of recognizing the successes of Medicaid, particularly at a time when there are many misperceptions about the program. It was noted that several recent significant research studies show how Medicaid improves the access to health care and the health status of low-income and vulnerable populations, including studies demonstrating improved birth outcomes and child health as well as reduced mortality for adults.[8, 9, 10, 11] However, even with these positive research findings and positive quality metrics, misperceptions about the program's effectiveness remain and have become part of the Medicaid expansion debate, leading to calls for program reform in some states.

Overall, there was consensus that as the Medicaid expansion is implemented and states continue to make delivery and payment reforms to the program, it will be important to share the successes of the program and communicate its effectiveness in connecting people to the care they need.

Conclusion

While states are in different places on the decision to move forward with the Medicaid expansion, all states are currently hard at work preparing to implement the ACA coverage expansions and enrollment simplifications that will take effect in in January 2014. All the directors participating in the discussion stressed that that they are making every effort to be ready by 2014. Despite different degrees of readiness at the start, they will continue to improve processes over time after initial implementation. At the same time, states are also continuing to pursue payment and delivery system reforms to better coordinate care for complex populations that the program serves.

Methodology

The Kaiser Commission on Medicaid and the Uninsured convened a focus group discussion with Medicaid directors who serve on the Board of the National Association of Medicaid Directors (NAMD). The discussion focused on state progress and concerns about implementing the ACA including eligibility system changes and state action on the Medicaid expansion decision as well as activity around payment and delivery system reform, and other budget and enrollment trends. The discussion took place in May 2013. Nine Medicaid directors from the NAMD Board plus the Michigan Medicaid Director and NAMD staff participated in the discussion. The following states were represented: Arizona, California, Georgia, Indiana, Michigan, South Carolina, Tennessee, Virginia, Washington, and West Virginia.

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Endnotes

[1] In its June 2012 ruling in *National Federal of Business v. Sebelius,* the U.S. Supreme Court limited the federal government's ability to enforce the ACA's Medicaid expansion requirement effectively making implementation of the Medicaid expansion optional for states.

[2] John Holahan, Matthew Beuttgens, Caitlin Carroll and Stan Dorn, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2012), http://www.kff.org/medicaid/report/the-cost-and-coverage-implications-of-the/. NOTE: These estimates do not include savings states will realize from reductions in state spending for mental health and other state-funded programs, or new state revenues from increased economic activity.

[3] "Status of State Action on the Medicaid Expansion Decision as of July 1, 2013," Kaiser Family Foundation State Health Facts, accessed July 17, 2013, http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[4] There is also concern that growth rates for the fourth quarter of 2012 and the first few quarters of 2013 are inflated due to one-time actions in response to federal tax changes related to the Fiscal Cliff as well as tax rate increases in California. Lucy Dadayan and Donald J. Boyd, *Data Alert: Strong Growth in Personal Income Tax Collections in First Quarter of 2013 but Cloudy Fiscal Outlook* (New York City, NY: The Rockefeller Institute of Government, June 5, 2013), http://www.rockinst.org/newsroom/data_alerts/2013/2013-06-SRR92_data_alert_djb_v2.htm.

[5] The Michigan director noted that the governor, who supports expansion, proposed to deposit savings into a dedicated fund to be used to fund coverage in later years essentially making the expansion budget neutral for 21 years through the year 2034.

[6] Robin Rudowitz, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2012), http://www.kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal/.

[7] Robin Rudowitz, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2012), http://www.kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal/.

[8] Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2013), http://www.kff.org/medicaid/issue-brief/medicaid-a-primer/.

[9] Benjamin D. Sommers, M.D., Ph.D., Katherine Baicker, Ph.D., and Arnold M. Epstein, M.D., "Mortality and Access to Care among Adults after State Medicaid Expansions," *New England Journal of Medicine*, 367 (Sept. 13, 2012):1025-1034.

[10] This study followed 10,405 persons selected in the lottery (the lottery winners) and 10,340 persons not selected (the control group). Katherine Baicker, Ph.D., and Amy Finkelstein, Ph.D., "The Effects of Medicaid Coverage – Learning from the Oregon Experiment," *New England Journal of Medicine*, 365 (August 25, 2011):683-685.

[11] Teresa A. Coughlin, Sharon K. Long, Lisa Clemans-Cope, and Dean Resnick, *What Difference Does Medicaid Make* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2013), http://www.kff.org/medicaid/issue-brief/what-difference-does-medicaid-make-assessing-cost-effectiveness-access-and-financial-protection-under-medicaid-for-low-income-adults/.

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