THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

REPORT

October 2013

Medicaid in a Historic Time of Transformation:

Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014

EXECUTIVE SUMMARY

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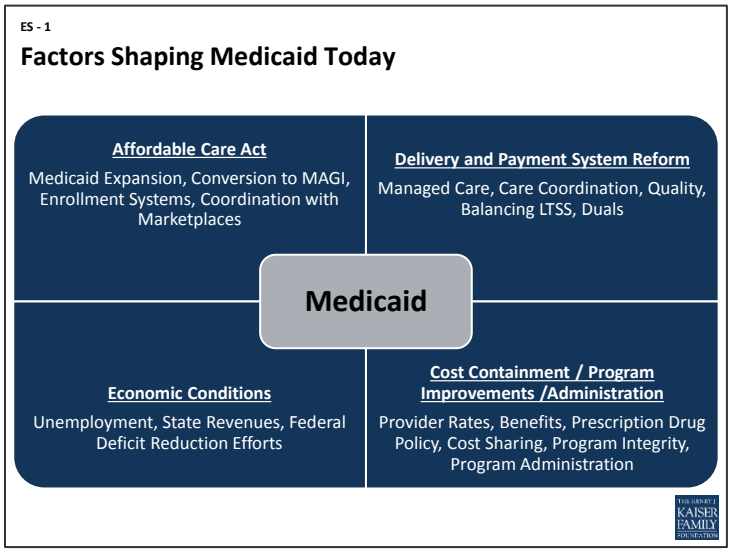
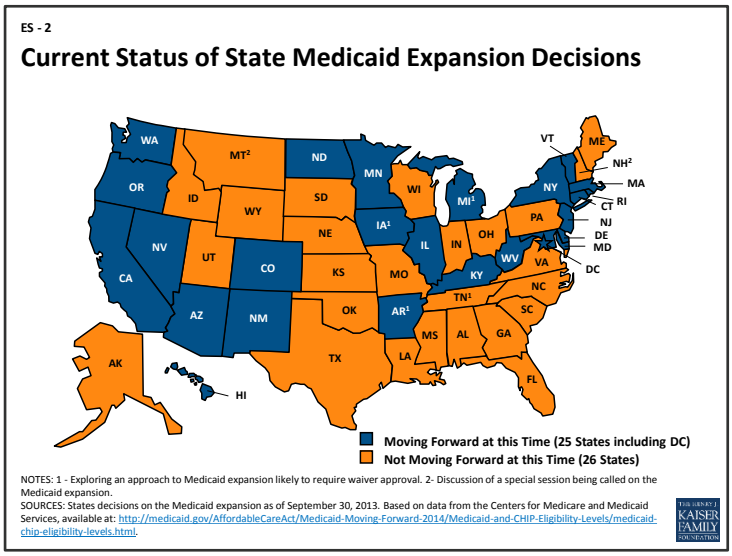
EXECUTIVE SUMMARY

The dominant forces shaping Medicaid during FY 2013 and heading into FY 2014 were the implementation of the Affordable Care Act (ACA) and the development and implementation of an array of delivery and payment system reforms. These changes represent some of the most significant changes to Medicaid since its enactment in 1965, and taken together, are transforming the role of Medicaid in the health care system in each state. At this time, the intensity of fiscal pressures and the focus on Medicaid cost containment were somewhat lessened as the economy slowly recovers; however, controlling costs and improving program administration are still important priorities for Medicaid program. (ES-1)



Today, Medicaid provides health and long-term care coverage to more than 66 million low-income Americans. Medicaid accounts for one in six dollars of all health care spending in the US but is the primary payer for long-term care services and supports (LTSS) and a major source of revenue for safety-net providers. Medicaid provides assistance for over 9.5 million low-income Medicare beneficiaries. The program continues to evolve as states implement programs to improve care, manage costs and improve quality using managed care as well as other care coordination initiatives.

As enacted in the ACA, Medicaid's role was broadened to become the foundation of coverage for nearly all low-income Americans with incomes up to 138 percent of the federal poverty level (FPL) ($15,856 per year for an individual in 2013). However, the Supreme Court ruling on the ACA effectively made the decision to implement the Medicaid expansion an option for states. Twenty-five states (including the District of Columbia) have announced plans to move forward with the expansion; the remaining 26 states are not moving forward with the Medicaid expansion at this time. (ES-2) State decisions about implementing the Medicaid expansion have important coverage and fiscal consequences for states. In states that do not expand Medicaid, adults may face large gaps in coverage.



The findings in this report are drawn from the 13th annual budget survey of Medicaid officials in all 50 states and the District of Columbia conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates (HMA). The report highlights trends in Medicaid spending, enrollment and policy initiatives for FY 2013 and FY 2014 with an intense focus on eligibility and enrollment changes tied to the implementation of the ACA as well as payment and delivery system changes. The report provides detailed appendices with state-by-state information and a more in-depth look at four case study states: Arizona, Florida, Kentucky and Washington.

Key findings from the survey include the following:

- Improvements in the economy resulted in modest growth in Medicaid spending and enrollment in FY 2013. In FY 2014, national enrollment and spending growth are expected to rise. States moving forward with the Medicaid expansion are expected to see higher enrollment and total spending growth driven by increases in coverage and federal funds.
- The implementation of the ACA will result in major changes to Medicaid eligibility and enrollment for all states whether they are implementing the ACA Medicaid expansion or not.
- Nearly all states are developing and implementing payment and delivery system reforms designed to improve quality, manage costs and better balance the delivery of long-term services and supports across institutional and community-based settings.
- Improvements in the economy have enabled states to implement more program restorations or improvements in provider rates and benefits compared to restrictions, but states also adopted policies to control costs and enhance program integrity.
- Looking ahead, FY 2014 will be a transformative year for Medicaid.

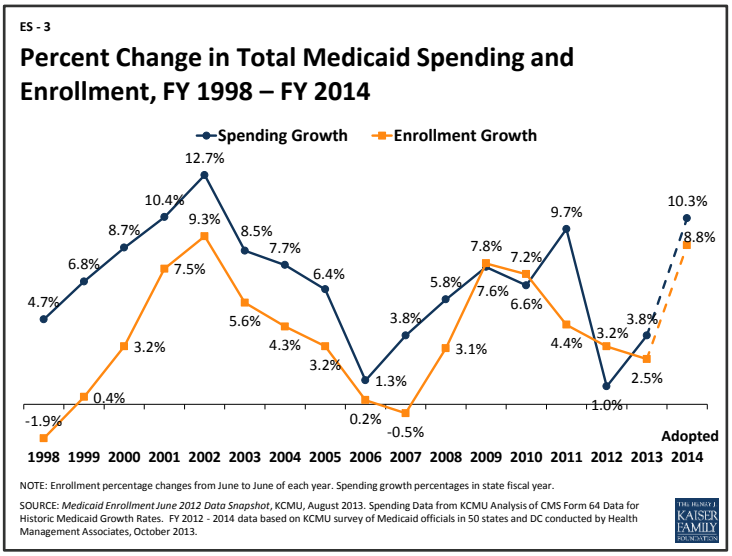
Methods

The KCMU/HMA Medicaid survey on which this report is based was conducted from June through August 2013. The survey instrument was designed to document policy actions states implemented in state FY 2013 and adopted for FY 2014 (which began for most states on July 1, 2013.) The Medicaid budget for FY 2014 had been adopted by all states at the time each survey was completed. Medicaid directors and staff provided data for this report in response to a written survey and a follow-up telephone interview. The survey was sent to each Medicaid director in June 2013. All 50 states and DC completed surveys and participated in telephone interview discussions in July and August 2013. The telephone discussions are an integral part of the survey to ensure complete and accurate responses and to record the complexities of state actions. For most states, the interview included the Medicaid director as well as Medicaid policy or budget staff.

The focus of the annual survey is on Medicaid policy changes and new initiatives that are implemented, or are adopted and planned for implementation. This survey asked state officials to describe policy changes that occurred in FY 2013 and those adopted for implementation for FY 2014. The survey does not attempt to catalog all Medicaid policies.

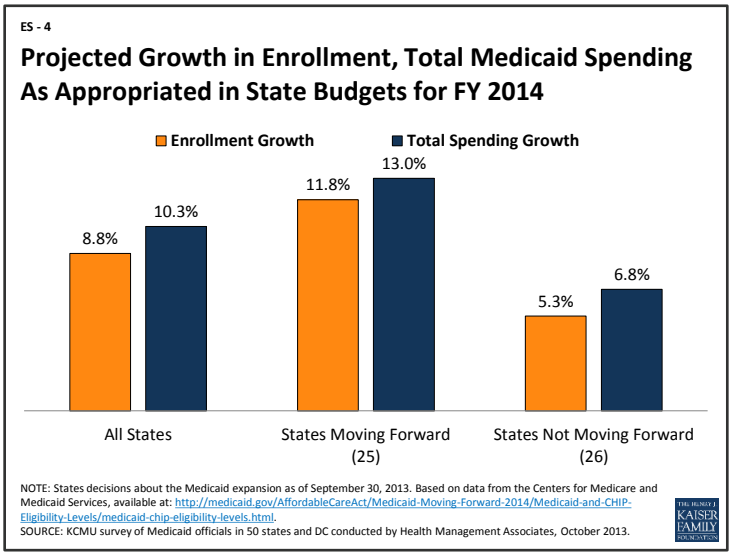
1. **Improvements in the economy resulted in modest growth in Medicaid spending and enrollment in FY 2013. In FY 2014, national enrollment and spending growth are expected to rise. States moving forward with the Medicaid expansion are expected to see higher enrollment and total spending growth driven by increases in coverage and federal funds.**

Headed into state fiscal year (FY) 2014, states are still recovering from the Great Recession as state revenues grow and national unemployment continues to fall slowly. As economic conditions have continued to improve, pressure on Medicaid enrollment and state budgets has lessened. In FY 2013, Medicaid enrollment growth slowed to 2.5 percent, the lowest rate of growth in six years, since the beginning of the Great Recession, and very close to original projections of 2.7 percent. Total Medicaid spending increased at an annual rate that averaged 3.8 percent across all states, relatively modest compared to historical growth rates and on target with original legislative appropriations. (ES-3) The state share of Medicaid spending increased by 3.1 percent in FY 2013.



For FY 2014, enrollment growth was projected to average 8.8 percent across all states. Part of the increase in expected enrollment is because all states (even those not implementing the Medicaid expansion) anticipate increases in Medicaid coverage due to additional participation among those currently eligible. These increases are tied to changes in enrollment processes that are required in all states.

State decisions about the Medicaid expansion had implications for anticipated spending and enrollment growth in FY 2014. The states that are planning to adopt the Medicaid expansion are expecting to see higher enrollment and total spending growth compared to the states not expanding Medicaid. These states are likely to see larger increases in coverage. The large difference in total Medicaid spending growth across these groups primarily reflects the cost of covering newly eligible enrollees which qualify for the 100 percent federal funding. A number of states moving forward expect to see net fiscal benefits from the ACA Medicaid expansion. (ES-4)

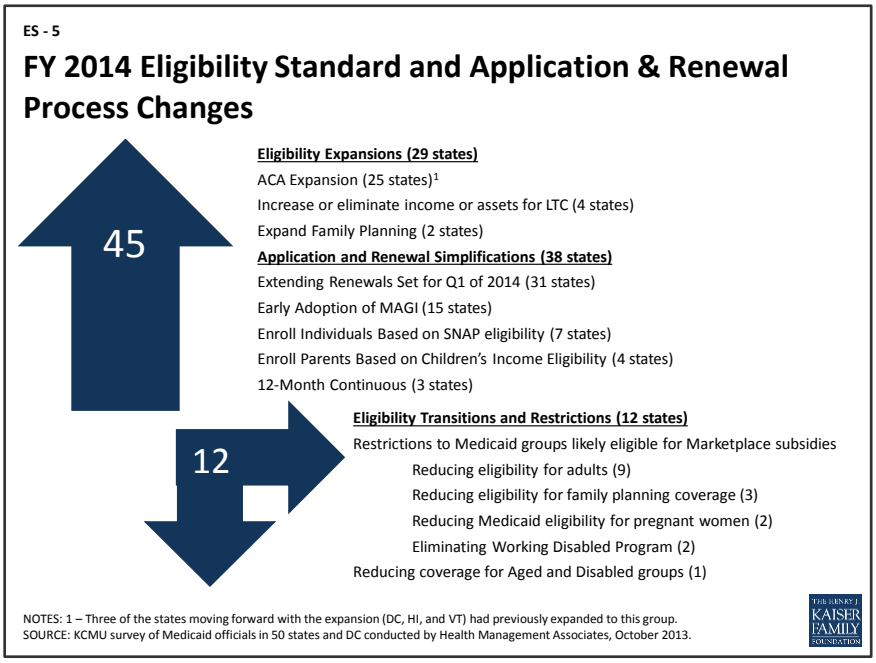


2. The implementation of the ACA will result in major changes to Medicaid eligibility and enrollment for all states whether they are implementing the ACA Medicaid expansion or not.

Leading up to 2014, states were generally limited from making eligibility cuts or restrictions due to the Maintenance of Eligibility (MOE) provisions in the ACA, which helped to maintain coverage during the economic downturn. A total of 18 states made positive eligibility or enrollment changes during FY 2013. Five states with a documented budget deficit restricted eligibility in FY 2013 for adults with incomes above 133 percent FPL, restrictions which were exempt from the MOE requirements.

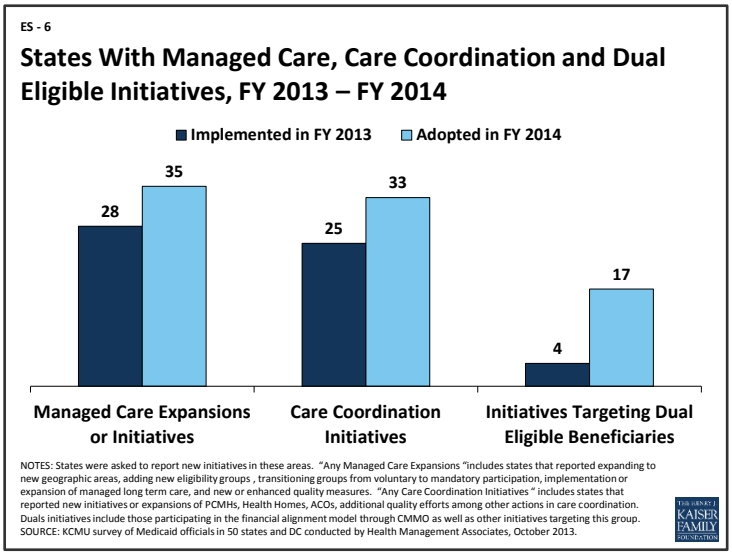
In FY 2014, states will implement some of the most significant modifications to eligibility and enrollment standards in the history of the Medicaid program. All states are required to transition to a uniform income eligibility standard using Modified Adjusted Gross Income (MAGI), transition children with income above 100 and up to 138 percent FPL from the Children's Health Insurance Program (CHIP) to Medicaid and implement new streamlined application, enrollment and renewal processes. In addition to these changes, Medicaid agencies will be required to coordinate with new Health Insurance Marketplaces. Working with the new Marketplaces, states will provide outreach to educate people about new health care options and assist consumers in navigating the enrollment process.

Beyond these requirements, nearly all states (45) reported eligibility and enrollment expansions and enhancements for FY 2014. Adopting the Medicaid expansion for nearly all low-income Americans with incomes up to 138 percent FPL (25 states) was the most significant eligibility change for FY 2014. Eight states reported plans to implement eligibility expansions aside from the ACA Medicaid expansion. Thirty-eight states reported changes to enrollment processes beyond the ACA required changes. The large majority of these changes were tied to states adopting new options to streamline enrollment that were authorized under guidance released May 17, 2013 by the Centers for Medicare and Medicaid Services (CMS). Twelve states are implementing Medicaid eligibility restrictions in FY 2014. However, these cuts are targeted to non-disabled adults; most of those that will lose Medicaid eligibility in these states will be able to obtain subsidies to purchase coverage in the new Marketplaces.



3. Nearly all states are developing and implementing payment and delivery system reforms designed to improve quality, manage costs and better balance the delivery of long-term services and supports across institutional and community-based settings.

In FY 2013 and FY 2014, state Medicaid programs focused attention on delivery system and payment reforms designed to improve quality and minimize unnecessary costs. A total of 39 states (28 in FY 2013 and 25 in FY 2014) reported a policy change or initiative to expand managed care, or to improve care through a managed care focused quality initiative. States continue to expand managed care into new geographic areas and add eligibility groups (including those made newly eligible for coverage under the ACA), and expand managed long term care. In addition, states are developing more sophisticated quality metrics and performance measures within managed care programs. Such initiatives were implemented in 21 states in FY 2013 and 22 states adopted initiatives for FY 2014. Outside of managed care, new or expanded care coordination efforts were underway in 40 states (25 states in FY 2013 and 33 states in FY 2014.) These initiatives include health homes, patient-centered medical homes, and Accountable Care Organizations as well as other quality related initiatives. (ES-6)

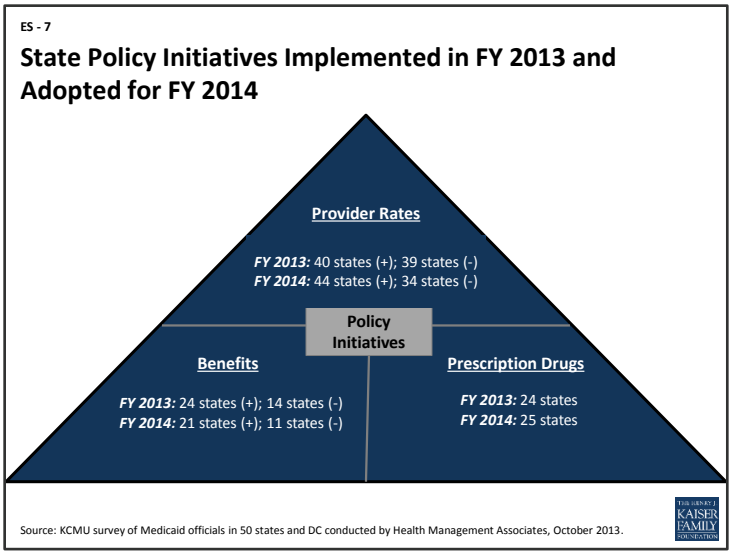


Many states reported initiatives designed to target specific populations or services such as coordinating care across physical and behavioral health and across long-term care and acute care services. For example, states are using multiple strategies to better integrate physical and behavioral health such as health homes or carving this service into managed care contracts, or implementing a new behavioral health organizations. Developing integrated, coordinated systems of care to serve dual eligible beneficiaries continues to be an area of focus for states. In FY 2014, a total of 14 states reported plans to implement a formal demonstration project pending final approval under the CMS financial alignment demonstration; three other states plan to implement their own initiatives to serve this group. Others are working toward implementation in FY 2015.

Efforts to better balance the delivery of institutional and community based long-term services and supports are on-going. States continue to expand the use of community based long-term care through traditional 1915(c) waivers and expansions of PACE programs. States are also taking advantage of new options in the ACA. Specifically, the number of states taking advantage or planning to adopt the time-limited Balancing Incentive Program (BIP) jumped to 19 in FY 2014, and the use of the 1915(i) HCBS State Plan option is also becoming more widespread, growing from 10 states in FY 2012 to an expected 16 by the end of FY 2014. However, state adoption of the Community First Choice (CFC) option has been limited, in part due to the lack of final federal regulations until May 2012. To date, only California and New York have implemented the option; however, seven states (Arkansas, Maryland, Minnesota, Montana, Oregon, Texas, and Wisconsin) reported plans to implement the CFC option in FY 2014. Under the CFC option, states providing Medicaid-funded home and community-based attendant services and supports will receive an FMAP increase of six percentage points for CFC services.

4. Improvements in the economy have enabled states to implement more program restorations or improvements in provider rates and benefits compared to restrictions, but states also adopted policies to control costs and enhance program integrity.

Largely due to improvements in the economy, more states adopted increases or enhancements to provider rates or benefits than restrictions in FY 2013 and FY 2014. A total of 40 states in FY 2013 and 44 states in FY 2014 adopted provider rate increases compared to 39 states in FY 2013 and 34 states in FY 2014 reporting restrictions. This trend was true across all major provider groups (physicians, managed care organizations and nursing homes) except hospitals. While implementation has been challenging, states reported that the federally funded increased payments to primary care providers required by the ACA have begun. For benefits, a number of states were able to expand or restore cuts to home and community-based services, dental care and behavior health; however, a smaller set of states made targeted restrictions largely in these same areas. As in previous years, efforts to manage prescription drug costs are on-going. About half the states continue to take steps to refine their pharmacy programs. Frequently cited focus areas include refinements to PDL and supplemental rebate programs, utilization or reimbursement initiatives relating to specialty and physician administered drugs, managed care-related changes including efforts to "carve-in" the pharmacy benefit into capitated managed care arrangements as well as continued state interest in adopting the "Actual Acquisition Cost" reimbursement methodology for ingredient costs. (ES-7) States also reported on an array of new program integrity initiatives including the use of advanced data analytics and predictive modeling, enhanced provider screening and data sharing initiatives.



5. Looking ahead, FY 2014 will be a transformative year for Medicaid.

At the start of FY 2014, Medicaid directors were relieved to have weathered the storm of the economic downturn while striving to minimize adverse impacts on the beneficiary population and, in some cases, restoring earlier program cuts. State Medicaid programs are dynamic and evolving, but never more so than looking ahead to 2014 and beyond. The scope and volume of change related to the implementation of the ACA, payment and delivery system reforms as well as controlling costs create enormous opportunities and challenges. These changes have placed intense pressure on Medicaid agencies that have already been operating with limited resources due to the effects of the recent recession. States face additional challenges and uncertainty as the federal budget and debt ceiling debates go unresolved and federal deficit reduction efforts loom. Notwithstanding intense challenges, Medicaid faces new opportunities to make improvements in program administration that underpin improvements in delivery systems, quality, outcomes and coverage.