The Hilltop Institute

analysis to advance the health of vulnerable populations

Transforming Medicaid in an Era of Health Reform: State Efforts to Thrive While Hoping to Survive

IGPA State Summit 2010: Reforming Medicaid in Illinois

December 7, 2010

Charles Milligan, JD, MPH

UMBC

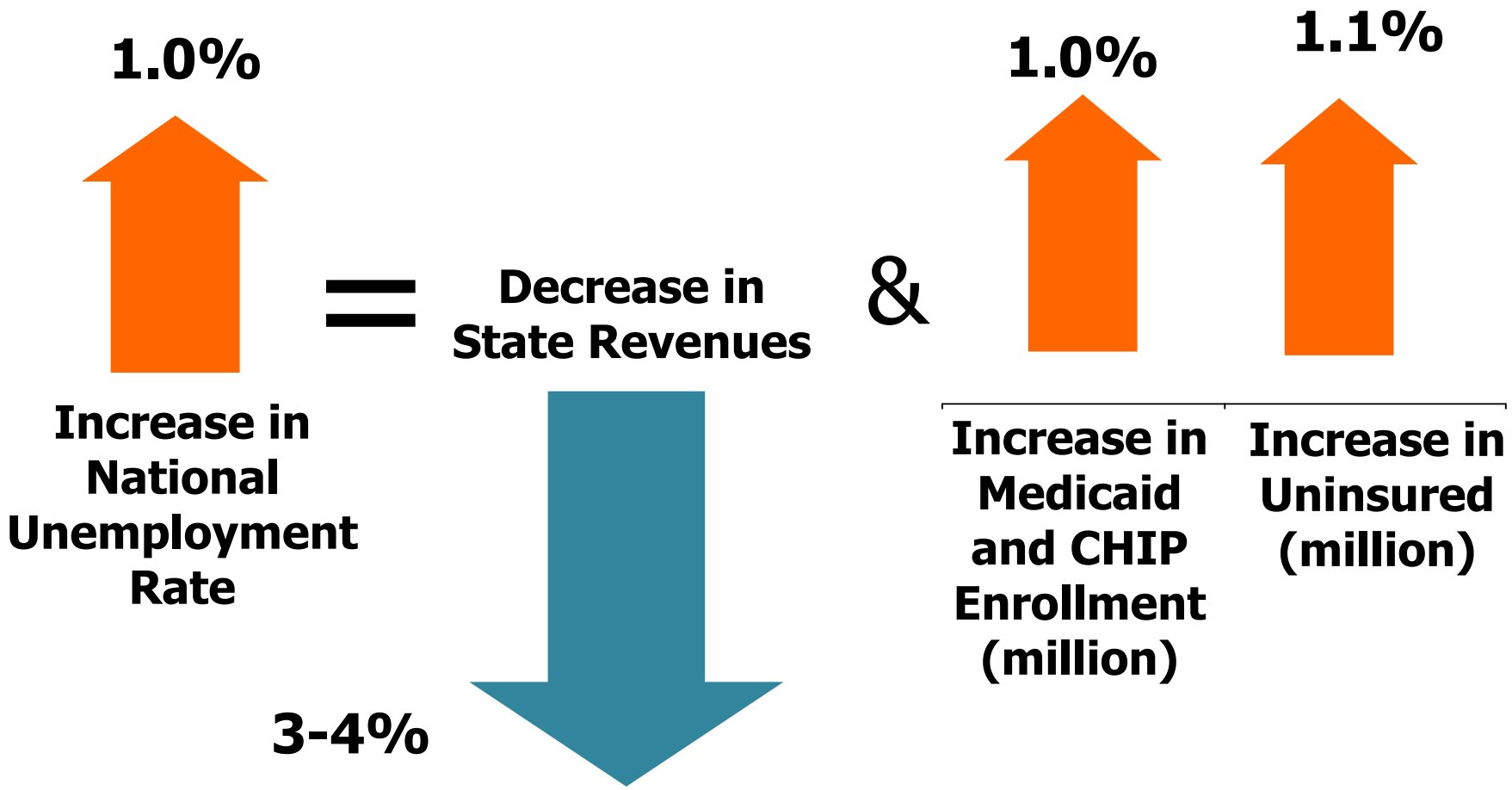
AN HONORS UNIVERSITY IN MARYLAND

Overview

- Economic Trends and Medicaid
- Health Reform
- Budget Tools and the Changing State/Federal Relationship

Economic Trends and Medicaid

A recession stresses state budgets with reduced revenue and an expanded Medicaid enrollment.



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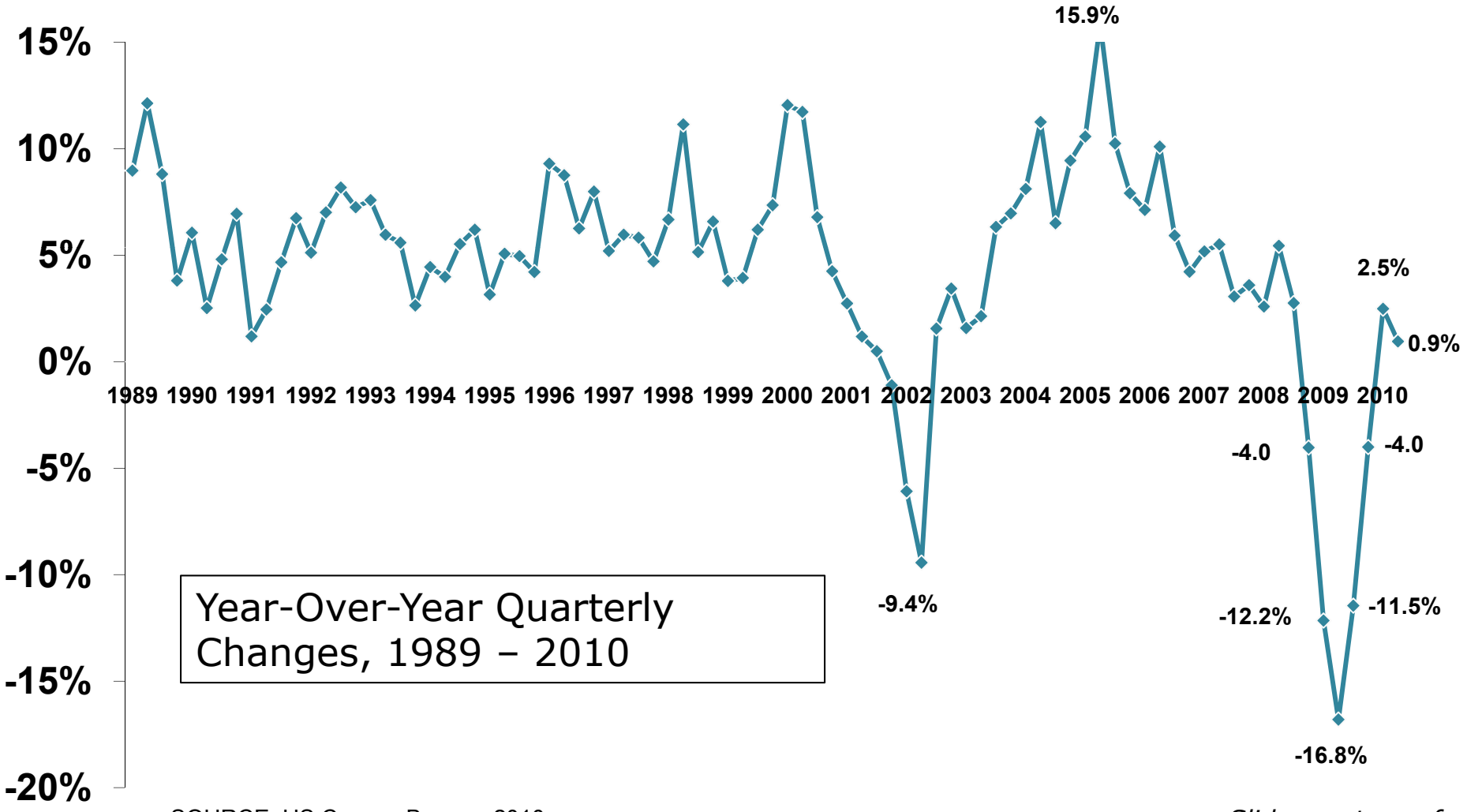
Source: John Holahan and Bowen Garrett, *Rising Unemployment, Medicaid, and the Uninsured*, prepared for the Kaiser Commission on Medicaid and the Uninsured, January 2009.

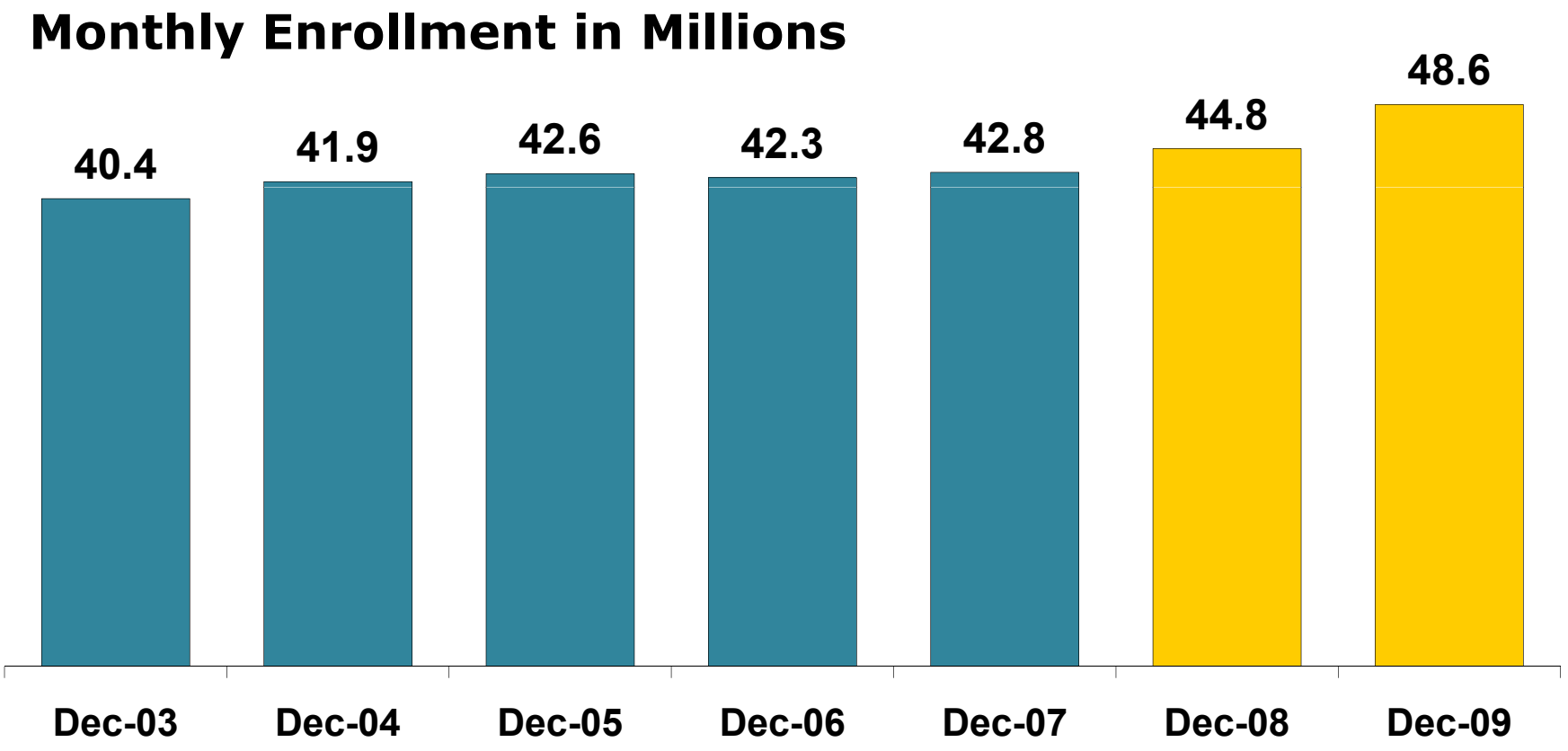
The past two years have reduced state revenues in historic ways.



SOURCE: US Census Bureau, 2010.

Slide courtesy of Vern Smith, Health Management Associates

Enrollment in Medicaid grew by nearly 6 million from December 2007 to December 2009.



SOURCE: Analysis for KCMU by Health Management Associates, from compiled state Medicaid enrollment reports

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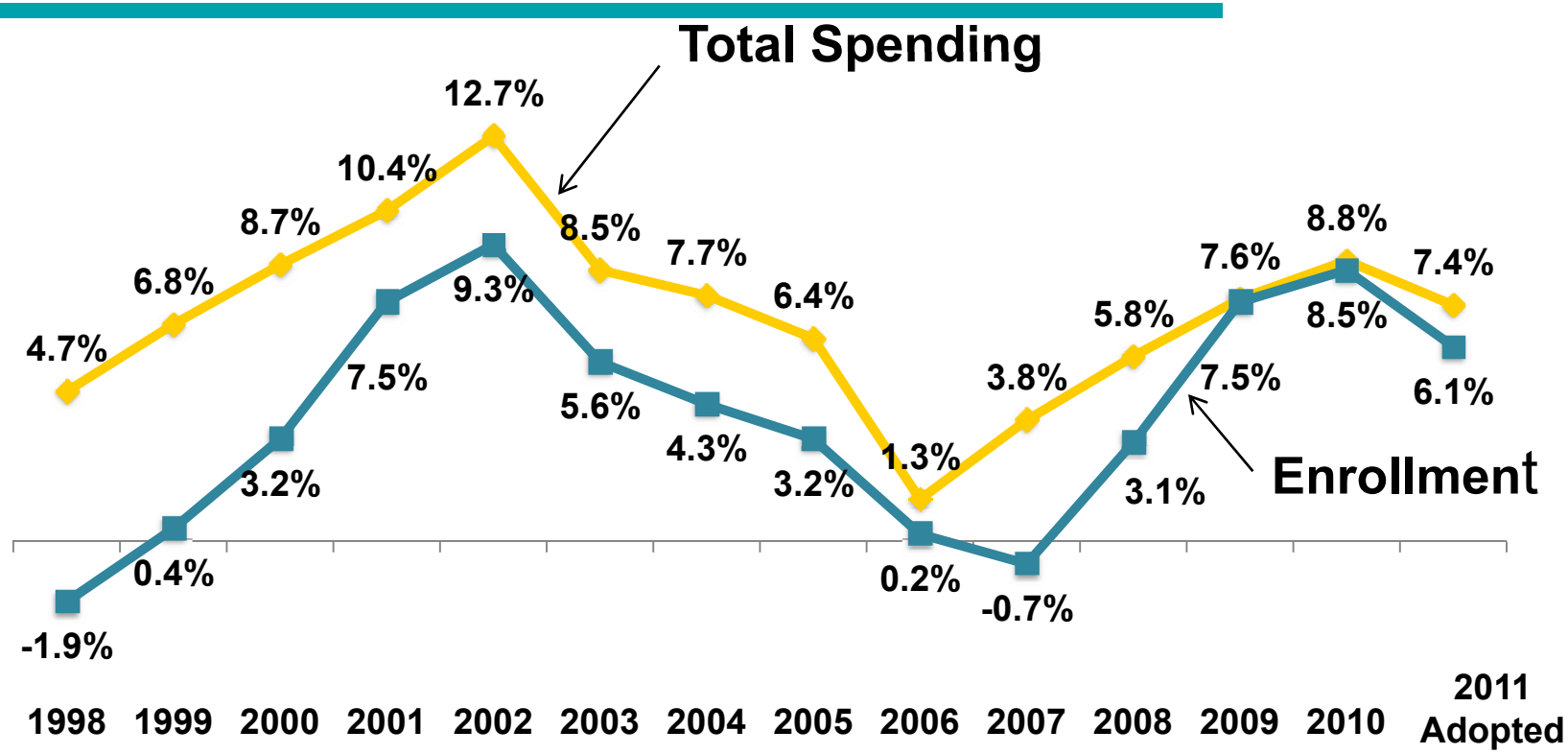
Medicaid has steadily substituted for a greater portion of employer-sponsored insurance.

Source of Coverage for Non-Elderly (0-64), Per 1000 Population, By Year

Source	1997	2003	2009
Employer	651	634	568
Other Private	69	55	48
Medicaid and CHIP	76	119	162
Other Public	49	42	32
Uninsured	154	150	190

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates;
HSC Community Tracking Study Household Survey, Tracking Report No. 94

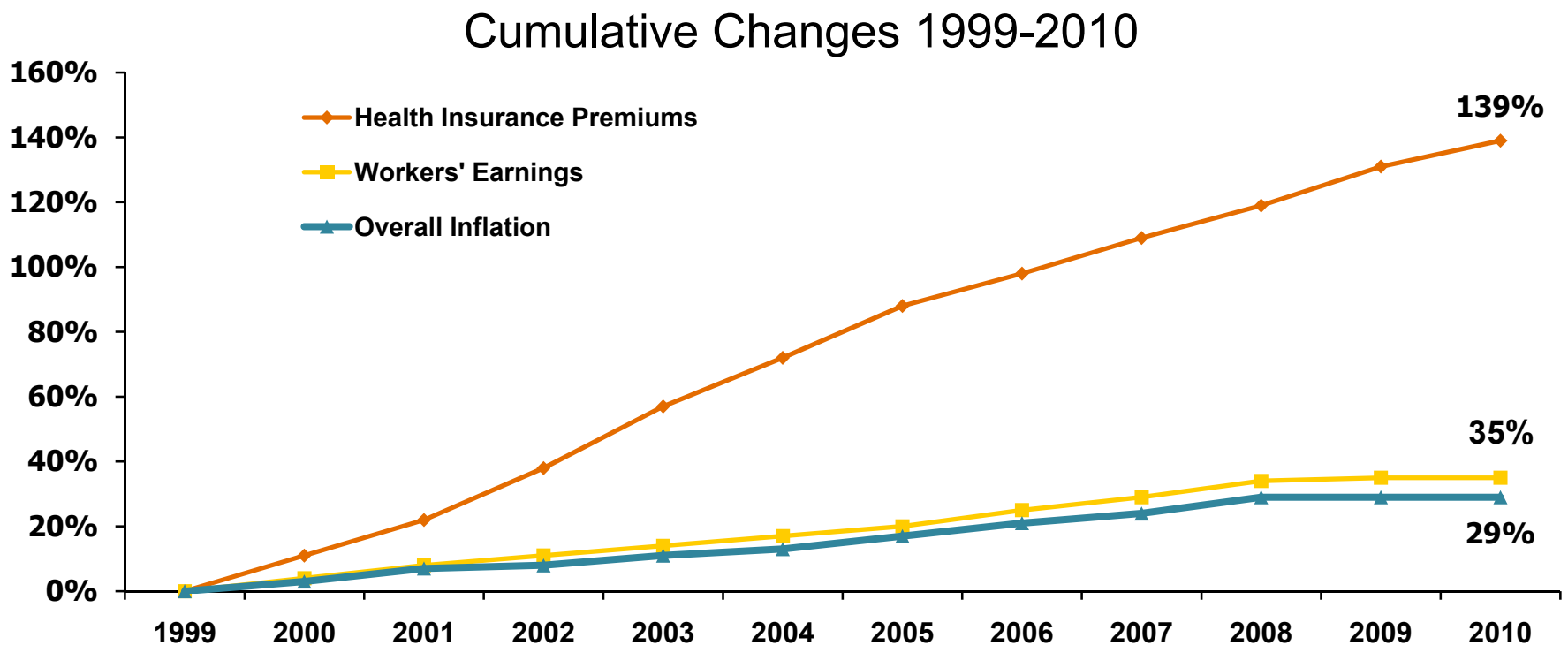
Medicaid spending has grown faster than Medicaid enrollment . . .



SOURCE: Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder, "Hoping for Economic Recovery, Preparing for Health Reform: Medicaid Spending, Coverage and Policy Trends," The Kaiser Commission on Medicaid and the Uninsured, September 2010. http://www.kff.org/medicaid/8105.cfm

NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

. . . which is unsurprisingly, given that health insurance premiums have increased much faster than inflation and earnings.



Slide courtesy of
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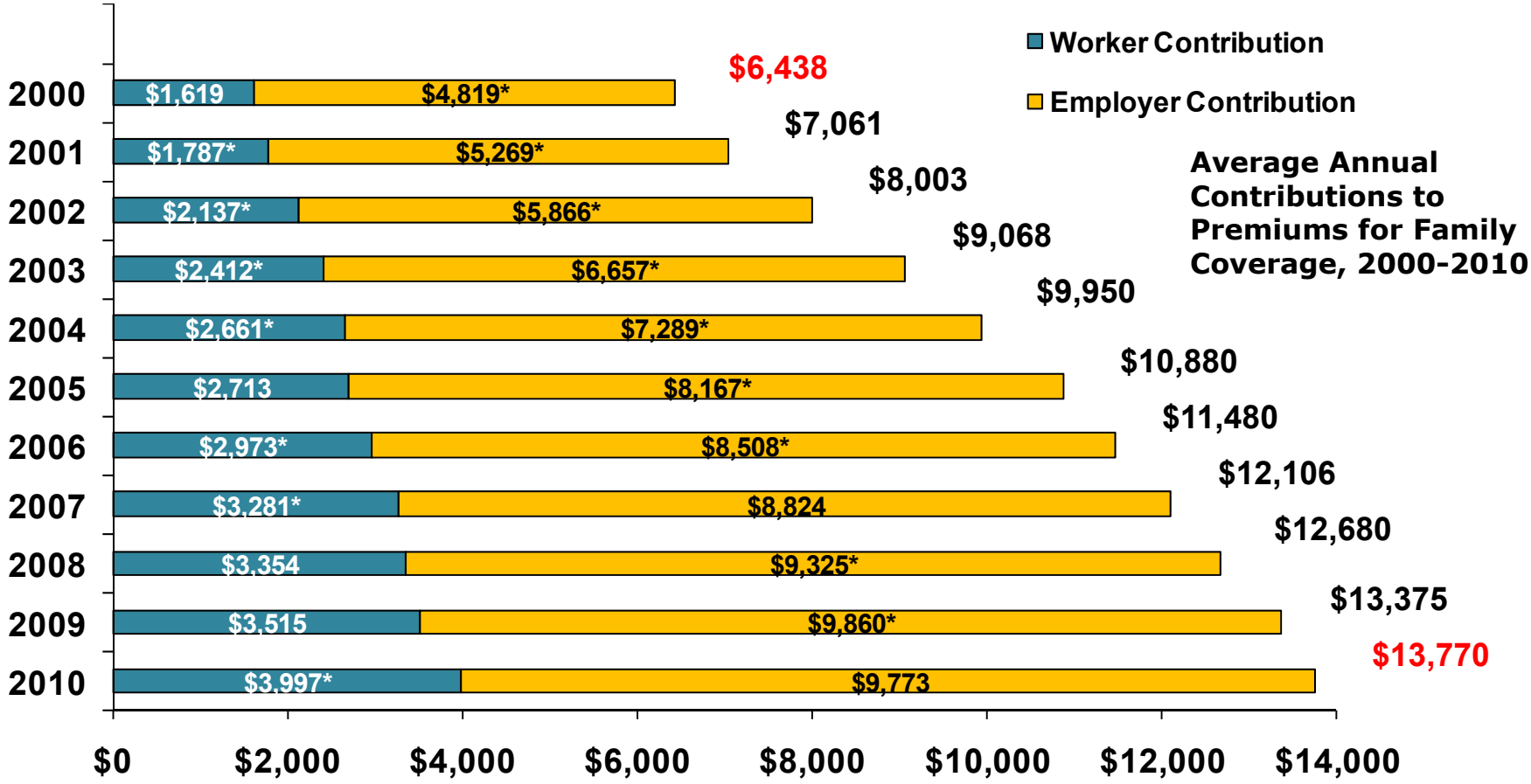
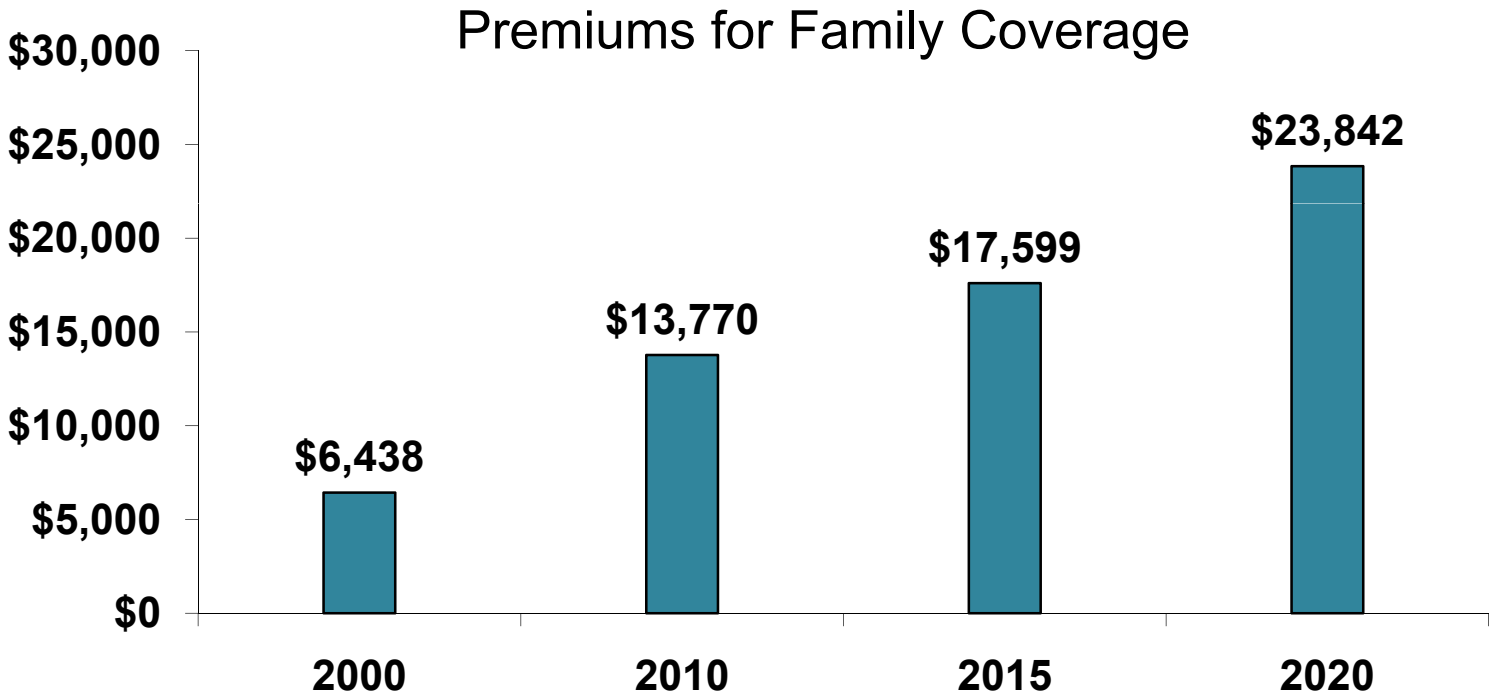
In the private sector, employers have responded to premium increases partly by shifting more costs onto employees.



Value is statistically different from the previous year shown (p<.05).

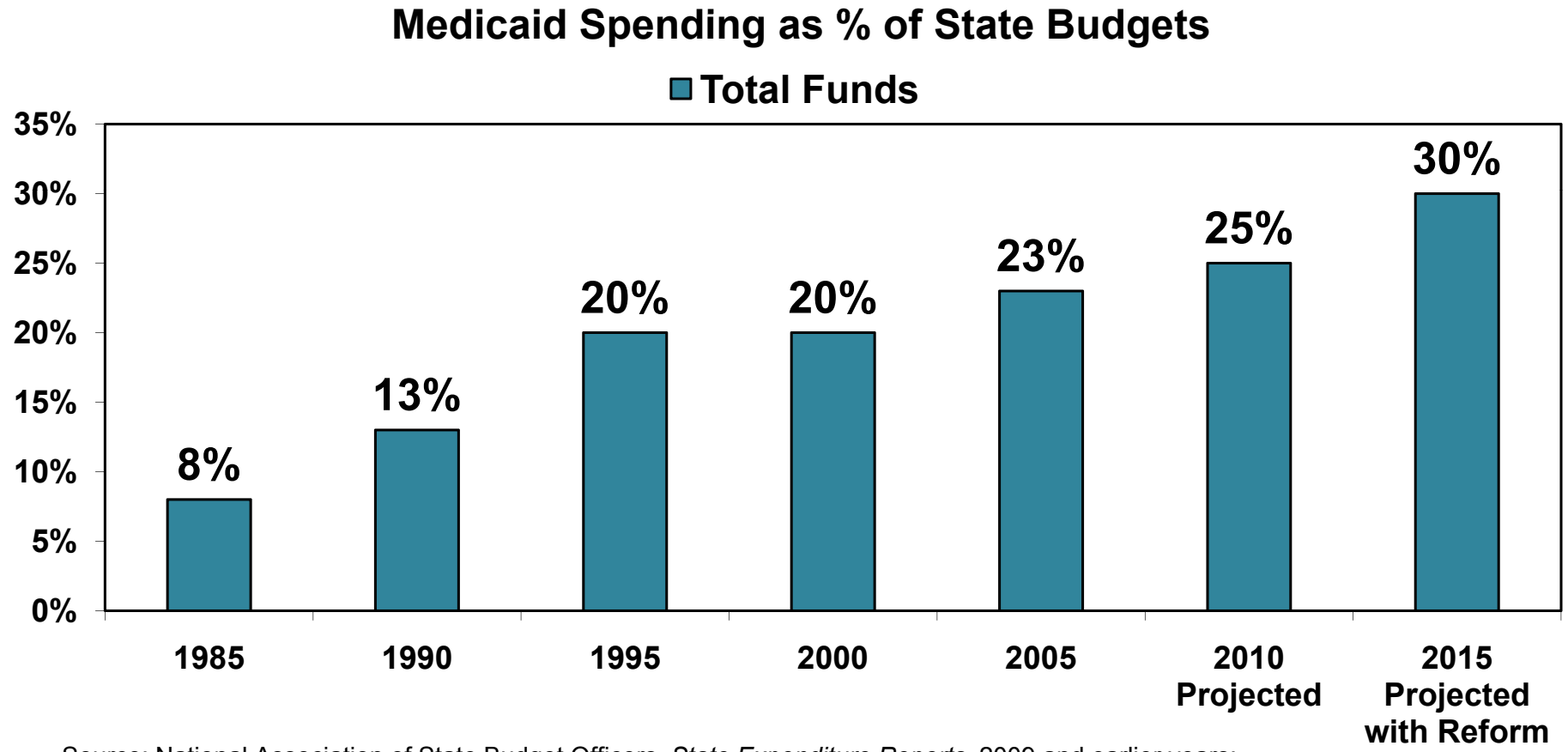
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000 - 2010.

Pre-ACA projections showed continued growth in family premiums.



Note: Projections are before health reform, and do not reflect any impacts of health reform.
Source: For 2000 and 2010, Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010 ; 2015 and 2020 based on CMS, Office of the Actuary, National Health Statistics Group, national health expenditures per capita annual growth rate, cited in: C. Schoen, J.L. Nicholson, S.D. Rustgi, *Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes, State-by-State Health Insurance Premium Projections With and Without National Reform* (New York: The Commonwealth Fund) August 2009.

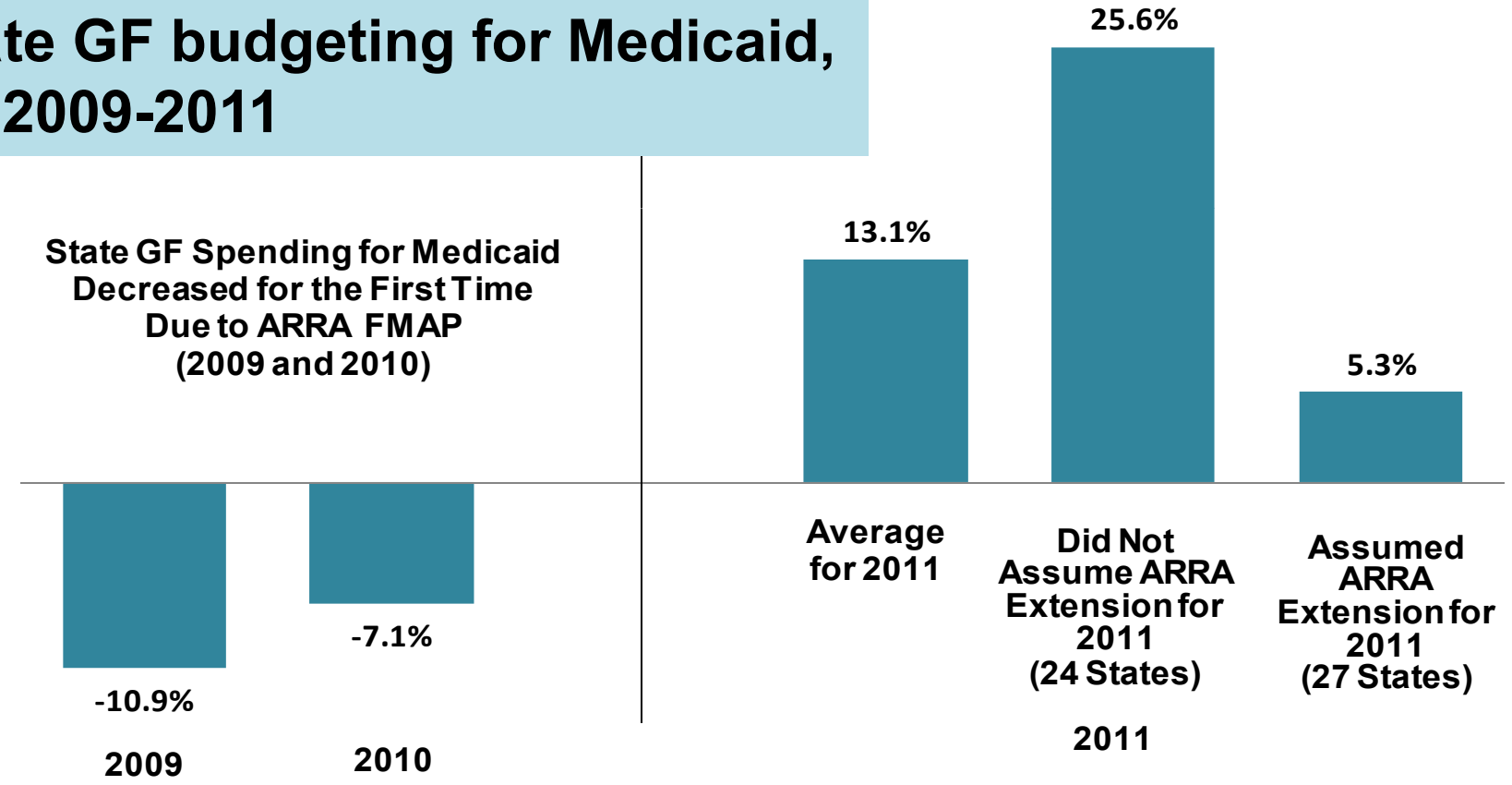
Medicaid is an increasingly large component of state budgets.



Source: National Association of State Budget Officers, *State Expenditure Reports,* 2009 and earlier years; Percentages for 2010 and 2015 projected by HMA, 2010.

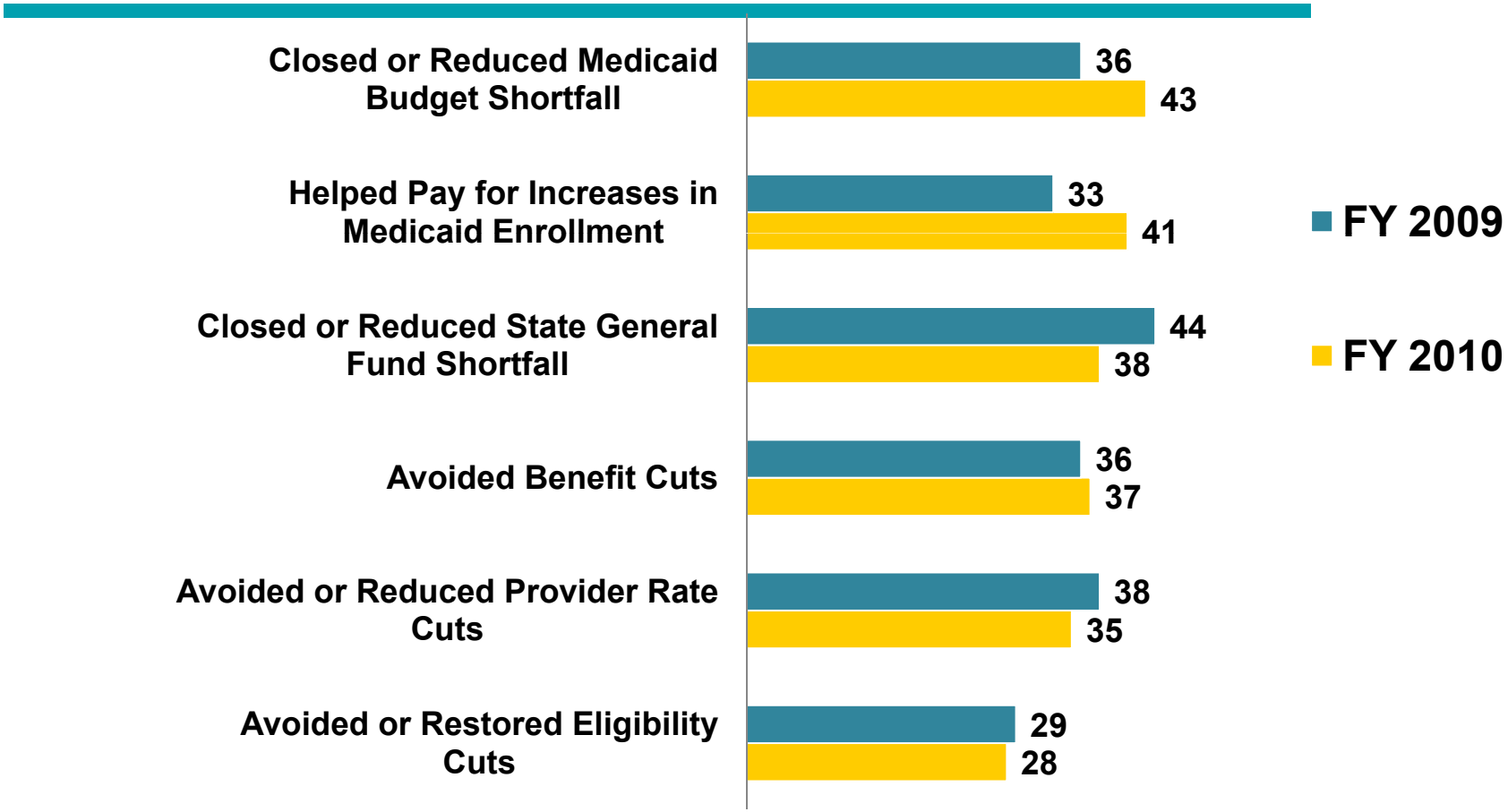
States received enhanced federal Medicaid matching funds under ARRA, and used these funds to reduce Medicaid general fund expenditures in FY 2009 and FY 2010.

State GF budgeting for Medicaid, FY 2009-2011



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010.

States used ARRA funding in FY 2009 and FY 2010 to shore up many components of Medicaid.



SOURCE: Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates for Kaiser Commission on Medicaid and the Uninsured, 2010.

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Yet ARRA prohibited states from reducing eligibility, so states have responded to the ongoing budget challenge with reductions in Medicaid benefits for adults . . .

Number of States Reducing Covered Medicaid Benefits, By Year

FY 2008	FY 2009	FY 2010
3	10	15

Source: Survey of states conducted by for the Kaiser Commission on Medicaid and the Uninsured

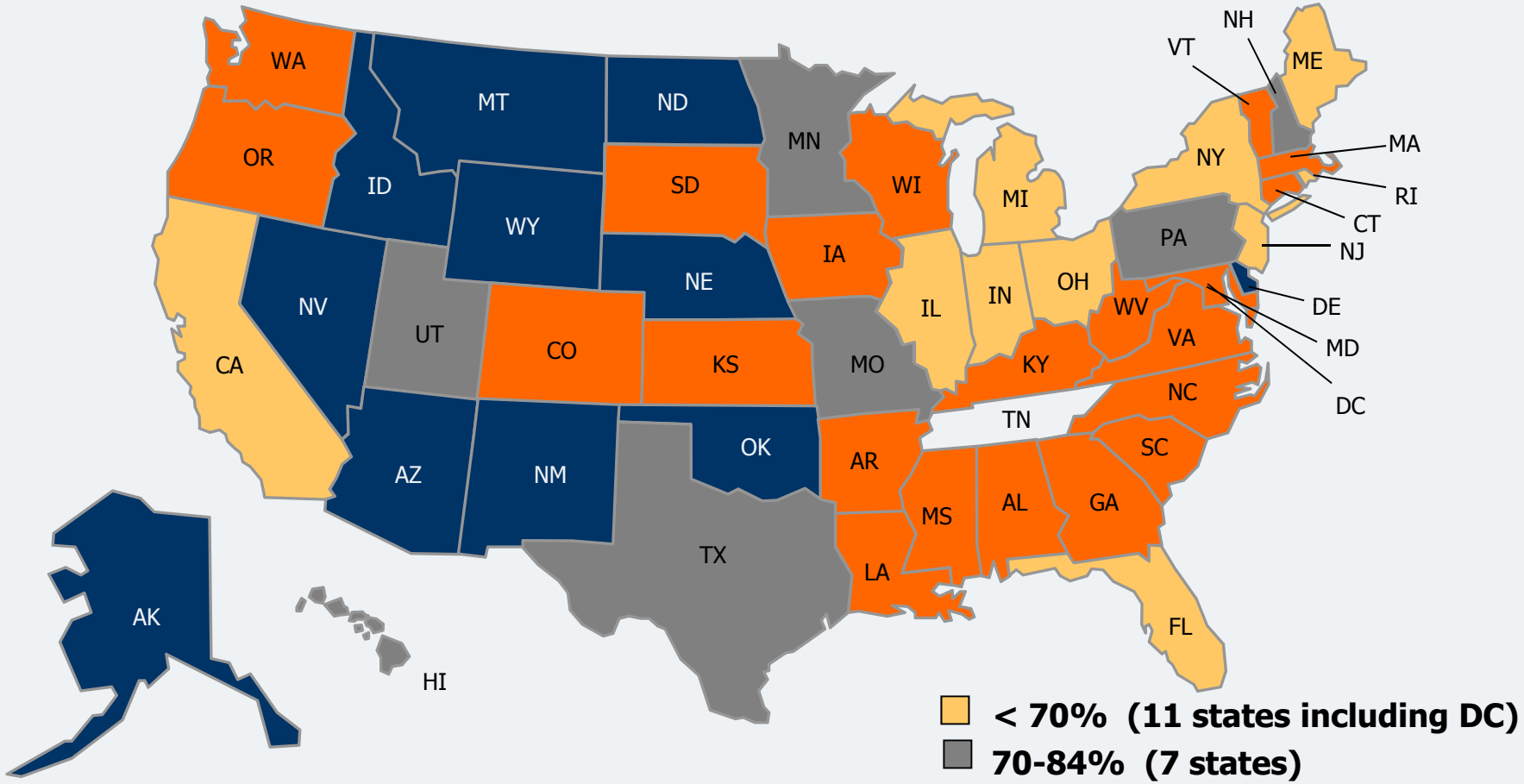
. . . and with reductions in Medicaid provider rates.

Number of States Reducing Medicaid Provider Rates, by Year

Provider Type	FY 2007	FY 2008	FY 2009	FY 2010
Inpatient hospital	17	16	27	33
Physician	0	1	8	13
MCO	0	1	5	5
Nursing home	6	5	14	26
Any of these	26	21	33	39

Source: Survey of states conducted for the Kaiser Commission on Medicaid and the Uninsured

Medicaid provider rates averaged 72% of Medicare by the end of 2008, across all services.



U.S. Average = 72% of Medicare fees

NOTE: Tennessee does not have a fee-for-service component in its Medicaid program
SOURCE: S. Zuckerman, AF Williams, and KE Stockley, "Trends in Medicaid Physician Fees, 2003-2008," *Health Affairs*, 28 April 2009.

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Providers prefer to accept new patients with a source of payment other than Medicaid . . .

Physician Acceptance of New Patients, By Payer, 2008

	% of physicians accepting all or most new patients	% of physicians accepting no new patients
Private Insurance	87	4
Medicare	74	14
Medicaid	53	28

Source: Boukus et al., "A Snapshot of U.S. Physicians: Key Findings From the 2008 Health Tracking Household Survey," Center for Studying Health System Change (September, 2009)

Note: % of physicians accepting "some" new patients is excluded from table.

. . . which has led, over time, to a greater concentration of Medicaid patients in Medicaid-focused physician practices . . .

Distribution of Medicaid Physician Practice Revenue

Percent of Revenue from Medicaid	1996-97	2000-01	2004-05
0-9%	10.6	9.0	7.8
10-19%	27.2	24.3	20.6
20-29%	19.1	20.7	20.6
30% or higher	43.1	46.1	51.0

Note: Physicians who derived no revenue from Medicaid are excluded.

Source: Cunningham, P., & May, J. (2006, August). Medicaid patients increasingly concentrated among physicians. *Center for Studying Health System Change, Tracking Report No. 16*.

. . . and potential access issues, the severity of which varies by physician specialty.

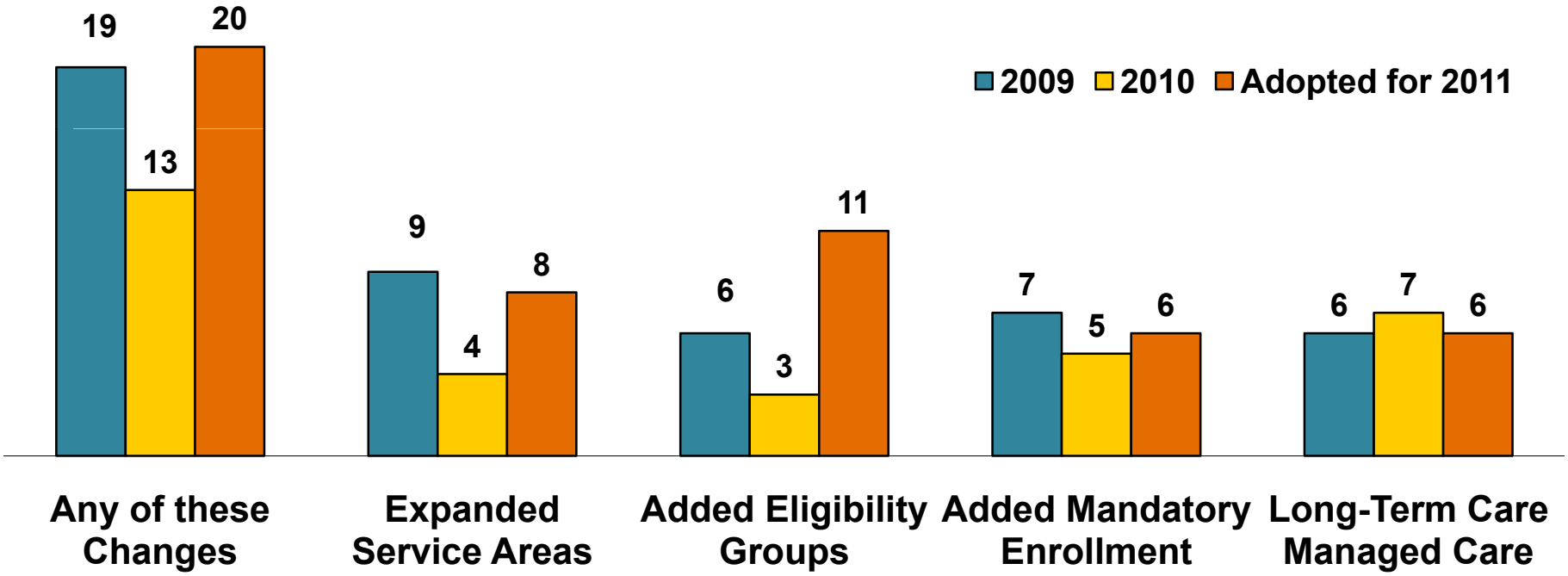
Percent of Physicians Accepting New Medicaid Beneficiaries, by Specialty, 2008

Specialty	Percentage Accepting New Medicaid Beneficiaries
Internal Medicine	40
Family Practice	44
Pediatrics	65
Medical Specialties	65
Psychiatry	42
Surgical Specialties	55
ObGyn	50

Source: Boukus et al., "A Snapshot of U.S. Physicians: Key Findings From the 2008 Health Tracking Household Survey," Center for Studying Health System Change (September, 2009)

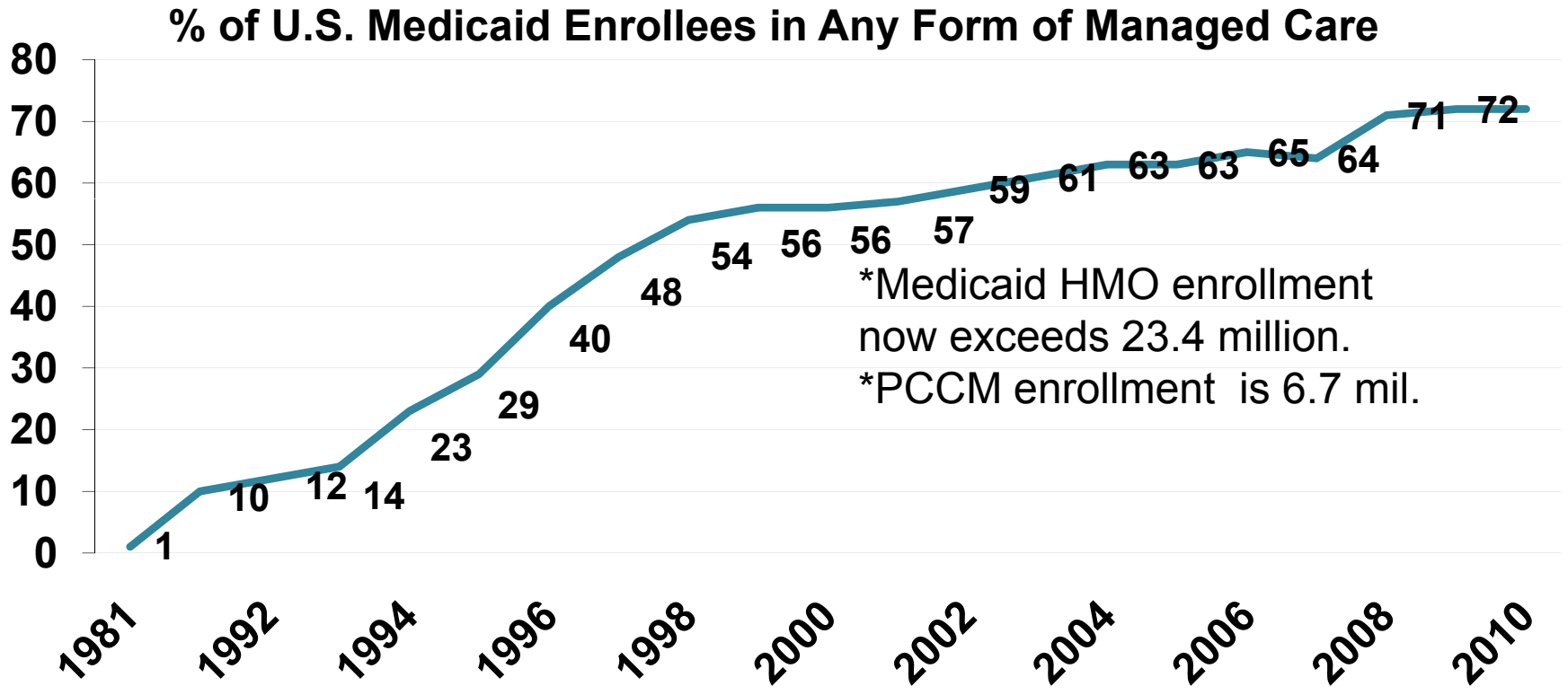
States also have tried to manage through the budget challenge by adopting delivery system reforms . . .

Number of States Adopting Medicaid Managed Care Change, FY 2009-FY 2011



Source: Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder, "Hoping for Economic Recovery, Preparing for Health Reform: Medicaid Spending, Coverage and Policy Trends," The Kaiser Commission on Medicaid and the Uninsured, September 2010. http://www.kff.org/medicaid/8105.cfm

. . . and more Medicaid beneficiaries are enrolled in some form of managed care.



Note: "Managed Care" includes HMOs, PIHPs, HIOs and state-administered Primary Care Case Management Plans (PCCMs).
Source: CMS, Medicaid Managed Care Reports, 1994-2009.

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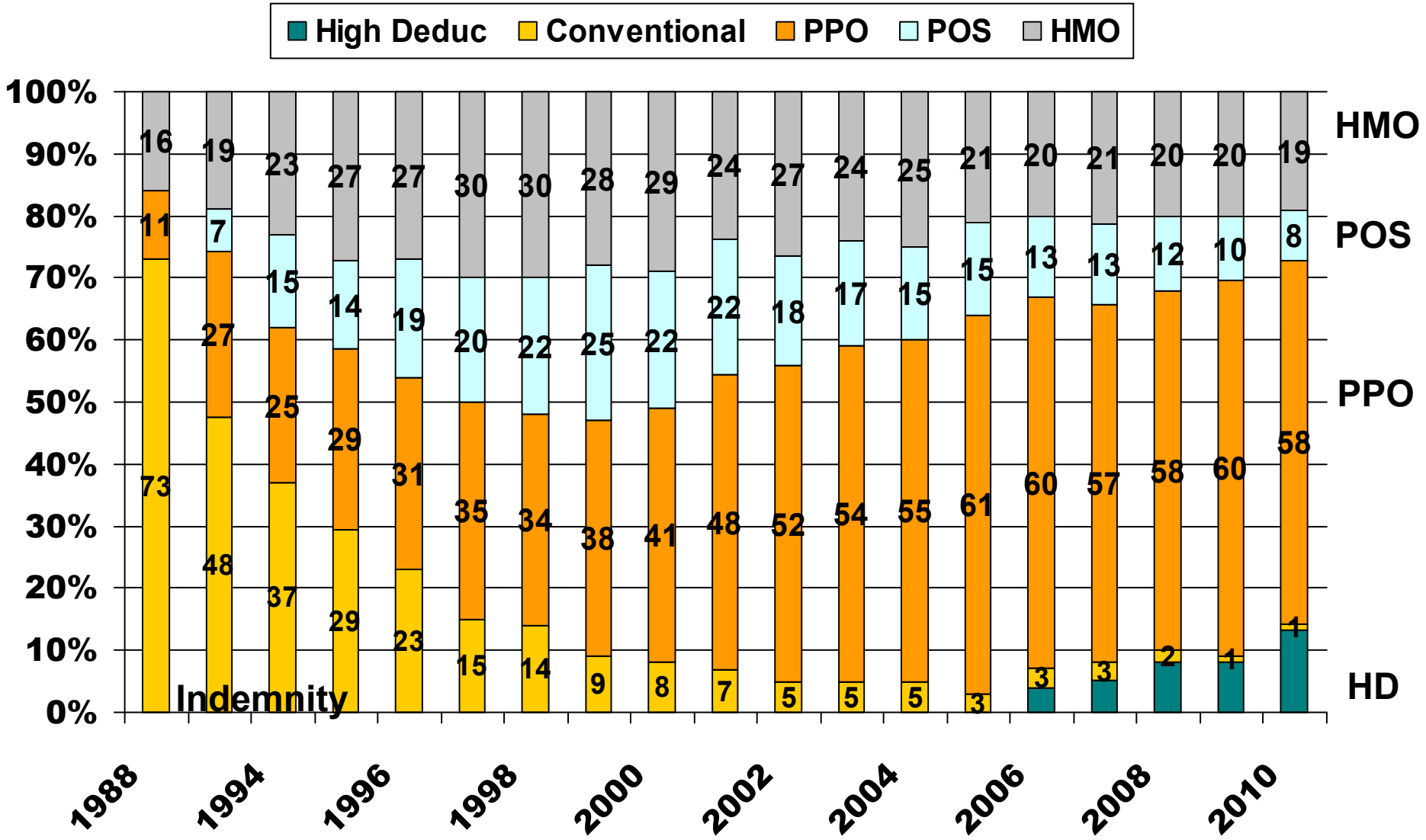
The growth in Medicaid managed care contrasts with the trend in private insurance.



Source: Kaiser/HRET Survey of Employers, 2009.

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States also have responded with leaner administrations . . .

- Only 4 percent of all Medicaid expenditures are devoted to administrative costs
- Pay freezes
- Furloughs
- Hiring freezes

. . . and by, among other things, adopting more efficient electronic health platforms.

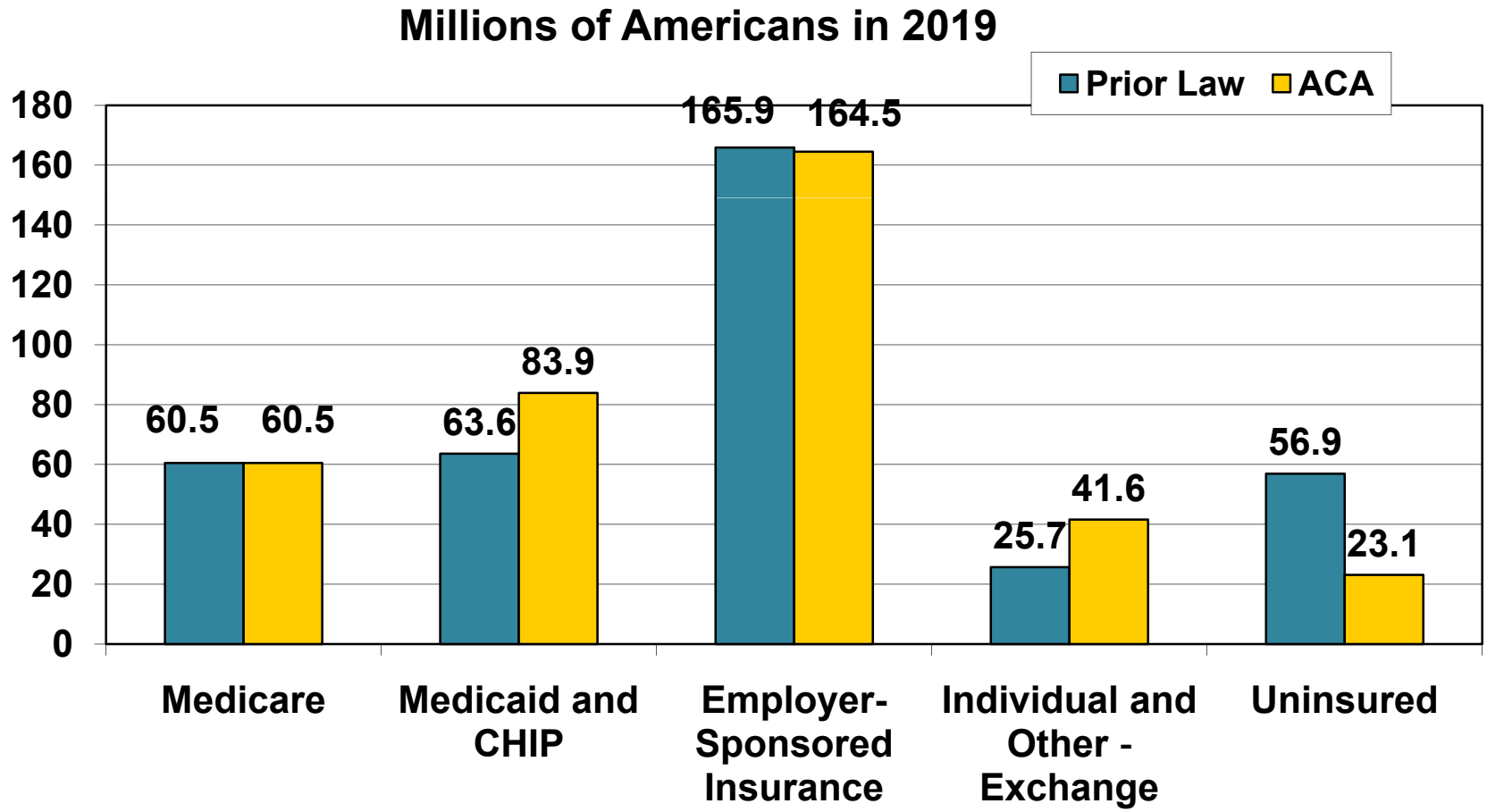
Number of States Participating in Initiative in Medicaid, Cumulative

Type of E-Initiative	FY 2009	FY 2010
E-Prescribing	23	32
Electronic Health or Medical Records	22	40

Source: Survey of states conducted by Health Management Associated
For the Kaiser Commission on Medicaid and the Uninsured

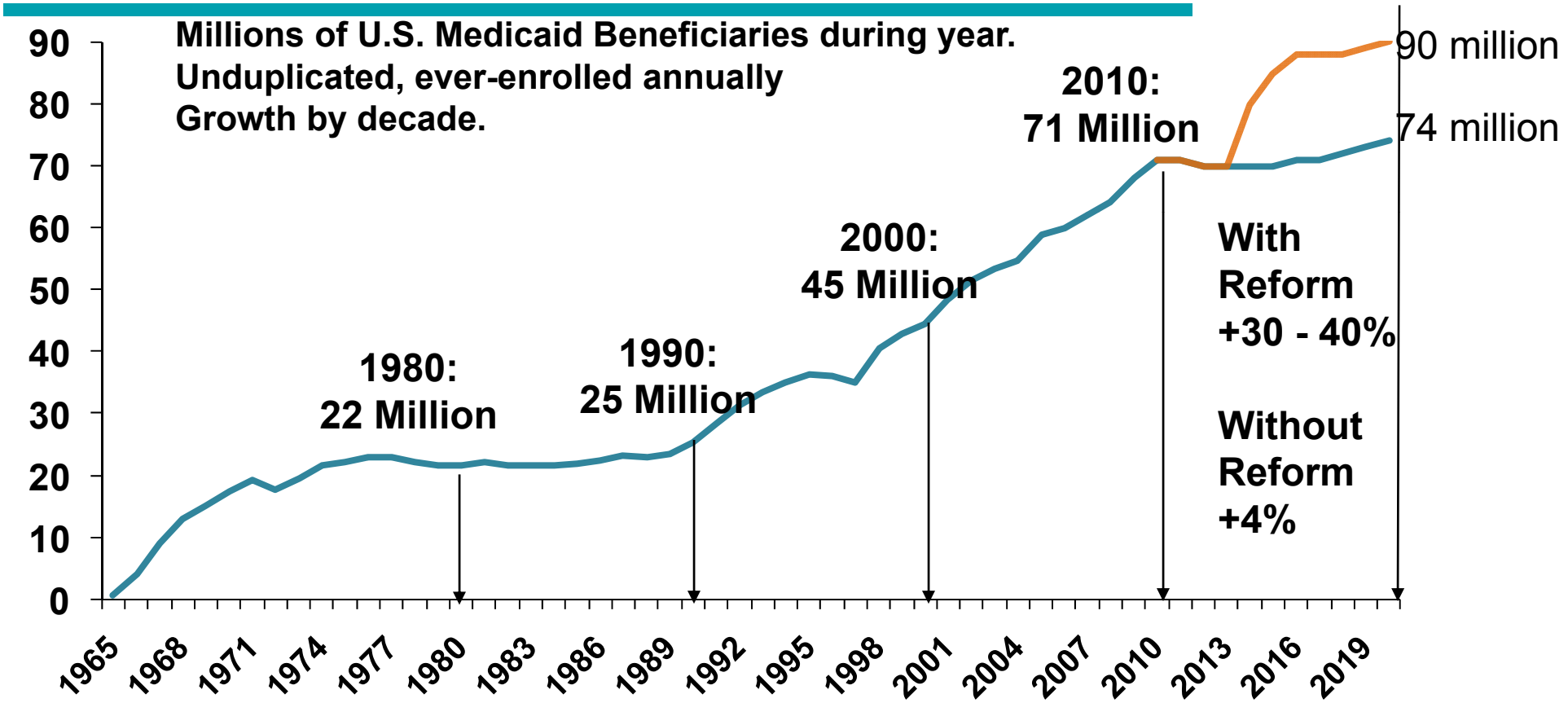
Health Reform

The Affordable Care Act (ACA) is expected to increase the Medicaid enrollment by 16 million . . .



Source: Richard Foster, Chief Actuary, CMS, 2010.

. . . rather than level after the recession is expected to end.



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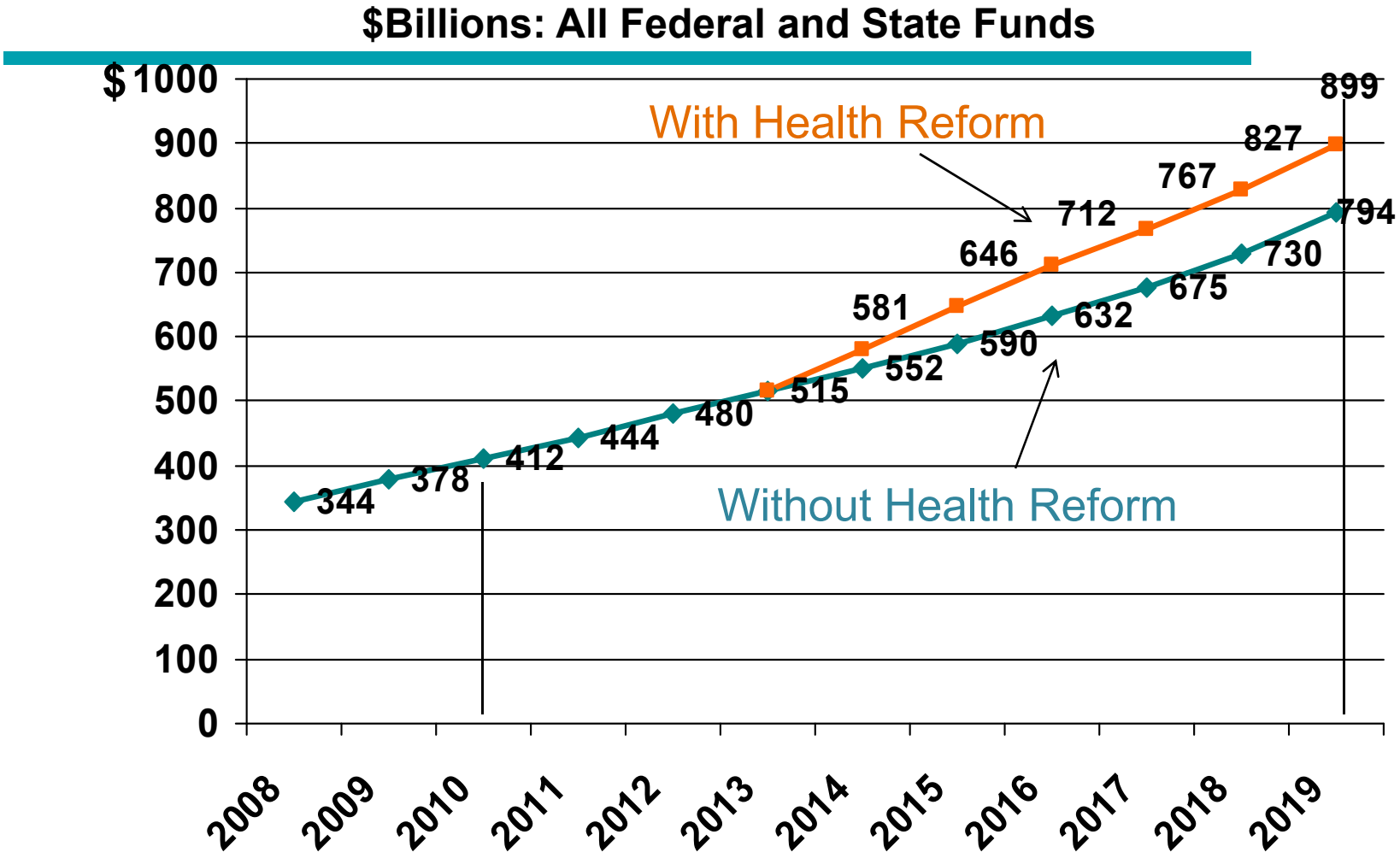
Medicaid spending is expected to double over the next decade, with over 95% of the expansion ACA financing coming from the feds.



Source: Analysis by Health Management Associates, based on: CMS, Office of the Actuary, March 2010; and CBO, March 2010.

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The ACA also included Medicaid reforms to encourage healthy behavior.

- $100 million in grants, beginning in January 2011, for states to encourage healthy behavior in Medicaid populations (control weight, tobacco cessation, lower BP/cholesterol, manage diabetes)
- As of October 2010, smoking cessation is a required Medicaid benefit, without cost sharing
- Beginning in 2013, states can get a 1 percent federal matching rate increase for preventive services for adults who are rated A or B by the U.S. Preventive Services Task Force, when covered without copays

The ACA includes delivery system opportunities.

- Health Home Option - enhanced funding for care coordination for individuals with chronic care needs
- The new CMS Center for Medicare and Medicaid Innovation (CMI) has broad authority to approve payment and delivery system waivers and demos
  - $10 billion for demonstrations and pilots to address quality, access, costs and efficiencies, beneficiary and provider satisfaction
- The new CMS Coordinated Health Care Office was created to study and approve new approaches to better serve Medicaid/Medicare dual eligibles

The ACA included myriad Medicaid Payment Demonstrations to improve care and reduce costs

- Global capitation payments to large safety net hospital systems; demo projects in 5 states, 2010 – 2012
- Bundled Medicaid payment demos for episodes of care that include hospitalizations; demos in 8 states, 2012 – 2016
- Accountable Care Organizations (ACOs) for pediatric providers in Medicaid and CHIP; demos for pediatric Medicaid providers organized as ACOs to share in savings (2012-2016) (Medicare ACO program to begin in 2012)

Medicaid Payment Demonstrations
continued

- Pilot for community health centers; the goal is to test the impact of individualized wellness plans to reduce risk factors for preventable conditions in at-risk populations
- Primary care payment rates will increase to Medicare levels in 2013 and 2014, with 100% federal funding ($8.3 billion) for the marginal increase in rates by state

Key Issues in Health Reform for Medicaid

- Managing state budgets through 2014 with the Medicaid and CHIP eligibility maintenance of effort, and the loss of enhanced match
- Ensuring provider participation and engagement in the face of rate cuts and with the adoption of managed care
- Building the infrastructure for the seminal changes
  - *Increase* provider networks
  - Eligibility system development to reflect paradigm shift
  - Interface with Exchange
- New strategic vision for purchasing strategy
- Long-term care reform, too

Budget Tools and the Changing State/Federal Relationship

Major State Budget Tools Involving Medicaid

Expenditures

1. Eligibility
2. Benefits
3. Provider Rates
4. Change Utilization

Revenues

5. Provider Taxes
6. New Revenue
7. “Maximization”

1. Eligibility

- Old Rules (pre ARRA)
  - Restrict or eliminate eligibility for optional categories of eligibility
  - Alter eligibility methods and periods
- ARRA Rules
  - In exchange for enhanced federal matching rate, states were barred from changing eligibility in more restrictive way
- Health Reform Rules
  - Maintenance of effort for adults through January 2014
  - Maintenance of effort for children through September 2019

2. Benefits

- Children (through age 21)
  - Pre and post ACA, benefits cannot be restricted, due to the "Early and Periodic Screening, Diagnosis, and Treatment" (EPSDT) requirement

- Adults
  - Optional benefits may be reduced or eliminated, and have been by many states (e.g., vision, dental, personal care, Rx)
  - For mandatory benefits, "amount, duration, and scope" restrictions are permitted, yet subject to CMS' new "90%" rule (the amount, duration, and scope of a mandatory benefit must be sufficient to fully meet the needs of 90% of all adults)

3. Provider Rates

- Old paradigm:
  - States had wide latitude to set rates. The statutory requirement is that a state must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers . . . to the extent that such care and services are available to the general population."

- New paradigm:
  - Decisions by the 9th Circuit have required CMS to exercise more oversight of state rates, and require proof of network adequacy after the proposed rate reduction
  - The Medicaid and CHIP Payment Advisory Committee, created in 2009, reports to Congress on Medicaid rates and access

3. Provider Rates continued

- More broadly, it is difficult for states to cut rates when the enrollment growth requires sufficient capacity in the delivery system for millions of additional beneficiaries

- AND: with the upcoming surge in Medicaid enrollment as a result of the ACA, retaining providers in Medicaid, as well as their trust in the state, is essential

4. Change Utilization

- States are adopting many approaches to change utilization patterns (both the volume and mix of services), such as:
  - Managed care expansions
  - Disease management
  - Dual eligible demos
  - Stricter utilization review in FFS
  - Beneficiary wellness and prevention incentives
  - Use of tiered copays
  - Payment reform (nonpayment for errors and avoidable events such as readmissions)

5. Provider Taxes

- States are using provider taxes and assessments, especially on hospitals, nursing homes, and MCOs, to increase federal financing without a net increase in state financing

- These approaches have certain rules, including:
  - Maximum permissible tax rate
  - Prohibition on “hold harmless” (some providers must lose $$)
  - Tax must be broad-based

- Congress and CMS are wary and always exercise strict oversight

6. New Revenue

- States traditionally have sought new revenue sources, such as:
  - Supplemental Rx rebates
  - Better coordination of benefits to obtain recoupments (especially with Medicare)
  - Estate recovery
- In the ACA, the federal government took the full share of certain supplemental Medicaid Rx rebates states had negotiated, to help pay for the expansion

7. “Maximization”

- States sometimes *intentionally* grow Medicaid, to move program otherwise entirely funded by state or local programs into Medicaid, to obtain partial federal financing. Examples:
  - School-based special education services
  - Juvenile justice
  - Foster care
  - Child and adult protective services
  - Adult mental health
- Congress and CMS are wary and often tighten rules
- State and local programs become subject to Medicaid rules

The Upshot

- State discretion is steadily diminishing (the eligibility MOE even without the ARRA enhanced match; the “90%” rule; oversight of provider rates; etc.)
- Federal financing, as a portion of all dollars, has increased (grants; demos; enhanced match for services, eligibility, and IT systems; primary care rate increases in 2013/2014, etc.)
- The federalism pendulum has swung in the direction of federal control, especially as states depend on federal $$
- States must *transform* Medicaid, using new models under the ACA, and likely involving other payers, to survive and thrive

About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels.

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Contact Information

Charles Milligan

Executive Director

The Hilltop Institute

University of Maryland, Baltimore County (UMBC)

410.455.6274

cmilligan@hilltop.umbc.edu