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The agenda for Medicaid and safety-net providers in 2011 will be shaped by state budget shortfalls and decisions about how best to implement the federal health reform law, according to stakeholder group officials, consumer advocates, and other analysts interviewed by BNA.

Despite an official end to the recession, states continue to grapple with significant budget gaps that are likely to force further cuts to Medicaid benefits and reimbursement.

And at the same time, states must prepare for the Medicaid expansion included in the Patient Protection and Affordable Care Act and make decisions about how the program will interact with the new insurance exchanges created by the law.

While the year is almost certain to be another tough one for Medicaid and the public health safety net, observers also said there could be bright spots as states and providers find ways to deliver high-quality, efficient care.

### **Budget Shortfalls.**

Most state fiscal years begin July 1, meaning states already are well into fiscal year 2011. As state legislatures convene in the coming weeks, they already will be making decisions about their FY 2012 budgets--and how to deal with the end of enhanced federal Medicaid matching funds.

The American Recovery and Reinvestment Act of 2009 provided a 6.2 percentage point bump to each state's federal medical assistance percentage, as well as additional support depending on unemployment rates. States also received other support under ARRA, such as through state stabilization funds.

While states still made cuts to Medicaid, the enhanced FMAP helped head off some of the most devastating plans. However, the increased ARRA funding will be phased out over the first half of 2011 and end on June 30--before states are expected to fully recover from the recession.

How states cope with the end of the ARRA funding in their budget plans is an early signal as to how the year will proceed for Medicaid.

"That's going to be the first real marker," Robin Rudowitz, an associate director of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured (KCMU), said.

The National Association of State Budget Officers and the National Governors Association said in a December 2010 report that while FY 2011 will be a slight improvement over FY 2010 in terms of state budgets, the end of the ARRA funding will be problematic.

"The removal of these funds, when combined with an extremely slow recovery in state revenue collections, could result in severe cuts to state programs and services," the report said.

In a December 2010 report, the Center on Budget and Policy Priorities said that already 40 states have projected budget gaps totaling \$113 billion for FY 2012 and the total is expected to reach \$140 billion after all states prepare estimates.

“States are likely to respond with spending cuts and tax increases even larger than those that have already been enacted,” the report said. For FYs 2009, 2010, and 2011, states already have closed \$430 billion in budget shortfalls, and 11 states still are grappling with midyear 2011 gaps, according to CBPP.

Medicaid directors expect Medicaid enrollment to grow 6.1 percent and spending to grow 7.4 percent in FY 2011, according to a September 2010 report by KCMU and Health Management Associates. Medicaid enrollment and spending grow during recessions, as more people qualify for the program.

The report by KCMU and HMA found that in FY 2010, 48 states implemented at least one new policy to control costs and 46 states planned to do so in FY 2011. The Medicaid directors reported that while the enhanced ARRA funding helped to avoid or lessen reductions in provider reimbursement, 39 states implemented a provider payment cut or freeze in FY 2010 and 37 planned to do so in FY 2011. States also restricted benefits and long-term care services to reduce spending.

### **State Budget Actions Unclear.**

With 2011 state legislative sessions just beginning, it is not yet clear what strategies states will use to trim their budgets. However, the economic recession undoubtedly has put “tremendous stress and strain” on state budgets, including Medicaid programs, according to Andrew Allison, acting president of the National Association of Medicaid Directors.

Allison, the executive director of the Kansas Health Policy Authority, said while it is difficult to generalize about how states will respond, the end of the enhanced ARRA funding presents another wrinkle in the budget picture that legislatures are just beginning to deal with.

Carolyn Ingram, senior vice president at the Center for Health Care Strategies and a former New Mexico Medicaid director, said states will be looking for both short-term and long-term solutions to their budget problems.

In the short term, Medicaid directors will look to make changes to utilization rates and the scope and duration of benefits with the goal of spending less money without jeopardizing beneficiaries, according to Ingram. She said states already have taken advantage of the “low-hanging fruit” that can save money, such as fraud and abuse prevention measures, meaning they must make ever tougher budget decisions.

At the same time, Medicaid directors are looking at how to provide more efficient and effective care, such as providing integrated care to those who are dually eligible for Medicaid and Medicare or those with chronic conditions, according to Ingram.

### **Safety-Net Provider Concerns.**

Safety-net providers said that while they are sympathetic to states' budget difficulties, they are concerned that further Medicaid cuts will undermine the program.

"If we gut Medicaid, it's going to be hard to implement the Affordable Care Act effectively," Bruce Siegel, chief executive officer of the National Association of Public Hospitals, said.

While NAPH will make a case for additional federal funding for Medicaid, the backdrop of mounting concerns about the federal deficit will be difficult to overcome. "I suspect we're going to be having a lot of discussions about deficit reduction and how to preserve the safety net," he said.

Dan Hawkins, senior vice president for public policy and research at the National Association of Community Health Centers, said an extension of the enhanced FMAP under ARRA would be "a huge stretch."

States and providers instead will have to hope for a speedy economic recovery. "Short of that, I don't see any additional relief," he said.

Safety-net providers will be watching Medicaid with great interest throughout the year, but also have other priorities they will continue to address.

Hawkins said that community health centers (CHCs) will be watching the appropriations process with keen interest this year. PPACA provides \$11 billion to CHCs over five years but that is beyond the \$2.2 billion the program is appropriated each year.

CHCs will be working to maintain their annual appropriations, or else the \$11 billion will have to be used to plug gaps created by lower appropriations, according to Hawkins.

"At that point, community health centers would just be treading water," he said.

Public hospitals also will keep a close eye on their funding this year and over the coming years, according to Siegel.

Disproportionate share hospital payments will drop by \$400 million in 2011, largely because of an end to increased funding provided through ARRA.

"That's painful because the number of people who need care has not dropped," he said.

PPACA includes further DSH cuts, and Siegel said NAPH will be looking for alternatives to those cuts this year.

Public hospitals also will be looking at the role they can play in various delivery system reforms, such as accountable care organizations, according to Siegel. He said NAPH will be thinking in particular about how a Medicaid ACO could work or how the dually eligible could be treated

under that model.

Hospitals that participate in the 340B program, which provides discounted outpatient drugs to safety-net hospitals, also will continue to press for the expansion for the program to inpatient drugs, according to Ted Slafsky, executive director of Safety Net Hospitals for Pharmaceutical Access.

In addition, 340B hospitals will be pushing for adequate enforcement to ensure drug manufacturers are in compliance with the program, according to Slafsky.

### **Maintenance-of-Effort Rules Limit Options.**

As states sort through their options to reduce spending, they are limited by maintenance-of-effort (MOE) provisions included in both ARRA and PPACA. Under the MOE requirements, states would lose some or all of their federal funding for Medicaid if they tightened their eligibility rules, a move that would reduce enrollment and spending.

Under ARRA, each state received an increase in federal Medicaid matching funds as long as they did not implement more restrictive eligibility rules. Under PPACA, as a condition of receiving any federal funding, states cannot switch to more restrictive eligibility rules than those that were in place when the law was enacted. The PPACA MOE is in effect for adult populations until a “fully operational” insurance exchange is operational in the state and for children younger than 19 until 2019.

However, 33 Republican governors and governors-elect Jan. 7 asked Obama administration officials and Congress to lift the MOE requirements (see related item in this issue), saying the federal requirements force states to cut other critical state programs, such as education, in order to fund a ‘one-size-fits-all’ approach to Medicaid.”

Judith Solomon, co-director of health policy at CBPP, said loosening the MOE provisions could be a continued area of interest in 2011--but not a preferable policy choice. “Certainly in advance of health reform, it would be troublesome to go backwards,” she said.

A Jan. 11 report by KCMU and the Georgetown University Center for Children and Families (CCF) found that 49 states, including the District of Columbia, held steady or made improvements in their Medicaid or Children's Health Insurance Program eligibility rules and enrollment procedures in 2010 (see related item in this issue).

Specifically, 13 states expanded eligibility for the programs, mostly for children, and 14 states improved their enrollment and renewal procedures, according to the report.

“This striking stability in public programs can be directly attributed to the federal government's decision both to provide temporary Medicaid fiscal relief to states through June 2011, and to require states to maintain their Medicaid and CHIP eligibility rules and enrollment procedures until broader health reform goes into effect,” a summary of the report said.

Tricia Brooks, a senior fellow at CCF, said of lifting the MOE that “no matter how you slice it, if you dismantle those protections, it means taking coverage away.”

### **Planning for PPACA Implementation.**

As states deal with their budgets, they also must juggle implementation of PPACA, which expands Medicaid eligibility to all those with incomes up to 133 percent of the federal poverty level.

“Depending on the state, it might be a double whammy or those two things might be able to work together,” Allison said.

Regardless of a state's fiscal situation, sources agree that 2011 will be an important one for states to plan and start working on implementation of the law, which includes not only the Medicaid expansion but the creation of insurance exchanges and a host of other responsibilities and opportunities.

Alan Weil, executive director of the National Academy for State Health Policy, said that states will move ahead with implementation, even as some challenge PPACA in court.

“I think states are going forward with what they need to do though they're obviously watching the lawsuits,” he said.

In addition, Weil said that despite rumblings from some state officials about the need to drastically overhaul Medicaid--or opt out of the program altogether--he has yet to see a model for spending less while still meeting the needs of beneficiaries.

### **Medicaid Expansion and Insurance Exchanges.**

According to those interviewed, one of the central questions states will seek to answer over the coming year is what happens as individuals and families transition between Medicaid and the insurance exchanges based on changes in their income or other factors, such as pregnancy.

For example, if a family is enrolled in Medicaid and then earns a few extra dollars, causing their income to rise over the 133 percent FPL threshold and pushing them into the individual health insurance market, when and how will their coverage change?

“The question every state is going to have to face is whether that increase in income will force a change in insurance for that family,” Allison said.

In addition to figuring out how people might move between the two systems, there is also the issue of how quickly and efficiently eligibility determinations and enrollment in either Medicaid or the exchanges will take place--ideally without having to run applicants through two systems.

Leonardo Cuello, a staff attorney at the National Health Law Program, said the systems must be nimble, so that people do not languish without coverage or enroll in a program that is not right

for them.

“Everyone is trying to think of ways to do this that are going to be both accurate and practical,” he said.

To help states develop those systems, the Centers for Medicare & Medicaid Services has published a proposed rule that would provide states with an enhanced matching rate for the development of eligibility systems. States would receive a matching rate of 90 percent for the design and development of new systems and 75 percent for maintenance and operations. States currently receive a matching rate of 50 percent for both categories.

In addition, the Department of Health and Human Services announced early innovator grants for leading states to design and implement information technology to operate health insurance exchanges, with the goal that they will serve as models for other states.

Allison said that quality guidance from the federal government, as well as work by philanthropic institutions, on the questions surrounding implementation of the law is essential “so we don't have to create the wheel 50 times.”

States also are awaiting further guidance and regulations on Medicaid benefit packages, the interaction between Medicaid and exchange benefits, income determinations, and health information technology.

### **Other Policy Changes, Options.**

State Medicaid program officials also must think through an array of other policy changes and options that are included in the health reform law, including how new entities such as the Center for Medicare and Medicaid Innovation and the Federal Coordinated Health Care Office, which is responsible for developing policies on dual eligibles, could influence their programs.

States will be looking to those new offices for program guidance and opportunities but also for a sense of how these new entities fit into the Medicaid world.

“It's states absorbing and coming to understand the direction of these offices and what they can do creatively,” Weil said.

Under PPACA states also can implement new home- and community-based care programs, and, in some cases, secure additional funding for doing so.

Another area states should think through is how best to leverage an increase in Medicaid reimbursement for primary care providers included in PPACA, according to Stephen Somers, president of the Center for Health Care Strategies (CHCS).

The law boosts Medicaid primary care payments to Medicare levels in 2013 and 2014 to encourage doctors to participate in Medicaid, as part of an effort to ensure access to care for beneficiaries.

“The idea is not to just treat this as a brief windfall,” he said.

Somers said planning for the bump must be done carefully, including using the rate increase to maintain and expand the provider network. Furthermore, Medicaid should make sure the increased payments are used to drive higher quality care.

### **Expanded Use of Managed Care.**

As states work to balance their budgets and plan for the Medicaid expansion, some also are looking to managed care as a way to hold down costs and provide care to beneficiaries.

Thomas Johnson, president and chief executive officer of Medicaid Health Plans of America, a trade group for private Medicaid insurers, said that states are interested in expanding their use of managed care--and quickly.

“We definitely see that states are looking to us to deal with their Medicaid budgets,” he said.

Many states already make extensive use of managed care plans, but now are looking to expand to populations that have not traditionally been covered by managed care, such as the aged, blind, and disabled, or those in need of long-term care, according to Johnson.

As states make plans to expand managed care, Johnson said it is important to make sure communities understand any changes and have the opportunity to provide input on those proposals.

### **Protecting Beneficiaries.**

Cuello said that as states consider Medicaid cuts and plan for implementation of PPACA, it is critical to consider how beneficiaries will be treated under the changes.

The expansion in particular brings with it a fair amount of upheaval--and consumer advocates do not want to see protections for beneficiaries undermined in the process, according to Cuello.

For example, as states experiment with new models of care delivery, beneficiaries should retain the ability to go out of network for treatment and should have proper notice of changes to their care, Cuello said.

Advocates also will be watching to see that the program's benefits packages, which have been crafted carefully to meet beneficiaries' needs, are not diluted.

In addition, Cuello said it will be essential for CMS to ensure that states experiment in transparent ways and appropriately monitor those efforts.

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