kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

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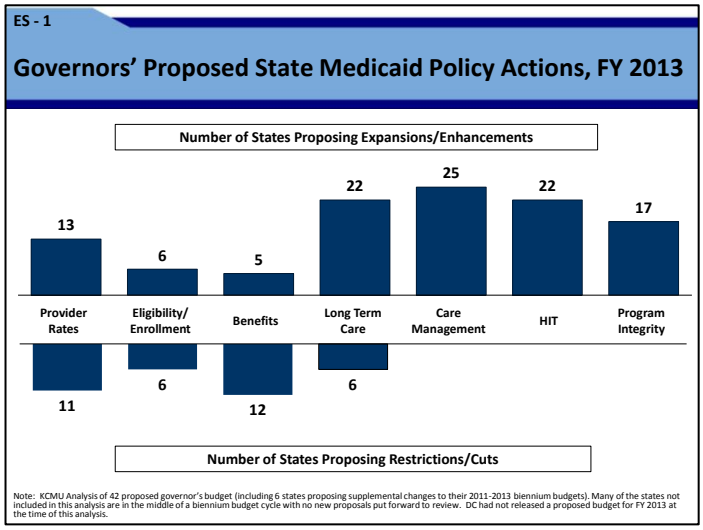
Governors' Budgets for FY 2013 – What is Proposed for Medicaid?

Executive Summary

As governors released their proposed budgets for FY 2013 the economic picture was mixed. On one hand, many states were still experiencing the ongoing effects of the Great Recession with high unemployment, revenues below peak levels from before the recession and continued high demand for public programs like Medicaid. On the other hand, the national unemployment rate hit a three-year low in January, revenues are slowly rebounding and spending and enrollment growth for Medicaid are slowing. Governors' proposed budgets reflect variation in economic conditions as well as policy priorities across states. This report provides Medicaid highlights from governors' proposed budgets for FY 2013, which starts July 1, 2012 for most states. Key findings include the following:

State fiscal situations in FY 2013 are better than the last few years, but many states are still facing budget shortfalls. Headed into FY 2013, at least 30 states were anticipating budget shortfalls totaling $49 billion. Fiscal responsibility, jobs and economic development were the primary focus in many governors' budgets. To address shortfalls, many proposed budgets included additional spending reductions, on top of significant reductions imposed over the last few years. A few governors also proposed revenue increases to achieve a balanced budget. However, with some improvement in fiscal conditions, several states were also making targeted investments in education, health care, higher education, transportation/infrastructure and public safety. A number of states also had significant proposals to cut taxes. In line with improving state economies, it appears Medicaid spending and enrollment growth are continuing to slow.

For Medicaid, proposed budgets included an array of policy actions to control costs, but also some targeted investments. In addition to both enhancements and restrictions of provider rates, eligibility, benefits, long-term care and cost-sharing, this analysis shows continued activity in care management, health information technology and program integrity (ES - 1).



- To control Medicaid spending growth, at least 11 states proposed policies to restrict payment rates; however, after multiple years of cuts, at least 13 states are proposing to increase at least some provider rates. A few states explicitly budgeted for additional federal funds tied to the primary care physician fee increase for 2013 that was included in the Affordable Care Act (ACA).

- At least six states proposed targeted eligibility expansions or simplifications for enrollment and renewal processes. Most restrictions to eligibility are prohibited under the maintenance of eligibility (MOE) requirements in the Affordable Care Act (ACA), but there are a few exceptions. At least 6 states proposed eligibility and enrollment restrictions. If these restrictions are passed by state legislatures, the Centers for Medicare and Medicaid Services (CMS) will need to determine if the restrictions are in compliance with the MOE requirements.
- Governors in at least 12 states proposed eliminating or restricting benefits in FY 2013 budgets compared to 18 states in FYs 2011 and 2012. A few states proposed significant benefit changes, other cuts were more targeted. Benefit cuts to dental, home health, personal care, therapy and vision services were proposed most often. At least 5 states also proposed to expand benefits, mostly for behavioral health.
- Proposed budgets continue trends to expand community based long-term care services.

Many states are proposing to move forward with an array of Medicaid care management initiatives as well as efforts to enhance health information technology and program integrity. Over half of the state budget proposals we reviewed include some new managed care initiative; often these initiatives were tied to savings. The scope of the initiatives varied from broad based health delivery system changes (sometimes as part of broader 1115 waiver proposals) to initiatives targeted to specific populations or geographic areas. The ACA established new options to coordinate care for high-need populations such as individuals dually eligible for Medicare and Medicaid (duals) or enrollees with chronic conditions. For example, a number of states proposed plans to implement the "health homes" option in the ACA where states can receive enhanced federal matching funds to provide care coordination for Medicaid enrollees with two or more chronic conditions. Other investments were tied to plans to enhance program integrity efforts. Twenty-two states proposed investments in health information technology projects in FY 2013 including major upgrades to Medicaid eligibility systems. States have begun to take advantage of a 90 percent federal match rate for many of these upgrades that will help states meet coordinated system requirements under the ACA and help to update antiquated systems.

Looking ahead, legislatures will work to pass balanced budgets, the Supreme Court will rule on the constitutionality of health reform and the federal government will debate deficit reduction measures. State legislatures will act throughout the spring to pass balanced budgets that may or may not include many proposals included in the governors' budgets. As of late March, 10 states, including Alaska, Arkansas, Florida[1], Maine, New Mexico, Oregon, South Dakota, Utah, West Virginia, and Wyoming have passed budgets for the upcoming fiscal year. For most states, enacted budgets will go into effect on July 1, 2012 and will be analyzed in greater detail in the Kaiser Commission on Medicaid and the Uninsured's annual 50-state Medicaid budget survey to be released in the fall of 2012. As states do their work, there will be issues to watch at the federal level. The Supreme Court will likely rule on the constitutionality of the Medicaid expansion and the individual mandate included in the ACA in late June and Congress will continue to debate about the federal deficit that will likely include proposals to cut federal Medicaid spending. All of these events will have significant effects on states and on the Medicaid program and its ability to provide health coverage and long-term care supports to millions of low-income Americans.

Methods

In total, we were able to review 42 proposed state budgets (including 6 states proposing supplemental changes to their 2011-2013 biennium budgets) that were released late in 2011 and early in 2012. Many of the states not included in this analysis (Indiana, Minnesota, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, and Texas) are in the middle of a biennium budget cycle with no new proposals put forward to review. The District of Columbia had not released a proposed budget for FY 2013 at the time of this analysis. This analysis captures major new proposals and changes included in proposed budgets. Budget documents vary and generally do not capture all of the activity in a given state. For example, some budgets include details about pending or proposed Medicaid demonstration waivers while others do not. Many states are also pursuing activities around health reform and care coordination for duals beyond those mentioned in proposed budgets.

[1] The legislature has passed the FY 2013 budget and sent the bill to the governor.

Introduction and Background

Medicaid is a federal entitlement program administered by the states providing health care and long-term services and supports to low-income Americans. Subject to federal rules, states have flexibility to structure their programs in terms of eligibility, benefits, delivery of services, and provider payments. Medicaid is jointly financed by the states and federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage, or FMAP. A state's FMAP is calculated annually and varies inversely with average personal income in the state, but is subject to a 50 percent floor.

Since Medicaid is a counter-cyclical program, spending and enrollment increased as a result of the Great Recession. During an economic downturn, individuals lose jobs, incomes drop, state revenues decline, and more individuals qualify and enroll in Medicaid which increases program spending. Medicaid spending and enrollment growth peaked in 2002 during the earlier economic downturn and then again in 2009 during the recent recession. While demand for government services increases, state revenues decline during recessions making it difficult for states to pay their share of Medicaid. During the Great Recession, state revenues dropped by record amounts resulting in unprecedented budget shortfalls for states. The American Recovery and Reinvestment Act (ARRA) provided fiscal relief to states in the form of an increase in the Medicaid match rate from October 2008 through June 2011. The enhanced funding expired at the start of state fiscal year 2012 resulting in an increase in state funds to replace the expiring federal funds from the ARRA enhanced FMAP.

Medicaid cost containment has been a dominant theme for much of the last decade. In response to tight budget constraints, every state has implemented an array of cost containment strategies over the last ten years. In FY 2012, 50 states implemented at least one new policy to control Medicaid costs. Generally, states restricted provider rates and benefits and implemented strategies to control spending for prescription drugs.[2] States also continue to move forward with a range of delivery system changes designed to improve care and control costs and to reorient the delivery of long-term care from institutional care to community based care. In recent years states have been prohibited from restricting Medicaid eligibility or tightening enrollment procedures under both the ARRA and the Patient Protection and Affordable Care Act (ACA) "maintenance of eligibility" requirements. While the focus has been on cost controls, a number of states have also implemented program improvements and coverage expansions to help reduce the number of uninsured.

States are still struggling with the lingering effects of the recession, but some positive signs are emerging as states look toward 2013. Since the adoption of FY 2012 state budgets, state economic conditions, on the whole, have continued to slowly improve. The nation's unemployment rate dropped to a three year low of 8.3 percent in January 2012[3] and overall state tax revenues slowly rebounding. Some states reported revenues exceeding original projections. Governors released budget proposals for FY 2013 in the context of fragile but recovering state economies. These budgets continue to propose new options for cost savings in Medicaid; however, some governors have also used a somewhat improved fiscal situation to make targeted investments in Medicaid and other programs. Some budget proposals in a few states also specifically include policy changes related to the ACA.

[2] Smith, V. et al. *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends.* Kaiser Commission on Medicaid and the Uninsured, October 2011. http://www.kff.org/medicaid/8248.cfm.
[3] The Employment Situation – January 2012, Bureau of Labor Statistics, February 3, 2012.

Methods

This report provides Medicaid highlights from governors' proposed budgets for FY 2013. The analysis is based on a review of state budget documents, news reports and other relevant documents. Links to proposed budget documents can be found in Table 1. In total, we were able to review 42 state budgets (including 6 states proposing supplemental changes to their 2011-2013 biennium budgets).[4] Generally, proposed budgets were released late in 2011 and early in 2012.

Many of the states not included in this analysis (Indiana, Minnesota, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, and Texas) are in the middle of a biennium budget cycle with no new proposals put forward to review. The District of Columbia had not released a proposed budget for FY 2013 at the time of this analysis; the budget year does not begin until October 1, 2012 whereas most other states begin July 1, 2012.[5]

This analysis is not comprehensive but is designed to capture major new proposals and changes included in the proposed budget. The level of detail presented in governors' proposed budget documents varies significantly and in most cases does not capture all of the activity in a given state. For example, some budgets include detail from pending or proposed waivers while others do not. Many states are also pursuing activities around health reform and care coordination for duals beyond those mentioned in proposed budgets.

At the time of writing of this report in late March, a number of state legislatures had acted to pass a budget for FY 2013. We have tried to incorporate legislative activity as well as enacted budget changes, but the focus of the report is on what was in governors' proposed budgets. Often proposed budgets are very different than what is ultimately approved by the state legislature. In addition, some proposed budgets include proposals that would also need to be approved by the Centers for Medicare and Medicaid Services (CMS) before a state could implement the policy. In the summer of 2012, the Kaiser Commission on Medicaid and the Uninsured with Health Management Associates will conduct a more comprehensive review of Medicaid changes that were adopted in state budgets for FY 2013. As in previous years, this analysis should be available in the fall.

[4] Included in this count are Arkansas and Oregon. Information about the governors' FY 2013 budget proposals for these states was included; however, official documentation of these proposals was not found. Also included in this count was Wisconsin though changes included in this analysis for that state were not part of a formal budget proposal from the governor. We also included changes from the first supplemental budget proposed by Maine's governor in December 2011; his second supplemental budget was released in mid-March 2012, which was too late to be included in this analysis.

[5] Other states that do not operate on the July 1 through June 30 budget cycle include Alabama and Michigan (October 1 – September 30), New York (April 1 – March 31), and Texas (September 1 – August 31).

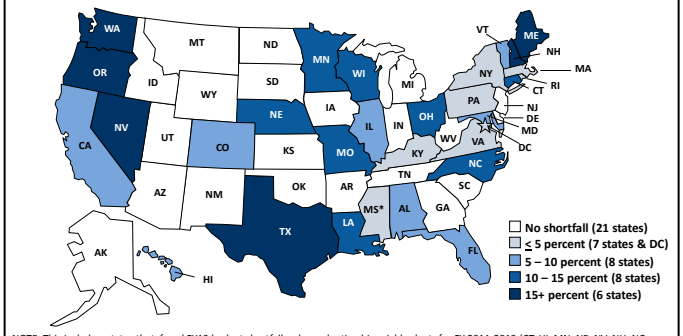
Key Findings

A. Budget Message

While many states still face shortfalls, Governors' budgets recognized modest improvements in the economy. For FY 2013, 30 states projected or addressed budget shortfalls of $49 billion (Figure 1).[6] These shortfalls were smaller than prior years, but still significant. In most states revenues were improving and in some cases coming in higher than previous projections, but governors were still faced with the tough reality that it may take several years for revenues to return to 2008 levels. Slow revenue growth and continued increase in the demand for government services added up to more tough choices in proposed budgets. In addition, governors mentioned state fiscal issues tied to the expiration of federal stimulus dollars, long-term obligations related to pensions and retiree health benefits, efforts to balance the federal deficit, and global economic uncertainty. A few states including Hawaii, Missouri and Vermont were still recovering from natural disasters that occurred over the last year which required additional state spending.

FIGURE 1

States with Budget Shortfalls in FY 2013



NOTE: This includes states that faced FY13 budget shortfalls when adopting biennial budgets for FY 2011-2013 (CT, HI, MN, NE, NV, NH, NC, OH, OR, and TX.) ME, WA, and WI faced FY13 shortfalls both before and after adopting their biennial budgets. Percentages represent the combined shortfall (before and after budget passage) as a percent of the state's FY12 budget. *MS has a confirmed shortfall, but the magnitude has not been reported.
SOURCE: CBPP, March 2012

Proposed budgets focused primarily on fiscal responsibility, jobs, economic development and some targeted investments. While states certainly vary in terms of their economies and priorities, there were several common themes in the overall messages for proposed budgets. A focus on fiscal responsibility, accountability, efficiency and a continued focus on jobs and economic development were common themes across many proposed budgets. Compared to the last few years, a number of states noted that fiscal conditions were improving and there were some funds to invest in targeted priorities. Investments in education, health care (Medicaid, coverage and services for behavioral health, and individuals with developmental disabilities), higher education, transportation/infrastructure and public safety were among the most commonly cited. A number of governors also mentioned investments in modernizing information technology in state government.

Many proposed budgets included additional spending reductions, on top of significant reductions over the last several years. Despite some funds for new investments, there was also a lot of discussion about cutting spending, and in many states these reductions were on top of prior year budget cuts. For example, Governor Beshear's budget for Kentucky included an 8.4 percent cut across most state agencies for FY 2013 (resulting in 25 to 30 percent reductions for some agencies and $1.3 billion in cuts over the last four years). Mississippi proposed a 5.5 percent cut for most agencies and Tennessee proposed a two percent across-the-board spending cut. Over the last four years, Louisiana reported cuts of 26 percent and Illinois reported cuts of 4 percent. Spending levels in Virginia are back to 2007 levels. Along with spending cuts, some budgets reported significant staffing reductions. Over the past few years, 1,000 positions have been cut in Delaware, 2,000 in Illinois and 6,000 in Louisiana.

[6] Elizabeth McNichol, Phil Oliff and Nicholas Johnson. *States Continue to Feel the Recession's Impact.* Center on Budget and Policy Priorities, March 21, 2012. http://www.cbpp.org/cms/index.cfm?fa=view&id=711. This includes states that faced FY13 budget shortfalls when adopting biennial budgets for FY 2011-2013 (CT, HI, MN, NC, NE, NV, NH, OH, OR, and TX.) ME, WA, and WI faced FY13 shortfalls both before and after adopting their biennial budgets.

While a few governors proposed spending cuts and revenue increases to achieve balanced budgets, there were a number of proposals to cut taxes. A few states, notably California, Maryland, and Washington mentioned an approach that used spending cuts and new revenue proposals to achieve a balanced budget. Even in these states with Democratic legislatures, the prospect of enacting revenue increases looks challenging. Despite large spending reductions in many states over the last several years, a number of governors had messages of no new taxes as well as tax cuts. A number of states proposed modest or targeted tax cuts for businesses or veterans. A few states have tax amnesty proposals where delinquent taxpayers would pay overdue taxes without penalty and interest. There were also major proposals to cut taxes in a number of states including Missouri where there may be a voter initiative on the ballot in November to abolish the income tax and increase the sales tax, Oklahoma where the governor proposed to provide immediate tax relief and then move to phase out the personal income tax, New Jersey where the governor has proposed a 10 percent cut in every income tax bracket phased in over three years, income tax cuts in Kansas, and South Carolina where the governor proposed a four-year plan to abolish the corporate income tax.

Proposed budgets also included fiscal reform proposals. There was also a focus on achieving long-term fiscal health in state budgets particularly on eliminating the use of one-time revenues to fund ongoing spending obligations and budget gimmicks. A number of governors were taking on pension reforms and fiscal reform in other areas of government ranging from Medicaid to school finance. For example, Kansas has plans to reform taxes, Medicaid, the pension system and school finance with Medicaid reform first on the list this fiscal year. A number of budgets also attempted to rebuild reserve or rainy day funds.

Budget Quotes

"Budgets are about priorities, and this budget makes clear that our top priorities are encouraging economic growth, making our public schools stronger, and ensuring that we are governing responsibly. The budget continues years of efforts to govern responsibly by finding ways to cut costs." Governor Jack Markell, Delaware

"We must continue to tighten our belts in all areas of state government." Governor Quinn, Illinois

"We must do more with less." Governor Patrick, Massachusetts

"I have put forth a responsible, balanced plan for New York State that continues… efforts to strengthen the economy while improving both the quality of services delivered and the accountability over State spending." Governor Cuomo, New York

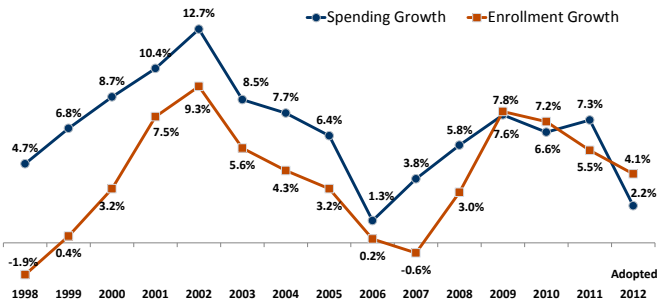
This is a "responsible budget that accomplishes the goals of reducing the tax burden on Oklahoma citizens, supporting core government functions, holding the line on spending and demanding a more efficient and effective state government." Governor Fallin, Oklahoma

B. Medicaid Spending and Enrollment

While most proposed budgets account for Medicaid enrollment and spending growth over the prior year, rates of increase look like they are continuing to slow. In the annual Medicaid budget survey, states projected Medicaid enrollment to increase on average by 4.1 percent in FY 2012 and spending to increase by 2.2 percent (Figure 2). In the mid-year update, the majority of states were anticipating spending and enrollment growth to be on target or lower than original projections.[7] While it was difficult to collect specific enrollment and spending projections, Medicaid enrollment and spending trends in many states are starting to slow as economic conditions are improving. For example, Arizona expects enrollment growth to drop from 5.1 percent in 2012 to 4.4 percent in 2013, well below the peak growth (24 percent) from 2008 to 2009.

FIGURE 2

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2012



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

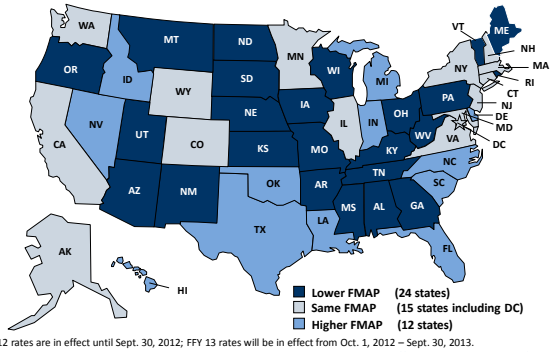
SOURCE: *Medicaid Enrollment June 2010 Data Snapshot*, KCMU, February 2011. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2011 and FY 2012 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2011.

For spending, proposed budgets include estimates for changes accounting for enrollment growth, changes in utilization, changes in the federal matching rates (FMAPs) as well as policy changes. For example, the proposed budget in California reflected a decline in Medicaid general fund spending due to policy changes; however, without these changes costs would have increased by an estimated 3.4 percent. Without reforms that held Medicaid growth flat in Mississippi, spending growth was expected to be 16 percent. In Illinois, the governor proposed to hold Medicaid appropriations in 2013 at 2012 levels, thus achieving $2.7 billion in savings over the projected cost of the program in 2013. No specific policies were proposed to achieve these savings. In Florida Medicaid was cited as the largest driver of general fund spending and was also the program to receive the largest share of proposed spending cuts.

Medicaid costs are shared by the states and the federal government on the basis of a statutory formula that is recalculated each year based on the most recent three years of state per capita income relative to the national average; FMAPs for FFY 2013 were published in November 2011 based on 2008-2010 income data. FMAPs range from a floor of 50 percent in relatively affluent states (California, where every state dollar spent on Medicaid yields $1 in federal funds) to over 73 percent in the poorest state, (Mississippi, where every state dollar spent on Medicaid yields almost $3 in federal funds). A number of states explicitly budgeted for declines in the FMAP. According to the FMAP projections for FFY 2013, 24 states show a decline in the FMAP (Figure 3 and Table 2) ranging from less than one tenth of a percentage point in Alabama to over three percentage points in North Dakota.

FIGURE 3

Change in FMAP between FFY 2012 and FFY 2013



NOTE: FFY 12 rates are in effect until Sept. 30, 2012; FFY 13 rates will be in effect from Oct. 1, 2012 – Sept. 30, 2013.

SOURCE: FY2012: Federal Register, November 10, 2010 (Vol 75, No. 217), pp 69082-69084, at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2010_register&docid=fr10no10-65.pdf. FY2013: Federal Register, November 30, 2011 (Vol 76, No. 230), pp 74061-74063, at http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-30860.pdf.

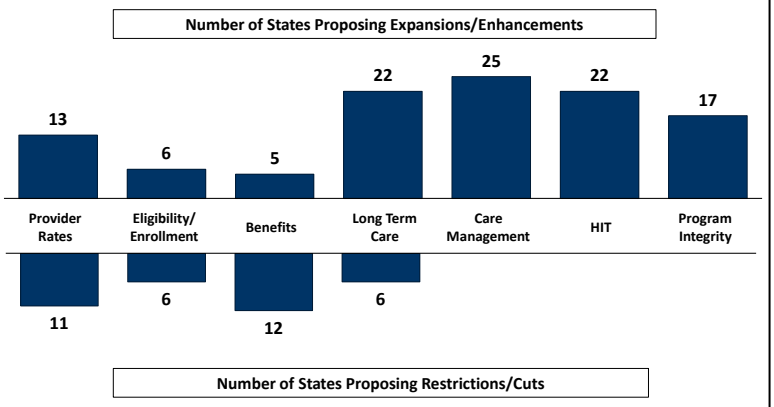
[7] *A Mid-Year State Medicaid Budget Update for FY 2012 & A Look Forward to FY 2013.* Kaiser Commission on Medicaid and the Uninsured, February 2012. http://www.kff.org/medicaid/8277.cfm

C. Medicaid Policy Actions

Proposed budgets included an array of policy actions to control costs, but also some targeted investments. This report captures proposed policy changes in 9 key areas: provider payment rates, eligibility, benefits, prescription drugs, cost sharing, care management, long-term care, health information technology, and program integrity. A summary of actions is included in Figure 4 and Table 3.

FIGURE 4

Governors' Proposed State Medicaid Policy Actions, FY 2013



Note: KCMU Analysis of 42 proposed governor's budget (including 6 states proposing supplemental changes to their 2011-2013 biennium budgets). Many of the states not included in this analysis are in the middle of a biennium budget cycle with no new proposals put forward to review. DC had not released a proposed budget for FY 2013 at the time of this analysis.

1. Provider Payment Rates

After many years of cuts, governors' budgets include a number of proposals to increase rates. State actions around provider rate changes are generally tied to state fiscal conditions. During economic downturns, states tend to cut rates and when economic conditions improve states are less likely to cut rates and more likely to restore rate cuts or increase rates. As the economy has started to recover, states are still restricting provider rates, but a number of proposed budgets included both broad based and targeted provider increases. In many instances, the rate increases were described as restorations from previous cuts. For example:

- After sustained rate freezes and cuts, the **Arizona** proposed budget included a 3 percent provider rate increase for physicians, behavioral health service providers, nursing facilities, home service providers and ambulatory surgery centers.
- **California** provided a 3.6 percent rate increase for managed care and also restored the 10 percent provider rate reduction for nursing homes that was scheduled to be implemented last year, but was then blocked by the courts.[8]
- **Maryland's** budget proposed a 1 to 1.5 percent increase in rates for most providers and targeted increases for mental health providers and community based care providers serving individuals with developmental disabilities.

[8] Over the last several years, California has passed laws to reduce reimbursement rates for a variety of Medicaid providers. Medicaid beneficiaries and providers filed suit against the state claiming that the rate cut would violate the equal access provision in federal Medicaid law. On October 3, 2011 the Supreme Court heard oral arguments on the question of whether beneficiaries and providers can sue the state to enforce federal law. In the meantime, CMS approved some of the rate cuts. The Supreme Court vacated the Ninth Circuit's rulings preventing the state from implementing the rate cuts and remanded the case to the lower court to decide whether beneficiaries and providers could sue to enforce federal law after CMS takes final action given the new circumstances of the case.

- **Tennessee's** budget included funding to restore 1.75 percent of the 4.25 percent rate reduction that was scheduled for implementation on January 1, 2012 for a range of providers including nursing homes, managed care organizations, transportation, lab and x-ray technicians, and dental providers.
- **South Dakota** proposed provider increases due to inflation and additional increases of 4.5 percent funded with one-time revenues.

Other states proposed targeted rate increases for Home and Community Based Service providers in Delaware; nursing homes in Georgia, New Mexico and West Virginia; and essential community providers in New York. A few states also extended, increased or implemented new provider taxes. Often the new taxes were to help pay for provider rate increases like the extension of the nursing home fee program in California and the increase in nursing facility fees in Georgia. Tennessee also proposed to extend their hospital coverage assessment for another year.

Several states explicitly included budget authority to accommodate the increase in federal funds for the primary care provider rate increase that will go into effect in 2013. Under this provision of the ACA, primary care provider rates in Medicaid will be increased to Medicare levels for 2013 and 2014. The increase (based on rates in effect in July 2009) will be financed with federal dollars. Louisiana, Michigan, Missouri and Virginia budgeted explicitly for this. Some states including Arizona, Louisiana, and Tennessee budgeted for increased costs related to this provision because the state has implemented provider rate cuts and will be required to pay with regular matching funds the costs associated with restoring rates to July 2009 levels. Colorado is requesting authority to establish an incentive pool for physicians using the enhanced federal funds for physician rates rather than increasing rates for specific codes and practitioners. Under this proposal, the Department would make supplemental payments to qualifying physicians based on quality measures calculated periodically.

Several states proposed additional provider rate restrictions. Reflecting tough fiscal conditions at the state level stemming from the recession, our annual budget survey showed that 39 states in 2011 implemented rate restrictions and another 46 had plans to do so in FY 2012. Examples of proposed rate cuts for FY 2013 include:

- General rate cuts ranging from 1 to 3 percent in Louisiana and a 1.5 percent rate reduction for nursing facilities in Colorado (continuation of a prior year cut);
- Managed care rate cuts in Florida (a continuation of a prior year cut), Missouri (through efficiency measures added to lower capitation payments), and Rhode Island (4 percent cut);
- Hospital rate cuts in Massachusetts and Maine (by 10 percent), and cuts to critical access hospitals in Maine and Washington.

Washington also proposed rate cuts for homecare agencies, assisted living facilities, and community residential providers. In Louisiana, funding cuts for the public hospitals (LSU) have raised concerns about negative impacts on private hospitals and layoffs and cuts in services (particularly for mental health) at the public hospitals.

A number of states also proposed changes to reimbursement methods or other payment reforms. Many of the reforms mentioned including payment reform for FQHCs and RHC in California were expected to result in savings. Florida noted plans to shift the rate band methodology for hospital services, Georgia was evaluating a new reimbursement method for outpatient services, and Louisiana proposed to move to Resource Utilization Group Systems or RUGS for nursing home reimbursement. Maryland proposed to constrain hospital costs by diverting patients to community providers.

2. Eligibility and Enrollment

A few governors proposed limited eligibility expansions or other policy changes aimed at increasing Medicaid coverage for certain groups. For example:

- **California** and **Colorado** are moving early to transition children with incomes up to 133% of poverty from CHIP into Medicaid. Under the ACA, all states currently providing CHIP coverage to children below 133 percent of poverty are required to transition them to Medicaid by 2014, but states have the option to move these children into Medicaid in advance of the 2014 deadline. In Colorado, pregnant women with incomes between 133 percent and 185 percent of poverty currently covered through CHIP are also being transitioned into Medicaid.

- **Colorado** also submitted a waiver to expand coverage to 10,000 adults without dependent children with incomes below 10 percent of poverty in December 2011. The state had originally intended to use the new ACA adult expansion option to cover all adults without dependent children under 10 percent of poverty but believed the cost of coverage would exceed available funding. Under the current proposal, applicants will be added to a waiting list when the 10,000 beneficiary limit is reached.

- In **Illinois**, the hospital district in Cook County is seeking to expand eligibility under the ACA state plan option to expand coverage to childless adults before 2014, when all states will be required to cover this population up to 133 percent of poverty. The Illinois Medicaid director has indicated her support for the measure.[9]

- **Vermont** set aside funding to expand coverage for family planning services under a state plan amendment, a new option made available under the ACA.

Several other states included proposals to streamline enrollment processes. Massachusetts and Oklahoma took steps to make enrollment more efficient and work to enroll eligible uninsured children. In 2011, Massachusetts received approval of a waiver to implement Express Lane Eligibility (ELE) for parents, using data already available from other programs to automatically renew coverage. The state is planning to implement ELE for children as well. Massachusetts also allocated $2 million in additional funding to improve the efficiency of the MassHealth enrollment and redetermination process and help manage enrollment growth. Oklahoma noted plans to implement SoonerEnroll, an initiative to build partnerships with community members and develop the infrastructure for outreach and enrollment for children who are eligible for Medicaid but are uninsured.

A number of states outlined administrative changes in their programs aimed at streamlining enrollment and making processes more efficient for Medicaid eligibility offices. For example, to help manage growing caseloads, Kentucky's proposed budget made provision to hire additional benefit workers to process a growing number of applications for Medicaid, SNAP, TANF, and other state assistance programs. Illinois plans to continue consolidating local eligibility offices to reduce overhead costs. New York is also proposing to shift local government administration of the Medicaid program to the state level as part of an initiative to provide administrative mandate relief[10] at the local level and achieve greater efficiency and effectiveness by centralizing administration of the program. These changes will help the state in accomplishing Medicaid reform proposals put forward by the New York's Medicaid Reform Team as well as federal health care reforms.

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[9] Thomason, Andrew. "IL Seeks to Add 100K People to Medicaid Program," *Illinois Statehouse News*, February 2, 2012. http://illinois.statehousenewsonline.com/7573/il-seeks-to-add-100k-people-to-medicaid-program/

[10] The state will also be taking over the growth in the local share of the program over a three-year period beginning in FY 2013 and fully eliminating the growth in the local share of the program by FY 2015.

Generally, states are prohibited from restricting Medicaid eligibility due to maintenance of eligibility (MOE) requirements included in the ACA; however, a few states have proposed eligibility restrictions. As a condition of receiving federal Medicaid funding, the ACA requires most states to maintain eligibility, enrollment, and renewal policies in place as of March 23, 2010, when the ACA was enacted, until January 2014 for adults and 2019 for children in Medicaid and CHIP. This "maintenance of eligibility" (MOE) requirement has few limited exceptions: states can scale back coverage to adults with incomes above 133 percent of poverty if they certify a budget deficit; states are not required to renew expiring waivers or continue coverage that is fully state funded; and states can scale back coverage expansions made after the enactment of the ACA. In spite of these restrictions, several states proposed significant cuts in Medicaid eligibility, mostly for adult coverage. Even if legislatures pass these changes, CMS will have to determine if the changes are in compliance with the MOE requirements.

- As part of a waiver proposal, **Connecticut** outlined several eligibility restrictions aimed at slowing enrollment growth in its Low Income Adult (LIA) program by imposing asset limits for new applicants. The Low Income Adult program was created under the ACA option to extend coverage to adults without dependent children under 133 percent of poverty ahead of 2014, when all states will be required to cover such populations.
- **Illinois** is moving forward with plans to verify residency of all individuals currently enrolled in Medicaid by matching their addresses against state driving records. While the state efforts are aimed at reducing fraud in the program, increased documentation requirements are likely to result in the loss of coverage and generate about $800 million in state fund savings over 5 years.
- **Maine** proposed to eliminate coverage through its Medicaid waiver program, MaineCare, for adults without dependent children aged 21 to 64 and to reduce the Medicaid income eligibility threshold for parents from 200 percent of poverty to minimum coverage levels (1996 welfare levels which were 36 percent of poverty for Maine). The supplemental budget, enacted in February 2012, cut eligibility for parents in MaineCare to 133 percent of poverty. The enacted supplemental budget maintained coverage for adults without dependent children in MaineCare but capped funding for the program, continued the enrollment cap, and established a sunset provision to eliminate this coverage.
- **Pennsylvania** proposed to modify minimum work requirements for medically needy recipients and tighten the definitions of medical conditions to qualify for Medical Assistance. The state also plans to eliminate cash benefits for the General Assistance program. The implications for Medicaid coverage are not clear. In addition, the state submitted an MOE waiver letter in February 2012 but it is not clear which population the waiver would apply to.
- **Virginia**, which is planning for the FY 2013-2014 biennial budget cycle, proposed to reduce the income level for an optional Medicaid eligibility group from 300 percent of Supplemental Security Income (SSI) to 250 percent of SSI beginning January 1, 2014, after the MOE requirements expire.
- **Washington** proposed eliminating the Basic Health Plan waiver program, which covers approximately 35,000 parents and adults without dependent children with incomes up to 133 percent of the poverty level.

3. Benefits

While a number of states have again proposed to restrict benefits to reduce Medicaid spending, it appears fewer states are doing so than in the past. Governors in at least 12 states proposed eliminating or restricting benefits in FY 2013 budgets compared to 18 states in FYs 2011 and 2012. At least 5 states also proposed to expand benefits, mostly around behavioral health. The most common proposed benefit cuts included cuts to dental benefits, home health and personal care services, therapy services (physical, speech, and occupational) and vision services. While some states proposed to make relatively minor changes to benefits, a number of states also proposed more significant changes to their benefit package, such as:

- **Connecticut** has proposed to submit a waiver to restrict eligibility and benefits for their new Low-Income Adult program. The waiver would limit nursing facility stays to 90 days per admission, institute limits on home health, independent therapy, and physician services, and limit medical equipment, devices, and supplies to a specific dollar amount.
- **Florida** proposed to restrict the number of emergency room visits to 12 per year and restrict hospital inpatient days from 45 to 23 per year for non-pregnant adults. The state is also proposing to limit the benefits covered for non-pregnant adults under the Medically Needy program to physician services, hospital inpatient and outpatient services, and prescription drugs. Dental, vision, hearing, clinic, home health, nurse practitioner, lab and x-ray, transportation, physician assistant, and private duty nursing services would be eliminated for this population in the Medically Needy program.
- **Maine** proposed to amend their FY 2011-13 budget by eliminating all optional services, including therapy services, podiatry, chiropractic, optometric services, dental, targeted case management, consumer directed attendant services and reimbursement for smoking cessation products. The state also proposed to limit outpatient hospital visits to 15 per year.
- **Nebraska** proposed to eliminate private duty nursing services and impose the following limits: limit home health services to 240 hours per year, limit personal assistance services to 3.5 hours per day with a 60 hour per month limit, and limit behavioral health therapy visits to 60 per year. The state also proposed to require individuals to meet the nursing home level of care requirements for personal assistance services.
- To help close the $1.4 billion budget gap in the FY 2011-2013 biennial budget, **Washington** proposed to eliminate routine dental care for persons with developmental disabilities, long-term care clients and pregnant women; increase the level-of-care requirements for a person to become eligible for personal care services; eliminate the Adult Day Health program; institute utilization management for mental health services; and eliminate medical interpreter services.

A few states had proposals aimed at improving or evaluating access. In Alaska, the state plans to continue collaboration with the Alaska Dental Society to encourage more participation of private dentists in the Medicaid program. California has proposed a process that will incorporate stakeholder input and determine cost-effectiveness before implementing changes in benefit design with a post-implementation assessment to ensure changes achieve intended results. This follows a lawsuit and a multitude of problems when the state proposed to eliminate adult day health care in FY 2012 and transition individuals to a new program called Community Based Adult Services. New York has also proposed to implement and expand data collection in their program to better measure and address health disparities.

4. Prescription Drugs

States continue to refine their Medicaid prescription drug programs to achieve greater cost savings and quality improvements. Common themes from FY 2013 proposed budgets included changing pharmacy reimbursement methodology and further increasing the use of generics. Two states (Iowa and Louisiana) specifically included plans in their FY 2013 budgets to move to the Actual Acquisition Cost (AAC) reimbursement methodology, which relies on random sampling of enrolled pharmacies to collect actual pricing information. CMS is also developing a database of National Average Drug Acquisition Costs (NADACs) and has been encouraging states to adopt an AAC methodology. Two states (Alabama and Oregon) have already implemented this reimbursement methodology; Alabama specifically accounted for continued savings in their FY 2013 proposed budget from this policy.

While state Medicaid programs generally have high generic dispensing rates, a handful of states also mentioned increasing the use of generic drugs in their programs. A number of states also indicated or accounted for savings related to higher collections for prescription drug rebates, some due to the ability to collect pharmacy rebates in managed care plans, which was first made an option for states under the ACA. Additional changes in prescription drug policy include adding or amending preferred drug lists (Alaska and Virginia), imposing script limits (Maine and Vermont), and eliminating coverage of over-the-counter drugs (Washington).

Colorado made several additional changes to their prescription drug program, such as adding coverage of select injections to help reduce the risk of preterm labor, expanding the physician administered drug enhanced rebate program, and selecting a preferred provider of diabetic testing supplies through a competitive bidding process. The state is also planning to institute a gain-sharing program for its Behavioral Health Organizations (BHOs) involving the use of psychotropic drugs. The goal would be to better manage the use of these drugs in select populations by allowing the BHOs to manage the pharmaceuticals for their clients to achieve cost-savings for the program and share in those savings.

5. Cost-Sharing

There is continued interest in the use of cost-sharing and premiums to help close budget shortfalls in Medicaid programs. Given that Medicaid serves low-income populations, copayments and premiums in the program are generally limited. However, copayment requirements are used to varying degrees by most state Medicaid programs. A total of 46 states (including DC) have copayment requirements, including five states (Delaware, Louisiana, Maryland, New Hampshire and West Virginia) that impose copayments only on drugs. Only five states (Connecticut, Hawaii, Nevada, Rhode Island and Texas) reported having no copayment requirements at all.[11] In FY 2012, 14 states had planned to implement new or increased cost-sharing in Medicaid (higher than previous years). Some of these plans to implement new or increased cost-sharing submitted as part of a demonstration waivers were not approved by CMS including cost-sharing proposals in Arizona, California and Florida.[12]

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[11] New Jersey reported no cost-sharing in their Medicaid program in response to our annual budget survey; however, their Family Care 1115 waiver program does include cost-sharing for use of the emergency room and prescription drugs for populations with incomes at 150% of poverty and above. Smith, V. et al. *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends.* Kaiser Commission on Medicaid and the Uninsured, October 2011. http://www.kff.org/medicaid/8248.cfm. and *Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012.* Kaiser Commission on Medicaid and the Uninsured, January 2012. http://www.kff.org/medicaid/8272.cfm.

[12] There have also been recent developments in waivers submitted by three states (Arizona, California, and Florida) in FY 2012 to apply cost-sharing beyond current limits under the program by either increasing copays above nominal levels or applying copays to groups currently exempt. CMS has recently denied parts of or all of these waiver requests. Specifically, on October 21, 2011, CMS denied Arizona waiver authority to expand mandatory copays to Medicaid populations subject only to nominal cost-sharing as well as the state's request to impose a $50 annual fee on childless adults who smoke. "Arizona's Section 1115 Research and Demonstration Waiver Factsheet." Arizona Health Care Cost Containment System, updated November 17, 2011. http://www.azahcccs.gov/reporting/Downloads/1115waiver/WaiverFactSheet.pdf.

At least 9 states proposed to increase or implement new copays or premiums in proposed budgets for FY 2013.[13] The most commonly proposed copays revolved around prescription drugs and non-emergency use of the emergency room. Other commonly proposed copays included non-emergency medical transportation and therapy services (physical, speech, and occupational). States that proposed significant changes around increased or new copays include:

- **Colorado** has proposed to make three changes related to copayments. First, the state would implement inflationary increases to their current copays. They would then implement new copays for a number of services including non-emergency medical transportation, outpatient substance abuse services, therapy services (physical, speech, and occupational) as well as home health services. The state also proposes to implement higher cost-sharing for non-emergent use of the emergency room.

- **Nebraska** has proposed to implement a $50 copay for non-emergent use of the emergency room and increase their copays for therapy services (physical, speech and occupational). The state also plans to account for the application of copays to their managed care population for the first time, citing federal Medicaid requirements.[14]

- **Washington,** as part of its supplemental budget for FY 2011-2013, has proposed to implement copays for prescription drugs, non-emergency medical transportation, non-emergent use of the emergency room, and physician services. This is particularly notable as the state did not impose any cost-sharing in their Medicaid program until last year.[15]

Two states (Colorado[16], mentioned above, and New Mexico[17]) have recently announced intentions to submit waivers related to cost-sharing for non-emergent use of the emergency room. Wisconsin is also in negotiations with CMS to add premiums for select populations in its program.[18]

On February 6, 2012, CMS denied California's request for waiver authority to impose new mandatory enforceable copayments on a number of services for all beneficiaries, regardless of age or whether they were served through the fee-for-service system or managed care. CMS Letter to California Department of Health Care Services, February 6, 2012.
On February 9, 2012, CMS denied Florida's requests to require a $100 copayment for non-emergent services provided in the emergency department as well as implement a $10 per member per month premium for beneficiaries enrolled in managed care. CMS Letter to Florida Agency for Health Care Administration, February 9, 2012.
http://www.fdhc.state.fl.us/Medicaid/statewide_mc/index.shtml#fedsubmiss

[13] This count includes proposals to increase copays in New Mexico as part of their waiver request which was not included in the governors' proposed budget but announced in March 2012.

[14] Letter to Nebraska Legislature from the State's Department of Health and Human Services. December 1, 2011. http://dhhs.ne.gov/medicaid/Pages/med_reform_reports.aspx.

[15] In March 2011, the state transitioned its state-funded Basic Health program into Medicaid through an 1115 waiver. At that time, the state instituted the same copayments from the Basic Health program and applied them only to this new population.

[16] Included in Colorado's budget proposal for FY 2013 was a plan to implement higher copayments for non-emergency use of the emergency room. The state indicated that it would prefer to implement this action through a 1916(a)(3) waiver but will pursue implementing this action through a state plan amendment under Section 1916(A).

[17] This is part of a broader waiver that was not included in New Mexico's proposed budget for FY 2013; the anticipated implementation date is outside of the FY 2013 budget window.

[18] Update from Secretary Smith to the Joint Committee on Finance, Department of Health Services, February 29, 2012. http://www.dhs.wisconsin.gov/MAreform/JFC2.29.12.pdf.

6. Care Management

Many states are proposing to move forward with an array of care management initiatives. The annual Medicaid budget survey showed that nearly half of the states were planning to implement some managed care/care management initiatives in FY 2012, an uptick from previous years. About two-thirds of the state budget proposals we reviewed included some new managed care initiative. Often these initiatives were tied to savings. The scope of the initiatives varied from broad based health delivery changes to initiatives targeted to specific populations or geographic areas. Some efforts were part of broad based Section 1115 Medicaid waivers and others were tied to new options made available under the ACA. California, Kansas and Louisiana mentioned in their budget proposals broader and more comprehensive initiatives related to managed care.

- The **California** proposed budget includes an expansion of managed care statewide beginning in June 2013. It also proposed to introduce an annual open enrollment period for beneficiaries to choose their managed care plan for the entire year instead of allowing beneficiaries to change their plan once a month as they do currently. California is also moving forward with transitioning dual eligibles into managed care in accordance with their Medicaid waiver.

- As part of the Medicaid reform effort in **Kansas**, the state is moving to include all populations except those in Intermediate Care Facilities for the Intellectually (ICF-IDs) in managed care. Under the plan, duals, foster care children and individuals with disabilities may be voluntarily enrolled in managed care but the state is seeking a waiver to mandatorily enroll these populations. Managed care contracts will include physical health, behavioral health, and long-term care services (including nursing facility services and home and community based services), as well as inpatient and outpatient mental health and substance abuse disorder services. Legislative hearings and news articles have detailed problems with the transition to managed care in Kansas related to reimbursement of claims and denial of care related to mental health and pharmacy services.

- **Louisiana** is moving ahead with full implementation of Louisiana Bayou Health, a program that coordinates care for 865,000 of the state's 1.2 million Medicaid enrollees. According to the state, the program enhances access to care, saves taxpayer money, and improves health outcomes. Louisiana has contracts with 5 health plans to move from fee-for-service to manage care incrementally across areas in the state with full implementation set for the end of FY 2012.

Additionally, a number of states mentioned implementing or expanding gain-sharing initiatives. For example, Colorado has proposed expanding their current Accountable Care Collaboratives (ACCs) Gain-sharing Incentive Payments program by providing Regional Care Collaboration Organizations and primary care providers with the opportunity for shared savings above the expected seven percent savings from the program. Colorado also plans to implement a gain-sharing program for FQHCs and RHCs and a gain-sharing program for Behavioral Health Organizations aimed at reducing the use of Psychotropic drugs. Massachusetts proposed to develop the infrastructure for Accountable Care Organizations (ACOs) that demonstrate care coordination and integration across care settings and support innovative payment strategies to reward providers for high value, patient-centered care. Utah submitted a waiver last summer to implement ACOs in its Medicaid program for this coming fiscal year.

States are also looking at initiatives to better integrate and manage care for individuals dually eligible for Medicare and Medicaid (duals). Duals account for only 15 percent of Medicaid enrollees, but 40 percent of all Medicaid costs, so there is a great deal of interest in better managing their care and costs. The ACA established new opportunities for states to better coordinate care for duals. The new CMS Medicare Medicaid Coordination Office awarded $1 million planning contracts to 15 states to establish

innovative approaches to integrate and coordinate care for duals.[19] In the fall, 37 states submitted letters of intent related to the opportunities to facilitate the coordination and integration of care for duals using a capitated or managed fee-for-service approach. In the budgets reviewed, California, Massachusetts and Oklahoma specifically mentioned care coordination for duals. California, Delaware, and Louisiana had proposals related more specifically to managed long-term care.

Several states included health homes and other targeted care management initiatives in their proposed budgets. A number of states including Colorado, Idaho, Iowa, Kansas, Maryland, Missouri, New York, Rhode Island and West Virginia mentioned health home proposals in the governors' budget proposals. Under Section 2703 of the ACA, states can establish "health homes" for persons on Medicaid who have two or more chronic conditions. States can receive a 90 percent federal matching rate for specified expenditures related to providing care through the health home for the first 8 quarters of implementation. CMS has approved 5 health home state plan amendments (SPAs) in three states: Missouri (2), Rhode Island (2), and New York. A number of other states have SPAs under review, health home planning requests or are working on plans to move forward with health homes.

Outside of health homes, several states mentioned targeted care management activities particularly around behavioral health. For example, Alaska, Louisiana, New York, and Virginia mentioned specific proposals related to either moving to or expanding the role of Behavioral Health Organizations (BHOs). Two additional states (Massachusetts and South Carolina) also proposed to enhance care coordination around behavioral health outside of the use of BHOs.

There were a number of states that proposed either expansion of or the creation of new programs to better manage the care of their beneficiaries. A number of these programs focused on reducing emergency room use (Colorado, Missouri, and Oklahoma) and better management of care around pregnancy (Michigan, Missouri, and Oklahoma). In addition, Colorado is implementing initiatives related to oral health, behavioral health, nutrition and fitness, reducing tobacco use. Massachusetts also proposed funding for a program related to pediatric asthma. Oklahoma's budget highlighted and the Chronic Disease Self-Management Program (CDSMP) designed to provide information and teach practical skills on managing chronic health problems for adults with chronic health conditions such as hypertension, arthritis, heart disease, stroke, lung disease and diabetes.

7. Long-Term Care

Consistent with recent trends, governors' budgets in at least 22 states included proposals to expand community based long-term care. Medicaid is the nation's primary payer for long-term care (LTC) services and supports both in institutions and in the community. For two decades, states have been expanding options for community based long-term care and shifting the delivery of long-term care from institutional care and into community settings. In FY 2011 and FY 2012, 32 and 33 states, respectively, took actions that expanded LTC services (primarily expanding HCBS programs). Some proposals in the governors' budgets for FY 2013 to expand community based long-term care services include additional waiver slots in Connecticut, Georgia, Iowa, Kentucky, Maryland, Michigan, New Jersey, South Carolina, Tennessee, Virginia, Washington, West Virginia and Wyoming. Additional capacity was created using Money Follows the Person funding (Connecticut, Delaware, Georgia, South Carolina and Washington), savings from the closure of institutional facilities (Illinois, Maryland, Virginia, and Washington), and new options in the ACA (the Community First Choice Option in Louisiana, Massachusetts, and Tennessee as well as the State Balancing Incentive Program in Georgia).

[19] For a summary description of proposed approaches in all 15 awardee states, see: *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS.* Kaiser Commission on Medicaid and the Uninsured, August 2011. http://www.kff.org/medicaid/8215.cfm.

Outside of Medicaid, at least 10 states allocated funds toward increased community based services and treatment for individuals with mental illness and substance abuse. Examples include Michigan, where the majority of the $3 billion allocated toward Mental Health Services are to be used to provide community mental health services, and New Jersey, which plans to fund new units of supportive housing, rental assistance for individuals receiving mental health services, and expanded psychiatric services for patients in the community. Delaware and Virginia also included plans to decrease reliance on institutional settings for individuals with developmental disabilities.

A few states proposed restrictions for long-term care including reduced rates for waiver services (Florida), delay in implementation of a waiver program for HIV/AIDS in Connecticut and some institutional long-term care closures. Tennessee has also proposed to increase the number of activities for daily living required for Medicaid beneficiaries to qualify for nursing facility care.

8. Health Information Technology

Nearly half of states outlined proposals to upgrade or make better use of technology in their Medicaid programs, frequently with the help of federal matching funds. Specifically, states focused on technology improvements in four areas – upgrading Medicaid eligibility systems, increasing the use of Electronic Health Records, modernizing Medicaid Management Information Systems (MMIS), and upgrading the coding system for billing and identifying diagnoses and diseases on Medicaid claims to comply with the International Classification of Diseases, Tenth Edition, known as ICD-10.

A number of states, including Connecticut, Idaho, Kentucky, Rhode Island, Virginia, and Wyoming, budgeted for major upgrades to their Medicaid eligibility systems in the upcoming fiscal year. Under health reform, states are expected to develop coordinated eligibility systems for Medicaid and the Exchange that will be able to determine applicants' eligibility in real time. The federal government will provide a 90 percent match to states to support these system modernizations. As of January 2012, 29 states indicated plans to begin upgrades.[20] Several state budgets included additional details about these upgrades, each of which will be funded through a 90 percent federal match rate. For example:

- Pending a decision by the Supreme Court on the ACA, **Arizona** estimated that computer systems will require modifications to manage coverage expansions and communicate with the exchange.
- **Kentucky**'s budget included plans to design, develop, and implement a new web-based system that will provide real-time determinations of applicant eligibility. The system will provide automatic verification of application information through electronic data matching with the IRS, Homeland Security, the Social Security Administration and other agencies.
- **Rhode Island** plans to create a new eligibility system for Medicaid that will function with other public assistance programs that link to the state's Health Insurance Exchange.
- **Virginia** plans to complete the modernization of the Commonwealth's social services eligibility systems. Current systems are more than 20 years old and are running on obsolete technology. The upgrade will improve error rates, improve operational efficiencies by eliminating hardcopy workflow and storage through the use of document imaging, and help meet workload pressures associated with new enrollment under health reform.

[20] Effective immediately, states can receive a 90 percent federal funding match (up from the regular 50 percent match for administrative functions and systems) for the design, development, and implementation of major upgrades or new systems. Maintenance and operating costs of these systems also may qualify for an ongoing 75 percent federal match. The intent is to help states prepare for the ACA requirement for data-driven, online, paperless systems that will deliver real-time eligibility decisions. For more information, see: *Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012.* Kaiser Commission on Medicaid and the Uninsured, January 2012. http://www.kff.org/medicaid/8272.cfm

- **Wyoming** plans to begin work on a four-year project to implement a new Medicaid eligibility System to integrate with CHIP, the Exchange, and other state agencies.

Several states are also investing in technology to increase the use of Electronic Health Records (EHR). ARRA provided incentive payments, to be paid by the Medicaid agency but which are 100 percent federally funded, to hospitals and individual providers who adopt and use EHRs in a meaningful way. Delaware began issuing incentive payments to providers for EHR use in December 2011 and proposed to expand the program to reward physicians using electronic prescribing technologies for medications. Florida proposed to invest over $235 million for the use of EHR in Medicaid in 2013.

Several states, including Delaware, Iowa, Louisiana, and Utah planned MMIS modernization activities. In addition, a few budgets highlighted plans for ICD-10 coding upgrades for billing and identifying diagnoses and diseases on Medicaid claims. Alaska, Georgia, Iowa, and Michigan, for example, allocated funds for continued changes to ICD-10 coding, which are needed for the ongoing operation of the Medicaid program. All states were previously required to implement these changes by October 2013, but the Administration recently delayed this deadline. The administration has also announced delaying the deadline for states to comply with the HIPPA 5010 requirements from January 1, 2012 to June 30, 2012, which are related to the ICD-10 changes.

States frequently cited the benefits of technology upgrades in increasing efficiencies in the Medicaid program or improving the effectiveness of services provided. Wyoming, for example, noted that Medicaid system upgrades would improve the accuracy and efficiency of the eligibility process, and in Maryland and Florida, proposed investments in technology would help control administrative costs and improve program efficiencies.

9. Program Integrity

Several states proposed new investments in initiatives to address Medicaid program integrity. A number of federal audit and program integrity initiatives have long existed in the Medicaid program to ensure that Medicaid funds do not pay for services that are the responsibility of private insurers or other payers, confirm that enrollees are eligible for services they receive, and detect fraud and abuse by providers and beneficiaries. The ACA expanded these efforts, adding a number of Medicaid program integrity provisions, including a national registry of providers terminated by any state Medicaid program and expanded MMIS data elements to detect fraud and abuse. Prompted by these requirements and a desire to recoup savings from inappropriate payments, a number of governors included program integrity measures in their proposed budgets. Some focused on hiring additional staff to support existing audit and oversight units, while others emphasized new data mining activities to verify claims and beneficiary data administratively. For example:

- As part of their Medicaid reform plan, **Kansas** is planning to implement its Kansas Eligibility Enforcement System Initiative, which will update its eligibility engine with emphasis on data matching with other agencies to prevent welfare fraud.
- **New Mexico** plans to invest $3 million in the upcoming fiscal year to modernize its Medicaid payment and fraud detection systems.

Expected savings from program integrity initiatives vary significantly across states. Virginia estimates that the expansion of its fraud detection unit will increase collections of overpayments by approximately $1.5 million annually while Colorado realized $65M in recovery efforts in FY 2011. Iowa estimates $18.6 million in state savings from efforts to recover Medicaid funds that should have been paid by other third-party payers. In a few states, savings from initiatives to reduce fraud are included as part of larger efforts to increase program efficiencies.

D. Health Reform

At the second anniversary of the passage of the ACA, states are closer to 2014 when the ACA coverage expansions go into effect along with new eligibility methodologies and systems for Medicaid that interface with new Health Insurance Exchanges. At the same time, the U.S. Supreme Court will consider the constitutionality of the individual mandate and the Medicaid expansion in the ACA. States are actively engaged in preparing to implement the ACA although much of this activity was not specifically addressed in governors' proposed budgets; biennium budgets that encompassed 2014 had more references to health reform.

Proposed budgets in Alaska, Arizona, Virginia and Wyoming included specific estimates of new enrollees as a result of the ACA. Kentucky estimated $4 million in savings in fiscal year 2013-2014 tied to the ACA provision that allows state inmates below 133 percent of the poverty level to enroll in Medicaid; the state currently covers the full cost of providing health care for this population. As mentioned earlier, a few state budget proposals (Arizona, Connecticut, Idaho, Kentucky, Rhode Island, Virginia, and Wyoming) specifically included plans to upgrade eligibility systems to help operations, process new enrollees under the ACA and access the new enhanced 90 percent match rate for these upgrades.

States are also taking up a variety of other options included in the ACA. Those with specific mentions in the proposed budgets include: the Community First Choice Option (Louisiana, Massachusetts, and Tennessee); the Health Homes option (Colorado, Idaho, Iowa, Kansas, Maryland, Missouri, New York, Rhode Island and West Virginia), and the State Balancing Incentive Program in Georgia.

In the provider rate section we mention several states including Arizona, Colorado, Louisiana, Michigan, Missouri, Tennessee, and Virginia that budgeted for the physician fee increase for primary care providers under the ACA. The governors' budget in New York included legislation to establish a New York Health Benefit Exchange, as a public benefit corporation that will serve as a centralized marketplace for the purchase and sale of health insurance, in accordance with the ACA.

Outlook

As governor's released budgets for FY 2013 states were continuing to experience the lingering effects of the recession with depressed revenues, high unemployment and budget shortfalls; however, states were also beginning to see positive signs of economic recovery. Throughout the recession and the slow recovery, Medicaid continues to play a vital role in providing health care for millions of Americans, though higher spending and enrollment from the increased demand for services continues to stretch limited state resources. To reduce pressure on state budgets, governors have proposed a wide range of Medicaid cost containment measures, including restrictions to provider rates, benefits and eligibility. Proposed budgets reflect recent trends that are focused on better care management, greater use of technology to streamline enrollment processes and manage care, and a shift to more community based long-term care. As the economy improves, some states are also making targeted investments in Medicaid, particularly to restore some provider rates. States are also preparing for the ACA coverage expansions and implementation of state Exchanges and are taking advantage enhanced federal matching dollars for some care coordination activities and development of new eligibility systems.

As of late March, 10 states, including Alaska, Arkansas, Florida[21], Maine, New Mexico, Oregon, South Dakota, Utah, West Virginia, and Wyoming have passed budgets for the upcoming fiscal year. Many more continue to be debated in state legislatures. Thus far, much of the legislative budget discussion has focused on the scope of proposed cuts. In Maine, the legislature approved a budget with a broad range cuts to Medicaid coverage for adults passed but rejected some of the most severe cuts proposed by the governor. Conversely, in Alabama and Iowa, legislators have proposed greater across-the board cuts to health services than included in the governors' proposals. In a few states such as Virginia and

[21] The legislature has passed the FY 2013 budget and sent the bill to the Governor.

Idaho, some lawmakers have discussed restoring funding to Medicaid for Medicaid services that have endured severe cuts in previous years because of large budget shortfalls.

For most states, enacted budgets will go into effect on July 1, 2012, the start of the 2013 fiscal year, and will be analyzed in greater detail in the Kaiser Commission on Medicaid and the Uninsured's annual 50-state Medicaid budget survey, to be released in the fall of 2012.

This report was prepared by Laura Snyder, Jessica Stephens and Robin Rudowitz from the Kaiser Family Foundation's Kaiser Commission on Medicaid and the Uninsured.

Table 1
Governors' Proposed Budget Sources

State	Budget Agency	Budget Type (Annual/Biennial)	Link to Proposed Budget
Alabama	Department of Finance	Annual	FY 2013 Budget Proposal
Alaska	Office of Management and Budget	Annual	FY 2013 Budget Proposal
Arizona	Office of Strategic Planning and Budgeting	Annual	FY 2013 Budget Proposal
Arkansas	Office of Financial Management	Biennial	Arkansas Budget Office
California	Department of Finance	Annual	FY 2013 Budget Proposal
Colorado	Office of State Planning and Budgeting	Annual	FY 2013 Budget Proposal
Connecticut	Office of Policy and Management	Biennial	FY 2013 Budget Proposal
Delaware	Office of Management and Budget	Annual	FY 2013 Budget Proposal
District of Columbia**	Office of the Chief Financial Officer	Annual	
Florida	Office of Policy and Budget	Annual	FY 2013 Budget Proposal
Georgia	Governor's Office of Planning and Budget	Annual	FY 2013 Budget Proposal
Hawaii	Department of Budget and Finance	Biennial	FY 2013 Budget Proposal
Idaho	Division of Financial Management	Annual	FY 2013 Budget Proposal
Illinois	Office of Management and Budget	Annual	FY 2013 Budget Proposal
Indiana*‡	Office of Management and Budget	Biennial	
Iowa	Department of Management	Annual	FY 2013 Budget Proposal
Kansas‡	Division of the Budget	Annual	FY 2013 Budget Proposal
Kentucky	Office of State Budget Director	Biennial	FY 2013 Budget Proposal
Louisiana	Office of Planning and Budget	Annual	FY 2013 Budget Proposal
Maine	Bureau of the Budget	Biennial	FY 2013 Budget Proposal
Maryland	Department of Budget and Management	Annual	FY 2013 Budget Proposal
Massachusetts	Executive Office for Administration & Finance	Annual	FY 2013 Budget Proposal
Michigan	Office of the Budget	Annual	FY 2013 Budget Proposal
Minnesota*‡	Minnesota Management and Budget	Biennial	
Mississippi	Office of Budget and Fund Management	Annual	FY 2013 Budget Proposal
Missouri‡	Office of Administration	Annual	FY 2013 Budget Proposal
Montana	Office of Budget Programming and Planning	Biennial	FY 2013 Budget Proposal
Nebraska	State Budget Division	Biennial	FY 2013 Budget Proposal
Nevada*	Division of Budget and Planning	Biennial	
New Hampshire*	Department of Administrative Services	Biennial	
New Jersey	Office of Management and Budget	Annual	FY 2013 Budget Proposal
New Mexico	Department of Finance and Administration	Annual	FY 2013 Budget Proposal
New York	Division of the Budget	Annual	FY 2013 Budget Proposal
North Carolina*	Office of State Budget and Management	Biennial	
North Dakota*	Office of Management and Budget	Biennial	
Ohio*	Office of Budget and Management	Biennial	
Oklahoma	Office of State Finance	Annual	FY 2013 Budget Proposal
Oregon*	Budget and Management Division	Biennial	
Pennsylvania	Governor's Budget Office	Annual	FY 2013 Budget Proposal
Rhode Island	Budget Office - Department of Administration	Annual	FY 2013 Budget Proposal
South Carolina	Budget and Control Board	Annual	FY 2013 Budget Proposal
South Dakota	Bureau of Finance and Management	Annual	FY 2013 Budget Proposal
Tennessee	Department of Finance and Administration	Annual	FY 2013 Budget Proposal
Texas*	Budget, Planning and Policy Division	Biennial	
Utah	Governor's Office of Planning and Budget	Annual	FY 2013 Budget Proposal
Vermont	Department of Finance and Management	Annual	FY 2013 Budget Proposal
Virginia	Virginia Department of Planning and Budget	Biennial	FY 2013 Budget Proposal
Washington	Office of Financial Management	Biennial	FY 2013 Budget Proposal
West Virginia	State Budget Office	Annual	FY 2013 Budget Proposal
Wisconsin	Division of Executve Budget & Finance	Biennial	
Wyoming	State Budget Division	Biennial	FY 2013 Budget Proposal

* indicates that the state is in the middle of a biennial budget cycle and did not propose any mid-year changes. Therefore, they were not included in this analysis. ** The District of Columbia has not yet released its FY 2013 proposed budget and is not included in this analysis. ‡ indicates that the state has an annual budget but some agencies receive biennial budgets. Minnesota has a biennial budget but some agencies receive annual budgets.

Table 2
Changes in Federal Medical Assistance Percentage (FMAP), FFY 2012 to FFY 2013

States	FFY 2012	FFY 2013	Difference
Alabama	68.62%	68.53%	-0.09%
Alaska	50.00%	50.00%	0.00%
Arizona	67.30%	65.68%	-1.62%
Arkansas	70.71%	70.17%	-0.54%
California	50.00%	50.00%	0.00%
Colorado	50.00%	50.00%	0.00%
Connecticut	50.00%	50.00%	0.00%
Delaware	54.17%	55.67%	1.50%
District of Columbia	70.00%	70.00%	0.00%
Florida	56.04%	58.08%	2.04%
Georgia	66.16%	65.56%	-0.60%
Hawaii	50.48%	51.86%	1.38%
Idaho	70.23%	71.00%	0.77%
Illinois	50.00%	50.00%	0.00%
Indiana	66.96%	67.16%	0.20%
Iowa	60.71%	59.59%	-1.12%
Kansas	56.91%	56.51%	-0.40%
Kentucky	71.18%	70.55%	-0.63%
Louisiana	61.09%	61.24%	0.15%
Maine	63.27%	62.57%	-0.70%
Maryland	50.00%	50.00%	0.00%
Massachusetts	50.00%	50.00%	0.00%
Michigan	66.14%	66.39%	0.25%
Minnesota	50.00%	50.00%	0.00%
Mississippi	74.18%	73.43%	-0.75%
Missouri	63.45%	61.37%	-2.08%
Montana	66.11%	66.00%	-0.11%
Nebraska	56.64%	55.76%	-0.88%
Nevada	56.20%	59.74%	3.54%
New Hampshire	50.00%	50.00%	0.00%
New Jersey	50.00%	50.00%	0.00%
New Mexico	69.36%	69.07%	-0.29%
New York	50.00%	50.00%	0.00%
North Carolina	65.28%	65.51%	0.23%
North Dakota	55.40%	52.27%	-3.13%
Ohio	64.15%	63.58%	-0.57%
Oklahoma	63.88%	64.00%	0.12%
Oregon	62.91%	62.44%	-0.47%
Pennsylvania	55.07%	54.28%	-0.79%
Rhode Island	52.12%	51.26%	-0.86%
South Carolina	70.24%	70.43%	0.19%
South Dakota	59.13%	56.19%	-2.94%
Tennessee	66.36%	66.13%	-0.23%
Texas	58.22%	59.30%	1.08%
Utah	70.99%	69.61%	-1.38%
Vermont	57.58%	56.04%	-1.54%
Virginia	50.00%	50.00%	0.00%
Washington	50.00%	50.00%	0.00%
West Virginia	72.62%	72.04%	-0.58%
Wisconsin	60.53%	59.74%	-0.79%
Wyoming	50.00%	50.00%	0.00%
States with Decreased FMAP			**24**
States with the Same FMAP			**15**
Sates with Increased FMAP			**12**

FY2012: Effective October 1, 2011 to September 30, 2012.Federal Register, November 10, 2010 (Vol 75, No. 217), pp 69082-69084, at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2010_register&docid=fr10no10-65.pdf.
FY2013: Effective October 1, 2012 to September 30, 2013. Federal Register, November 30, 2011 (Vol 76, No. 230), pp 74061-74063, at http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-30860.pdf.

Table 3
Medicaid Policy Changes Noted in FY 2013 Proposed Budgets

States	Provider Payment		Eligibility and Enrollment		Benefits		Rx	Cost-Sharing		Long Term Care		Care Management	HIT	Program Integrity
	+	-	+	-	+	-		Dec.	Inc.	+	-			
Alabama						x				x		x		
Alaska							x					x	x	
Arizona	x												x	
Arkansas														
California	x		x									x		
Colorado		x	x		x	x	x		x			x	x	x
Connecticut		x		x		x				x	x	x	x	
Delaware	x									x		x	x	x
District of Columbia**														
Florida		x				x	x		x	x	x		x	x
Georgia	x							x		x		x	x	x
Hawaii														
Idaho												x	x	
Illinois			x	x						x	x			
Indiana*														
Iowa							x			x		x	x	x
Kansas												x		x
Kentucky										x			x	
Louisiana	x	x				x	x			x		x	x	x
Maine		x		x		x	x							
Maryland	x				x					x	x	x	x	
Massachusetts		x	x							x		x		x
Michigan					x					x		x	x	x
Minnesota*														
Mississippi														
Missouri		x								x		x		
Montana													x	
Nebraska						x			x	x				
Nevada*														
New Hampshire*														
New Jersey										x				
New Mexico	x								x					x
New York	x				x	x						x		
North Carolina*														
North Dakota*														
Ohio*														
Oklahoma			x							x		x		x
Oregon												x		
Pennsylvania		x		x					x			x		x
Rhode Island		x				x						x	x	x
South Carolina										x		x	x	x
South Dakota	x								x					
Tennessee	x						x	x		x	x		x	
Texas*														
Utah	x											x	x	
Vermont	x		x			x	x	x	x					x
Virginia		x		x		x	x			x		x	x	x
Washington		x		x	x	x	x		x	x	x		x	
West Virginia										x		x	x	
Wisconsin									x			x		x
Wyoming	x									x			x	
Total	**13**	**11**	**6**	**6**	**5**	**12**	**10**	**3**	**9**	**22**	**6**	**25**	**22**	**17**

NOTES: "+" indicates a positive policy action from the beneficiary's perspective; "-" indicates a negative policy action from the beneficiary's perspective. For cost-sharing, "inc." indicates that the state increased cost-sharing (premiums or copays) and "dec." indicates that the state decreased cost-sharing. * indicates the state is in the middle of a biennial budget cycle and did not propose any mid-year changes; ** indicates the state is on an annual cycle but had not released a FY 2013 proposal. These states were not included in this analysis.

SOURCE: KCMU analysis of Governors' Proposed Budgets for FY 2013, March 2012.

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