Medicaid and State Budgets
Where We are….. Where We're Going

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

Joy Johnson Wilson, Health Policy Director
National Conference of State Legislatures
Before the
Illinois State Senate and House of Representatives
March 22, 2012

Where We Are…..

"States continue to grapple with the lingering effects of the Great Recession on state revenues and Medicaid spending, although many states are beginning to see signs of economic improvement. While most have avoided the need for additional mid-year budget cuts, a few states have yet to close budget gaps for FY 2012. The outlook for FY 2013 and beyond remains difficult with continued pressure to find Medicaid cuts, although few options for additional savings remain."

A Mid-Year State Medicaid Update for FY 2012 and a Look Forward to FY 2013 (February 2012), Kaiser Commission on Medicaid and the Uninsured

Federal Medicaid Policy – "THEN & NOW"

- **Medicaid - THEN**
  - **Mandatory Eligibility Categories/Optional Eligibility Categories** – States could eliminate optional eligibility categories with proper notice
  - **Provider Rates** – After the repeal of the "Boren Amendment" states had tremendous flexibility with respect to setting provider rates
  - **Mandatory/Optional Benefits and Services** – States could eliminate optional services with proper notice
- **Medicaid - NOW**
  - States cannot change **eligibility standards, methodologies, or procedures**
  - Pending rules may make it harder for states to **reduce provider reimbursement rates**
  - States are still able to reduce/eliminate optional benefits and services
  - States must replace the temporary enhanced matching funds that ended June 30, 2011

Key Medicaid Financing Mechanisms

- **Disproportionate Share Hospital (DSH) Payments** – Required supplemental payments to hospitals that serve large numbers of low-income and uninsured individuals. States have a lot of flexibility in designating which hospitals receive DSH payments.
- **Upper Payment Limit (UPL)** – Establishes a limit on Medicaid payments for which states can receive federal matching payments (FMAP). UPLs are set at an estimate of what Medicare would pay a category of provider, in the aggregate, for comparable services.
- **Intergovernmental Transfers (IGTs)** – A transfer of funds between government entities (e.g. counties to states). These funds are used to assist in matching federal funds.

Provider Taxes and Donations

- **Provider Taxes** – Taxes, fees etc imposed on or donations received from health providers.
  - **Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991** (P.L. 102-234) provides that health-related taxes and donations: (1) Apply to all health-related taxes and donations regardless of use; (2) Must be broad-based and uniform; (3) Can hold no provider harmless; and are (4) Limited to classes of providers delineated in the law or by rule.
  - **Deficit Reduction Act of 2005 (DRA)** – P.L. 109-171 - Under previous law, Medicaid managed care organizations (MCOs) were considered a separate class under the law. The DRA eliminates Medicaid MCOs as a special class. Under the new law, managed care organizations is the provider class and all entities within the class would have to be taxed.
  - **Provider Taxes and Donation Final Rule** (2010) - Replaced objective formula for calculating "hold harmless" with a subjective administrative process run by HHS staff.

Upper Payment Limit (UPL)

- In late 2000, the HHS Secretary determined that regulations in effect at that time created a financial incentive for states to make higher than usual payments for care provided at non-state government facilities (county and city facilities). States required these facilities to transfer some or all of the excess funds back to the state, which the state used to contribute to the state share of Medicaid costs and/or for other purposes.
- After HHS issued a proposed rule in October of 2000 designed to halt these practices, Congress mandated additional changes to upper payment limits in the *Benefits Improvement and Protection Act of 2000* (incorporated by reference into P.L. 106-554, FY 2000 Consolidated Appropriations Act).
- Final regulations were released by the Clinton Administration on January 12, 2001 and were later revised by the Bush Administration.
- The rule established a separate UPL for inpatient services provided by non-state government facilities based on an estimate of what Medicare would have paid for comparable services.

Other Medicaid Regulations

- **Medicaid Provider Rates** (2010)
  - Regulation pending that would require extensive reporting requirements and studies by states before a rate reduction can be imposed
- **1115 Waiver Transparency** (2012)
  - **Final rule** issued that imposes a number of public participation requirements during the 1115 waiver process
  - May increase the time it takes to get waivers approved

Key Federal Laws

- Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 - P.L. 102-234
- Deficit Reduction Act of 2005 (DRA) – P.L. 109-171
- American Recovery and Reinvestment Act (ARRA) – P.L. 111-5
- Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA) – P.L. 111-148 and P.L. 111-152 respectively

ARRA/PPACA

- **ARRA Provisions**
  - **Enhanced Match/Maintenance of Effort (MOE) -** States received enhanced match, but had to agree to maintain existing eligibility standards, methodologies and procedures.
  - **Children's Health Insurance Program (CHIP) – CHIP** became a grant condition for Medicaid participation
- **PPACA**
  - **Medicaid Expansion in 2014 and Extension of MOE, no Enhanced Match** – MOE expires in 2014 for Medicaid and 2019 for CHIP.
  - **Disproportionate Share Hospital (DSH) Payment Reductions** - $14.1 billion reduction over 10 years beginning in FY 2014.
  - **Temporary increase in payments to primary care physicians –** Medicare rates for Calendar Years 2013 and 2014.

Key FY 2013 Federal Budget Proposals

- **Blended Federal Matching Rates for Medicaid and CHIP**
  - Blends Medicaid (including enhanced match for newly eligible Medicaid beneficiaries after 2014 and CHIP into one matching rate for each state)
  - Enhanced matching for administrative services would continue
  - Proposes countercyclical assistance during economic downturns
- **Provider Taxes**
  - Phases-down the provider tax from 6% under current law to 4.5% beginning in FY 2015, 4% in FY 2016 and 3/5% in FY 2017 and thereafter
- **Medicaid Block Grants**
  - Multiple proposals are likely.

Douglas v. Independent Living Center of Southern California

- **U.S. Supreme Court - Douglas v. Independent Living Center of Southern California**
  - At issue was whether Medicaid providers and beneficiaries, including pharmacies serving Medicaid beneficiaries, could challenge state Medicaid cuts based on a private action under the Supremacy Clause of the U.S. Constitution
  - The *Douglas* case arose from three statutes the California Legislature passed in 2008 and 2009, changing that state's Medicaid plan. The first statute, enacted in February 2008, reduced by 10 percent payments that the state made to various Medicaid providers, such as pharmacies, physicians and clinics. The second statute, enacted in September 2008, replaced the 10-percent rate reductions with a more modest set of cuts. The last statute, enacted in February 2009, placed a cap on the state's maximum contribution to wages and benefits paid by counties to providers of in-home supportive services.
  - In U.S. Supreme Court remanded back to lower court

Douglas v. Independent Living Center of Southern California

- After the Supreme Court heard oral argument on October 3, 2011, CMS, which had originally denied California's proposed amendment to its state plan as inconsistent with federal law, changed course and approved several of California's statutory amendments to its state plan.
- Because of this change in circumstances, the majority in *Douglas* did not address whether the lower courts properly recognized a private cause of action based on preemption of federal law. Instead, the Supreme Court suggested that the Medicaid providers and beneficiaries could challenge the CMS determination under the federal Administrative Procedure Act (APA).
- **The Supreme Court therefore vacated the Ninth Circuit's judgments and remanded the cases back to the Ninth Circuit**.

PPACA

- **U.S. Supreme Court – Constitutionality of the Medicaid Expansion in the PPACA**
  - Question---"Does Congress exceed its enumerated powers and violate basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress's spending power that this Court recognized in *South Dakota v. Dole*, 483 U.S. 203 (1987), no longer apply?"

State Medicaid Budgets in 2012

- **What have states done?**
  - Reduced provider reimbursement rates
  - Reduced scope and/or duration or placed other restrictions on mandatory benefits and expanded the use of co-payments
  - Closed some institutions (aggressive moves to home & community-based care.
  - Eliminated or reduced optional benefits
  - Expanded managed care to additional populations and to larger areas of the state
  - Enacted reductions in education(K-12 and higher education), health and human services, and corrections to close remaining gaps

Where Are States Going

- **Integrated and Coordinated Care for Medicaid-Medicare "Dual-Eligible" Beneficiaries**
- **Medicaid Managed Care Expansions (less "carve-outs")**
- **Global Budgets/1115 Waivers**
- **Provider Reimbursement Reforms**
  - **Quality and Outcomes Oriented**
- Innovative Strategies for Behavioral Services
- Improved Management of Pharmacy Services and Durable Medical Equipment and Supplies
- Coverage of Inmates

Buzz Words for FY 2012 and Beyond

- **Key Words**
  - Transformation, Coordination, Integrated/Managed Care, Quality/Outcomes/Effectiveness, Accountability, Community-Based Systems
  - **GLOBAL BUDGETS/1115 WAIVERS**
    - Allows a state to: (1) receive FMAP for services that are don't usually qualify (2) Allows a state to build on existing state policy; and (3) provide for program growth.
- **Who's Doing It?**
  - California, **Illinois**, New York, Oregon, Rhode Island, Texas & Vermont

Illinois Coordinated Care Program

- Illinois Care Coordination Program includes:
  - Managed care expansion
    - Carves out some rural counties
      - Enhanced primary care case management
      - Voluntary expansion of approved HMOs
  - Hospital reimbursement reform
  - Provider incentives
  - Program utilization controls
  - Limit/eliminate some optional services
  - Moratoria on admission to institutional settings

Additional Illinois Savings

- **Additional Proposed Illinois Savings**
  - State-funded health programs
  - Medicaid Optional Services/Benefits
- **Observations**
  - Be sure to evaluate downstream financial, legal and political impacts of proposals
    - Elimination of adult dental services (increased hospitalizations)
    - Adult organ transplantation services
    - Elimination/reductions in services that support home and community-based care
  - Be very careful when considering reductions that might interfere with compliance with consent decrees

Joy Johnson Wilson
Health Policy Director, NCSL
Joy.Wilson@ncsl.org
www.ncsl.org - Click on “Health Reform”