CHAPTER 1

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Medicaid and the State Children's Health Insurance Program (CHIP) play significant roles in U.S. health care, with an estimated 73 million people covered by Medicaid and 8 million by CHIP in fiscal year (FY) 2012. These individuals primarily include low-income children and their families, children and adults with disabilities, and low-income seniors. Together, these joint federal-state programs cover nearly half of the nation's children for at least part of the year, over 6 million seniors, and about 10 million persons with disabilities. In addition, reflecting the diversity of needs in the populations it covers, Medicaid provides benefits—most notably long-term services and supports (LTSS)—not typically offered (or not covered to the same extent) by other payers, including Medicare and CHIP.

As major purchasers of care, Medicaid and CHIP accounted for 15.5 percent of national health care spending in 2011. In addition to financing services for enrollees, these programs help finance the nation's health care safety net and reduce the burden of uncompensated care for certain providers (MACPAC 2013, 2011).

As MACPAC presents this report to the Congress, the fifth since its inaugural report in March 2011, Medicaid and CHIP are at a critical juncture in their evolution. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), although not fully implemented, is already changing integral aspects of Medicaid and CHIP as well as the landscape of the broader health care system. Medicaid is on the cusp of a major eligibility expansion that will heighten its role as a major purchaser of health services. At the same time, Congress is considering the future of CHIP, a program that interacts with Medicaid and, as of 2014, the subsidized coverage offered through newly created health insurance exchanges.

Continued growth in health care spending, a challenge for all payers of health services, is a major focus for federal and state policymakers charged with administration and oversight of Medicaid and CHIP. At a time of heightened concerns about state and federal budgets, this growth has created renewed pressure to pursue delivery system and

payment innovations that can enhance program efficiency and promote better health outcomes. And as the baby boom generation begins to retire, Medicaid faces new pressures with respect to the financing and delivery of LTSS, for which it is the predominant payer.

In this report, MACPAC presents analyses related to four issues facing Medicaid and CHIP: (1) interactions among Medicaid, CHIP, and new exchange coverage related to eligibility, (2) the growing population of persons served by both Medicare and Medicaid (referred to as dual eligibles), (3) Medicaid policies for payment of Medicare premiums and cost sharing, and (4) improving Medicaid payment methodologies for integrated care plans that combine acute care and long-term services and supports. This chapter explores how these issues fit into the larger context of Medicaid and CHIP program improvements, focusing on how issues affecting health care in the U.S. are influencing the two programs.

Implementing the Patient Protection and Affordable Care Act

At its enactment in 1965, Medicaid initially offered coverage to low-income families with children, persons with disabilities or blindness, and seniors. Over the years, the Congress has made numerous changes to the program in terms of eligibility, covered services, and financing. In addition, CHIP was enacted in 1997 to offer health coverage to many low-income children who were uninsured at that time. While smaller than Medicaid in terms of enrollment and spending, CHIP has had a great impact on uninsurance for children: while 22.8 percent of children were uninsured in 1997, only 9.7 percent were uninsured in 2012 (Martinez and Cohen 2012).

Implementation of the ACA will be one of the most fundamental changes in Medicaid since its enactment. The ACA has the potential to expand Medicaid eligibility in 2014 to nearly all adults with income up to 138 percent of the federal poverty level (FPL, $15,856 for a single person in 2013), and is expected to expand Medicaid and CHIP coverage by 8 million people in 2014—most of them low-income adults (CBO 2013a, CBO 2013b).

Even in states that choose not to expand Medicaid coverage, the coordination of eligibility and enrollment systems among Medicaid, CHIP, and the exchanges is also expected to increase the enrollment of individuals into Medicaid and CHIP for those who were previously eligible but not enrolled in the programs. This is sometimes referred to as the "woodwork" or "welcome mat" effect.

The ACA also creates a federal subsidy program for individuals not eligible for Medicaid but with income below 400 percent FPL to purchase health insurance through health insurance exchanges. For Medicaid and CHIP, the existence of exchange coverage will create new market dynamics with potentially wide-ranging effects on individuals, providers, and health plans, as well as states and the federal government.

For Medicaid program administrators, implementing the 2014 eligibility expansion and managing the policy and operational interactions with exchange coverage are a high priority in 2013 (KFF et al. 2013). States are on the front line of the expansion, with numerous operational, policy, and financing issues at the forefront of their agendas. In addition to preparing to enroll a large number of new individuals, states are redesigning and upgrading information technology systems to determine eligibility and share information with health insurance exchanges; implementing new eligibility policies and procedures; and planning for

longer-term funding of the expansions (NASBO 2012).

Of particular concern to policymakers is how the use of new income determination methodologies for Medicaid and CHIP will affect eligibility and enrollment. Issues of importance include the accuracy of such income determinations; the number of individuals who will move from one source of coverage to another and how frequently; and the potential impact on families whose members have different sources of coverage, including different benefits, cost-sharing requirements, and provider networks.

Addressing Growth in Program Spending

Like Medicare and private payers, Medicaid and CHIP face spending pressures. Total federal and state spending on Medicaid was $436 billion in FY 2012 (MACStats Table 6). Overall health care spending growth has moderated in recent years, and Medicaid spending grew by only about 1 percent between FY 2011 and FY 2012. Factors contributing to slower Medicaid spending growth included state efforts to slow spending, lower enrollment growth during the period, and expiration of a provision that temporarily increased the federal financial contribution for Medicaid (Truffer 2013). In FY 2012, 48 states implemented at least one Medicaid cost-control measure and 47 had plans to do so in FY 2013 (Smith et al. 2012).

However, factors including enrollment growth and the increasing cost of Medicaid benefits per beneficiary will lead to Medicaid spending growth in the coming years. Federal outlays for Medicaid are expected to rise over the next decade, from 1.8 percent of gross domestic product (GDP) in 2014 to 2.2 percent in 2023. In comparison, CBO expects Medicare to grow from 3.0 to 3.5 percent of GDP over the same period (CBO 2013b). Concerns about federal spending generally have created renewed scrutiny on all entitlement programs.

Medicaid and CHIP also account for a large and rising share of state budgets (NASBO 2012). The state share of Medicaid spending accounted for 13.4 percent of state-funded budgets in state fiscal year (SFY) 2011 (MACStats Table 15). This was up from 12 percent in SFY 2010, partly due to the expiration of the temporary increase in Medicaid funding (MACPAC 2013). Such growth is of particular concern to governors and state legislators given that states are required to balance their budgets each year.

Medicaid officials have relied on a number of blunt strategies for moderating costs, including restricting eligibility (a practice limited under the ACA), reducing or slowing the rate of growth in payments to providers, and tightly managing covered benefits. For some states, these strategies may have reached their limits. Instead, Medicaid programs are seeking better value by pursuing more creative ways to meet the health needs of the program's diverse populations while creating incentives for more efficient use of high-quality services.

This move toward prudent purchasing is not new; over the years, Medicaid and CHIP have pursued many strategies including enrolling populations into comprehensive risk-based managed care and primary care case management and implementing medical homes. Today, programs are also testing innovative payment approaches, including tying payment to health outcomes, exploring new models for bundled and global payments, and expanding the reach of risk-based managed care from low-income children and parents to populations with more extensive health care needs. The policy focus is particularly intense for the dual-eligible population, who, while accounting for

a relatively small share of total Medicaid enrollees account for a large amount of program spending, particularly for LTSS (see Chapter 3). A number of states and the federal government are working together on financial alignment demonstrations that will extend the use of risk-based managed care for dual eligibles. The diversity of the dually eligible population in terms of their health needs, service use, and spending patterns, however, may suggest that careful thought and planning are needed as strategies are developed.

Analysis to Frame and Support Congressional Decisions

The policy context for Medicaid and CHIP, as well as continued pressure to ensure a sustainable path for program spending while meeting the health needs of the low-income populations served by the two programs, provide the backdrop for MACPAC's consideration of the policy issues in this report.

With a mission to assist Congress in examining Medicaid and CHIP issues and to provide evidence-based, data-driven, non-partisan information and recommendations for program improvement to the Congress, the Secretary of the U.S. Department of Health and Human Services, and the states, MACPAC has sought in this report to build on the foundational, largely descriptive work undertaken during the Commission's start-up period. The Commission's initial reports describe many key features of Medicaid and CHIP including financing and payment; access to care for children and adults; the role of managed care; a profile of services, spending, and quality measures for persons with disabilities; program integrity; and data for program management and monitoring; as well as MACStats data supplements. Building on a sound analytic foundation, the Commission looks forward to offering the Congress more in-depth analyses and recommendations going forward.

As the 113th Congress weighs the issues facing Medicaid and CHIP, this MACPAC report provides information on and analyses of four key issues as well as state-specific Medicaid and CHIP data and program information:

- **Medicaid and CHIP interactions with exchange coverage related to eligibility.** The expansion of Medicaid coverage to adults with incomes up to 138 percent FPL and implementation of the new income counting methodology (known as modified adjusted gross income or MAGI) raise a number of policy issues, explored in Chapter 2. For example, small changes in income may lead to individuals changing coverage between Medicaid and subsidized exchange coverage, a phenomenon known as churning. The chapter examines the extent and impact of churning and includes a recommendation to the Congress to minimize churning by permitting states to implement 12-month continuous eligibility for adults in Medicaid and children in CHIP.

  Additionally, the chapter reviews the historical experience and rationale for Transitional Medical Assistance (TMA), a program that provides additional months of Medicaid eligibility for certain individuals whose incomes increase. TMA may no longer be needed, given the availability of exchange coverage with premium tax credits and cost-sharing reductions for individuals whose incomes are too high for Medicaid. The Commission makes recommendations regarding the future of TMA in the context of the Medicaid expansion.

- **Service use and spending patterns for persons dually eligible for Medicare and Medicaid.** Dual eligibles are a diverse group with service needs that vary widely. Chapter 3 examines that diversity by exploring their service use and spending based on their use of LTSS. The data confirm that a small number of enrollees with substantial need for LTSS drive Medicaid spending for full-benefit dual eligibles. This spending and service use analysis illustrates the need for delivery system and payment solutions that are targeted to specific subgroups of the dually eligible population.
- **State Medicaid policies for payment of Medicare premiums and cost sharing.** Chapter 4 examines one aspect of the interaction between Medicaid and Medicare in serving low-income individuals for whom Medicare is the primary payer: Medicaid's coverage of Medicare premiums and cost sharing. To date, there has been no single source of information on state policies for Medicaid payment of Medicare cost sharing. MACPAC undertook this analysis to better understand the array of state policies and to lay the foundation for future work on this topic including how payment policies may affect access to care for dual eligibles. The results of that work are presented here, along with details of the eligibility and benefits available to partial-benefit dual eligibles whose higher incomes qualify them for varying levels of assistance in paying Medicare premiums and cost sharing.
- **Medicaid rate setting for integrated managed care plans serving dual eligibles.** As states and the federal government continue to pursue integrated care delivery models for dual eligibles, payment adequacy and accuracy are key issues. Chapter 5 explores the details of capitation rate development and refinement for high-cost, high-need enrollees, focusing on the complexities of accounting for LTSS use.
- **MACStats.** A standing supplement to MACPAC reports, MACStats features state-specific data on Medicaid and CHIP enrollment, spending, income eligibility levels, enrollee characteristics, and other program features.

Looking Forward

MACPAC has already begun the process of analyzing issues that it will share with the Congress in June of this year and in subsequent reports. Through its own analyses of Medicaid administrative data, efforts to collect information not readily available from existing sources, consultation with states and others expert in the Medicaid and CHIP programs, and review of the research literature, MACPAC will be developing more in-depth analyses on a number of issues over the coming year, including:

- further examination of the new market created by the ACA; interactions among Medicaid, CHIP, and exchange coverage;
- new analyses of populations such as persons with disabilities and dual eligibles who have high rates of service use and spending, to inform program improvements that could lower cost growth and improve quality;
- consideration of the future of CHIP;
- analyses on supplemental payments for institutional providers;
- an assessment of Medicaid waivers;
- identification of gaps in data availability, consistency, and quality to ensure that timely information is available for program management and policy development; and
- additional attention to program integrity efforts, including developing a better

understanding of the effectiveness of individual programs, how federal and state agencies are coordinating their efforts, and the impact of new program integrity activities created by the ACA—an issue particularly relevant with the substantial expansion of Medicaid in 2014.

MACPAC plans to focus special attention on the future of CHIP given that, under current law, no federal CHIP funding is available after FY 2015. Whether Congress extends CHIP funding and, if not, how children enrolled in CHIP will transition into either Medicaid or exchange coverage remains to be seen (MACPAC 2013).

The Commission also plans to spotlight the role of Medicaid and CHIP with respect to maternity care, oral health, and behavioral health. The Commission will continue work related to access to care for Medicaid and CHIP enrollees, consistent with its statutory charge. MACPAC will continue to support congressional deliberations by providing objective and data-driven analyses on these and other issues.

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