

## Health Reform Law Creates New Opportunities for States to Save Medicaid Dollars

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**Health care reform offers opportunities for cash-strapped Medicaid programs to save money and get extra federal dollars. Amid the budget shortfalls that most states are experiencing, state policymakers should carefully consider the new opportunities presented by health care reform and direct their resources to those that will both improve health outcomes and services and realize cost savings or efficiencies.**

### Introduction

After making steep cuts during their 2009 through 2011 budget cycles, states continue to experience budget problems. Recent projections indicate that 44 states and the District of Columbia will see budget shortfalls during fiscal year (FY) 2012, which begins July 1, 2011, in most states.<sup>1</sup> In many states, increased Medicaid enrollment caused by the recession is a significant contributor to these deficits. The new health reform law—the Patient Protection and Affordable Care Act (ACA)<sup>2</sup>—provides opportunities for cash-strapped states to find savings in the Medicaid program and to take advantage of grant and demonstration opportunities that enable them to receive additional federal dollars. One of the opportunities will not be available until 2014, when the new law takes effect. The remaining opportunities are available for states to consider immediately. This Insight on the Issues explores some of these opportunities and is intended to serve as a tool for state health policymakers as they consider what the new law has to offer.

In response to the impact of the recession on state economies, the American Recovery and Reinvestment Act (ARRA) of 2009 provided states with extra federal funds to help defray their Medicaid costs through December 2010.<sup>3</sup> Another law extended the enhanced federal ARRA funding through June 2011.<sup>4</sup> In return for these extra federal dollars, ARRA imposes a maintenance of effort (MOE) requirement on states under which they are required to maintain Medicaid eligibility levels that were in effect as of July 1, 2008, until the end of June 2011.<sup>5</sup>

### The Maintenance of Effort Requirement in the Health Reform Law

In addition to the maintenance of effort (MOE) requirement imposed by ARRA (see text box), the ACA creates a new mandatory Medicaid expansion to additional populations and provides extra federal funds to states to finance

the expansion.<sup>6</sup> The law imposes an additional MOE requirement in return for the enhanced funding. The health reform MOE requires states to maintain the eligibility and enrollment policies and procedures that were in effect on March 23, 2010 (the date of enactment of the ACA).

On February 25, 2011, the Centers for Medicare & Medicaid Services (CMS)—the federal agency that administers the Medicaid program—issued a State Medicaid Director Letter and an associated Q&A Document related to the MOE requirement in the ACA.<sup>7</sup> The letter reinforced the policy that states cannot cut eligibility levels, increase premium or enrollment fees, or use more restrictive enrollment policies. And, unlike the MOE associated with ARRA, the MOE requirement in the ACA applies to children in the Children's Health Insurance Program (CHIP) as well as Medicaid enrollees. The MOE for adults ends on the date the Secretary of the Department of Health and Human Services (HHS) determines that the new health insurance exchanges—competitive health insurance marketplaces—are fully operational (presumably January 1, 2014); for children in Medicaid and CHIP, the MOE ends October 1, 2019.

An exception to the MOE requirement in the ACA would allow a state to certify to the Secretary that it has or projects a budget deficit for the current or following state fiscal year. The certification period is limited to January 1, 2011, through December 31, 2013. This exception limits states to eligibility changes for persons with income above 133 percent of poverty who are not pregnant or disabled.<sup>8</sup>

Faced with the steepest decline in state revenues since the Great Depression, increased demand for publicly funded services—including Medicaid—and the end of enhanced federal Medicaid

available to states under an extension of ARRA,<sup>9</sup> states are desperately seeking ways to deal with budget shortfalls and meet their constitutional obligations to balance their budgets. Many states have already made cuts to their Medicaid programs, and more cuts are being contemplated. In addition, at least one state (Arizona) has submitted a request to CMS for a waiver of the MOE requirement in the ACA so that the state can drop 280,000 people from its Medicaid program.<sup>10</sup> Unlike most other states, Arizona is allowed to end coverage of many adults without running afoul of the MOE, since Arizona has a scheduled expiration of a Section 1115 waiver that provided expanded coverage for a time-limited period.<sup>11</sup>

While not directly responding to the broader request from states for relief from the MOE, on February 3, 2011, the Secretary of HHS released a letter to governors reminding them of the existing flexibilities available to manage their Medicaid programs efficiently.<sup>12</sup> The strategies identified include taking advantage of opportunities to leverage enhanced federal matching dollars, modifying optional benefits, imposing higher cost sharing on beneficiaries (within limits), purchasing prescription drugs more efficiently, managing high-cost beneficiaries more efficiently, and increasing efforts to eliminate fraud and abuse.<sup>13</sup>

In addition to these flexibilities, the recently enacted ACA provides a number of new opportunities for states to realize Medicaid savings without having to make cuts that hurt low-income people or severely limit access by deepening cuts in provider payments. These opportunities, which exist on both the acute and long-term care sides of the Medicaid program (with some overlap depending on the program), are discussed below.

While we recognize that state Medicaid programs are under a great deal of stress to comply with a myriad of federal requirements (including planning for the implementation of ACA provisions), and many agencies are woefully short staffed, we offer these options as strategies to consider both now (if it makes financial sense) and in the future when state fiscal situations improve.

- Taking up the state option to implement freestanding birthing centers
- Participating in the Medicaid Emergency Psychiatric Demonstration
- Implementing Medicaid program integrity initiatives (mandatory provision)

### New Opportunities for Acute Care Medicaid<sup>14</sup>

#### Overview

The ACA provides a number of opportunities on the acute side of the Medicaid program for states to realize savings or gain access to extra federal dollars to serve beneficiaries. While there are some mandatory program changes, the majority are options for states to consider. These opportunities are as follows:

- Recategorizing certain adults as newly eligible for the Medicaid expansion group
- Reducing state and locality costs associated with uncompensated hospital care
- Taking up the health home option
- Taking advantage of the incentive in Medicaid to prevent chronic diseases
- Taking advantage of the state demonstration to integrate care for dual eligibles
- Taking up the state option to eliminate cost sharing for preventive services
- Implementing the federal prohibition on payment for hospital-acquired conditions (mandatory provision)
- Taking up the family planning option

#### Recategorizing Certain Adults as Newly Eligible for the Medicaid Expansion Group

Beginning January 1, 2014, the ACA requires states to provide Medicaid benefits to individuals with income at or below 138 percent of the federal poverty level (FPL) who are not pregnant; are under age 65; are not enrolled in or eligible for Medicare; and are not currently receiving access to the full Medicaid benefit package. The remaining group of people with income at or below 138 percent of the FPL will fall into a catchall Medicaid eligibility category designated for people who are called *newly eligible*.

The law defines *newly eligible* for the purpose of identifying Medicaid-covered individuals who are eligible for enhanced matching funds. The federal government will cover 100 percent of their Medicaid costs from 2014 through 2016, phasing down to 90 percent by 2020. For purposes of the enhanced match, the newly eligible are those with income at or below 138 percent of the FPL who—

- Are between ages 19 and 65;
- Were not receiving the full Medicaid benefit package (or a benchmark equivalent benefit package) under the state plan or a waiver as of December 1, 2009; or

- Are eligible for, but not enrolled (or are on a waiting list) for waiver services.

Beginning in January 2014, states will be required to code their eligibility systems to account for those who become newly eligible as a result of the ACA's Medicaid expansion requirement. Some states will benefit financially from this requirement by reclassifying certain individuals as newly eligible and thus receiving the enhanced federal match for them. These individuals are those who were receiving a limited Medicaid benefit package or who were subject to an enrollment cap.

The following populations would be eligible for the enhanced federal payment:

- People who qualify as medically needy in states that do not offer this group the full Medicaid benefit package<sup>15</sup>
- Adults who qualify for Medicaid under a Section 1115 waiver that allows the state to provide them with a limited benefit package
- Adults with tuberculosis, breast cancer, or cervical cancer who now receive a limited Medicaid benefit targeted at curing their condition
- Adults who are on waiting lists to receive waiver services

Although the final rules on the newly eligible provision have not yet been promulgated, states can begin to identify groups that fit within the definition of the law and could potentially qualify as newly eligible for purposes of the enhanced federal match.

### **Reducing State and Local Costs Associated with Uncompensated Hospital Care**

Uncompensated care is health care that is not fully paid for, either directly by

the patient or by an insurance payer.<sup>16</sup> Because millions of people will have access to health insurance as a result of the ACA, federal, state, and local uncompensated care costs should be markedly reduced. The Medicaid program contributes to the cost of uncompensated care in two ways. First, the program provides disproportionate share hospital (DSH) payments to hospitals. A state's Medicaid program makes DSH payments to hospitals that the state designates as serving a disproportionate share of low-income or uninsured patients. A portion of these DSH funds is used to pay for uncompensated care.<sup>17</sup> States contribute to DSH payments, and the federal government matches these payments.<sup>18</sup> Medicaid also contributes to the cost of uncompensated care through supplemental provider payments or the upper payment limit program used by most states. This program allows states to provide additional funds to selected classes of hospitals by raising their Medicaid rates above the average Medicaid payment rates, but not higher than Medicare levels.<sup>19</sup>

In 2008, the estimated cost of uncompensated care was \$57.4 billion, with public funds financing \$42.9 billion or about 75 percent of the cost.<sup>20</sup> Of this amount, \$17.2 billion is attributable to direct state and local government payments for uncompensated care.<sup>21</sup> For the period 2014–2019, it is projected that \$170.2 billion will be attributable to state and local spending on uncompensated care.<sup>22</sup> A portion of this amount will still be needed to match DSH payments (which will decrease over time under the ACA as more people become insured) and provide support for a smaller but much-needed safety net for those who remain uninsured. Thus, the recovery of 25 percent in state and local spending on uncompensated care would result in a savings of \$42.6 billion for states and localities; if half the money is recovered, states and localities would save \$85.1 billion.<sup>23</sup>

### Taking up the Health Home Option

Section 2703 of the ACA gives state Medicaid agencies the option to establish health homes (also known as medical homes) for certain Medicaid beneficiaries with specified chronic conditions using the State Plan Amendment (SPA) process.<sup>24</sup> The overarching goals of health homes are coordination, efficiency, economy, and quality of care, with a focus on the whole person.<sup>25</sup>

The ACA defines a health home as a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by the individual. Eligible individuals are those who—

- Have at least two qualifying chronic conditions;
- Have one qualifying chronic condition and are at risk for having a second chronic condition; or
- Have one serious and persistent mental health condition.<sup>26</sup>

Health home providers are required to coordinate care across settings; provide case management; collaborate with patients and caregivers; facilitate referrals to community services; provide quality, cost-effective, culturally appropriate, patient/family-centered care; and use health information technology as appropriate.<sup>27</sup>

Beginning January 1, 2011, the federal government provides states with up to \$25 million for planning activities related to the development of an SPA for a health home.<sup>28</sup> These funds must be matched at the state's pre-Recovery Act federal medical assistance percentage for medical expenses. Once the health home option is approved and implemented, states will receive an enhanced federal medical assistance percentage (FMAP)

of 90 percent for the first eight fiscal quarters that the health home SPA is in effect; thereafter, states revert to their regular FMAPs. As of May 25, 2011, CMS had approved planning requests from eight states: Arizona, Arkansas, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, and West Virginia.<sup>29</sup>

Because dual eligibles—those eligible for both Medicare and Medicaid—are the poorest, sickest, and most costly Medicaid beneficiaries, state policymakers should consider them an ideal target population for the health home option. But because Medicare is the primary payer for the care of dual eligibles—covering their primary care, inpatient hospital, and subacute care—states will likely not realize much savings by selecting duals for the health home option. One possible remedy is for the federal government to work with states to identify a strategy for them to share in any savings that accrue to the Medicare program as a result of the health home option. The federal government has already approved some demonstration projects that are testing the shared savings model.<sup>30</sup> The outcome of these experiments could lead to more opportunities for Medicaid to share in Medicare savings.

States can also realize savings by taking up the option with a focus on high-cost Medicaid beneficiaries who are not dual eligibles and who are able to participate in their care. Examples of these populations include the following:

- Non-dual eligibles with high mental health costs (e.g., persons with developmental disabilities who do not have a qualifying work record)
- Non-dual eligibles for whom there are evidence-based best practices for reducing unnecessary hospitalizations<sup>31</sup>

States will potentially save more money by focusing on non-dual eligibles than by focusing on duals, because the savings associated with avoiding hospitalizations for duals will typically accrue to the Medicare program, not Medicaid. This could change if CMS designs the program in a way that will allow Medicaid to share in the Medicare savings. However, before taking up the option, states need to consider whether they have the resources to implement and monitor their programs once they reach the implementation phase and whether they will have the financial resources to sustain their efforts after the 90 percent FMAP is no longer available.

#### **Taking Advantage of the Incentive in Medicaid to Prevent Chronic Diseases**

Section 4108 of the ACA appropriates \$100 million over five years (beginning January 1, 2011) in grants to states to provide incentives to Medicaid beneficiaries to adopt healthier lifestyles. CMS will cover the entire cost of these programs for services not otherwise covered by Medicaid. Up to 15 percent of the grant funds may be used for state administrative costs. Reimbursable administrative costs include key staff, grant-related travel, training, outreach and marketing, and information technology infrastructure development. The overall purpose of the initiative is to test approaches that may encourage behavior modification among the Medicaid population and develop scalable solutions.<sup>32</sup>

The Medicaid state agency is required to be the lead applicant for the grant project. However, states are allowed to implement their programs through arrangements with Medicaid providers, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes, or other organizations.<sup>33</sup> In addition, states are

allowed to partner with their substance abuse and public health agencies.<sup>34</sup>

States must commit to at least a three-year program, and conduct outreach and education campaigns to make providers and Medicaid beneficiaries aware of the program.<sup>35</sup> State Notices of Intent were due to CMS by April 4, 2011; applications were due by May 2, 2011; and grant awards will be announced on August 1, 2011. The grant period of performance will be August 1, 2011 through December 31, 2015.<sup>36</sup> Although the grant application deadline has passed, Congress might renew the program if it proves successful at modifying health behaviors while saving Medicaid dollars. In addition, states that are not participating in the program can monitor the progress of participating states and benefit from their lessons learned.

The initiatives—called the Medicaid Incentives for Prevention of Chronic Diseases programs—must be comprehensive, evidence-based, widely available, and easily accessible, and address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or improving diabetes management.<sup>37</sup> Incentives to beneficiaries may include direct cash incentives, supplemental preventive and support services not otherwise Medicaid covered, free goods, transportation support, or reduced Medicaid program fees. Incentive payments may be made directly to participants or to family members, friends, or community agencies that support and facilitate a participant's preventive program attendance.<sup>38</sup>

Analysts have suggested that significant reductions in the need for health care are an important component of bringing health care costs under control. This program seeks to do just that. Because the program is funded 100 percent by

the federal government, it offers states a risk-free opportunity to improve the health of a population while, at the same time, mitigating the impact of any cost-sharing increases imposed on beneficiaries. In addition, it gives states the opportunity to target high-cost populations for interventions that, if successful, could significantly decrease Medicaid costs over time.

In deciding whether to take advantage of this program, states should consider whether they have the resources to manage the required outreach and education component of the grant. In addition, resources will be needed to track beneficiary participation and outcomes, collect individual-level data and transmit such data to CMS, perform state-level evaluations, and develop mandatory program evaluation for the Secretary of HHS.

### **Taking Advantage of State Demonstrations to Integrate Care for Dual Eligibles**

Dual eligibles are the poorest and sickest of all Medicare beneficiaries, accounting for 15 percent of Medicaid enrollment but close to 40 percent of program spending.<sup>39</sup>

The ACA created the Center for Medicare & Medicaid Innovation (Innovation Center) to explore new approaches to pay for and deliver health care in ways that will enhance quality, improve health outcomes, and lower costs. In addition, the ACA created the Federal Coordinated Health Care Office (Office of the Duals) to support the design and implementation of innovative strategies to coordinate care for dual eligibles.

The Innovation Center, in partnership with the Office of the Duals, recently released a request for proposals for State Demonstrations to Integrate Care for Dual Eligible Individuals. The goal of the demonstrations is to identify and validate

delivery system and payment integration models that can be rapidly tested and, if successful, replicated in other states.

Under phase one of the contract process (the design phase), 15 states have been selected to receive up to \$1 million each to develop proposals for innovative models. The states that were awarded design contracts are California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. The models that states develop must include interventions that improve quality, care coordination, and cost-effectiveness.

Phase two is the state implementation phase, during which states will implement approved models. The receipt of a program design contract does not guarantee support for the implementation phase.<sup>40</sup> States that are approved for the implementation phase will receive federal funding to prepare state infrastructure for conducting the model demonstration. Development and infrastructure costs may include systems change costs at the state level for testing a new payment approach, development of a more efficient data exchange feed for near real-time tracking of claims, and additional resources necessary to ensure successful demonstration of the implementation.<sup>41</sup>

This demonstration provides states with the opportunity to develop and implement programs that, if successful, could help them rein in the high costs of providing care to dual eligibles. This is especially the case for states that design programs that integrate Medicare and Medicaid dollars into a single system of care that would allow Medicaid to share in the savings that accrue to Medicare. The Medicare Payment Advisory Commission—an independent congressional agency that advises Congress on issues affecting the Medicare program—has concluded

that combining Medicare and Medicaid financing streams is a prerequisite to fully aligning provider and program incentives in a way that results in better care coordination for dual-eligible beneficiaries.<sup>42</sup>

Even though the 15 states have already been selected for the design phase of the program, they will still have to decide whether they have the resources to engage during the implementation phase. States that can design demonstrations that combine enhanced federal funding associated with the health homes demonstration (especially if they are allowed to share in the Medicare savings) with funding from the state demonstration to integrate care could realize tremendous savings related to care for dual eligibles. Presumably, the states that have been awarded contracts have the human resources to commit to the project. Those that make it to the implementation phase will receive additional federal funding to develop the infrastructure to support their programs.

### **Taking up the State Option to Eliminate Cost Sharing for Preventive Services**

Cost sharing has been shown to decrease use of preventive services.<sup>43</sup> The ACA seeks to lower this barrier by giving states the option to make certain preventive services and immunizations available to Medicaid beneficiaries without cost sharing beginning January 1, 2013.<sup>44</sup> States that elect the option will receive a one percentage point FMAP increase. Although the increase might seem insignificant, states should carefully consider the consequences of not treating preventable illnesses, and the potential downstream savings that screening and vaccines may offer.

Take, for example, colon cancer screening. The ACA mandates that all states provide Medicaid to people with income at or below 138 percent of the FPL, beginning

January 2014. When this coverage expansion begins, a significant number of adults are expected to enroll in the program, many of whom will be between ages 50 and 64. It is recommended that people begin colon cancer screening at age 50. The costs of treating a single case of colon cancer—which might have been prevented by an appropriate screening<sup>45</sup>—can range from \$30,000 for early stage cancers to more than \$120,000 for those caught at a later stage.<sup>46</sup> The average cost of a screening colonoscopy in a physician's office is \$395.83.<sup>47</sup>

In considering whether to elect this option, states should carefully review estimates of the numbers of older (pre-Medicare) adults their program expects to serve, determine whether they have the resources to conduct effective outreach to encourage people to use the prevention benefit, and evaluate the adequacy of the provider networks available to deliver the services. States that do not take up the option right away may want to consider monitoring their utilization data to determine whether they are paying for an inordinate number of inpatient hospitalizations related to vaccine- or screening-preventable illnesses. Such information could provide an impetus to implement the option.

### **Implementing the Prohibition on Payment for Health Care-Acquired Conditions**

Every year, billions of dollars are spent on remediating preventable health outcomes. The National Quality Forum—a nonprofit organization whose mission is to improve the quality of American health care—publishes a list of serious reportable events (commonly referred to as *never events*).<sup>48</sup>

To address the growing problem of preventable reportable events, the Deficit Reduction Act (DRA) of 2005<sup>49</sup> established the Medicare hospital-acquired condition (HAC) program,



under which certain conditions are not Medicare reimbursable.<sup>50</sup> These conditions are those that (1) are associated with high cost of treatment or high occurrence rates within hospital settings; (2) are coded as complicating conditions that result in higher payments to the facility when submitted as a secondary diagnosis; and (3) can be reasonably prevented by adherence to evidence-based practice guidelines.<sup>51</sup>

Contemplating that hospitals might attempt to bill denied Medicare claims to Medicaid if the patient is a dual eligible, the DRA gave state Medicaid agencies the option to deny payment as well.<sup>52</sup> As of February 17, 2008, nearly 20 states had eliminated, or were considering eliminating, payment for some or all never events, and one state was using a “medically unnecessary” standard to deny payment.<sup>53</sup>

Section 2702 of the ACA creates a mandatory health care-acquired conditions (HCAC) initiative in Medicaid, effective July 1, 2011. The law defines HCACs as medical conditions that could have been identified by a secondary diagnosis code that is not related to the primary purpose of the medical encounter. On February 17, 2011, CMS published a proposed rule to implement the HCAC provision.<sup>54</sup> The rule proposes to give states the flexibility to go beyond the Medicare requirement and deny payment in other venues besides inpatient hospital settings. The policy would also apply to Medicaid-contracted managed care organizations. The law also requires the secretary of HHS to implement the HCAC provision in a way that does not result in a loss of access to care or services. The rule addresses this issue by proposing that payment reductions be limited to amounts directly linked to the provider-preventable condition and resulting treatment.<sup>55</sup>

When Medicaid payment systems are coded to take into consideration this new payment policy, this provision is likely to result in improved quality of care as well as savings for Medicaid. This is especially the case since the regulation proposes allowing states to deny payment across multiple care settings. In addition, this policy will allow states to track adverse events and focus resources on those that occur most frequently. Some administrative costs (which are matched with federal dollars) will be associated with implementing this policy. But, over time, states should be able to realize savings by not having to pay for untoward health conditions acquired in medical settings.

### **Taking up the Family Planning Option**

Half of all pregnancies in the United States are reported by the mother as being unintended; and more than half of these are to unmarried women in their twenties. Rates of unplanned and teen pregnancy are higher among young unmarried women and lower-income women.<sup>56</sup> Unintended childbirth, especially among teens, has serious social and economic consequences, including increased rates of poverty and reliance on public assistance. In addition, multiple, closely spaced pregnancies or births contribute to increased rates of maternal and infant morbidity and mortality.<sup>57</sup>

Recognizing the importance of family planning services in helping women avoid the consequences of unintended pregnancies, beginning in 1972 Congress required states to provide family planning services and supplies to Medicaid-eligible populations, with the federal government paying 90 percent of the cost.<sup>58</sup> Since then, studies have documented the effectiveness of the services in helping women avoid unintended pregnancies, while at the same time saving federal and state dollars (see text box).<sup>59</sup>

Federal law distinguishes between family planning services and supplies and family planning-related services. Family planning services and supplies are reimbursed at a 90 percent FMAP, and providers and plans are not allowed to charge any cost sharing. On the other hand, family planning-related services are reimbursed at the state's regular FMAP.<sup>60</sup>

Family planning services and supplies that are eligible for the enhanced match include prescription contraception, sterilization and reversals, preconception care (e.g., clinical examinations and sex education and counseling), and cancer screening. Family planning-related services are diagnosis and treatment services that are provided as a follow-up to a family planning service in a family planning setting.<sup>61,62</sup> Examples include pharmaceutical treatment for sexually transmitted diseases or infections.<sup>63</sup>

Despite the success of Medicaid-financed family planning services, federal law prohibited states from making family planning services available to people who were *not* Medicaid-eligible unless they used a cumbersome Section 1115 waiver process that granted them special permission to do so.<sup>64</sup> As of November 1, 2010, 22 states had taken advantage of the waiver option. A federally funded evaluation of the family planning waivers found that some states—Alabama, Arkansas, California, Oregon, and South Carolina—saved more than \$15 million each in a single year by helping women avoid unintended pregnancies that would have led to Medicaid-financed births.<sup>65</sup> Evaluations funded by states are even more impressive—Wisconsin estimates

that its program generated \$159 million in net savings in 2006; data from Texas show that the state's family planning expansion yielded net savings of \$42 million.<sup>66</sup>

Acknowledging the effectiveness of family planning in reducing unwanted pregnancies while saving money on Medicaid-financed pregnancy-related services, the ACA created a new state plan option for states to provide family planning services at the 90 percent federal matching rate to people who are otherwise *not* eligible for Medicaid. Effective March 23, 2010, the law establishes a new optional categorically needy coverage category that makes previously ineligible men and women eligible for family planning services if they are not pregnant and their income does not exceed the state-established income eligibility level (which may not exceed the highest income level for pregnant women under the state's existing Medicaid or CHIP plan). States that elect to provide the service also have the option to provide a period of presumptive eligibility under which people seeking family planning services who *appear* to be qualified to receive them are presumed eligible for a certain period of time.<sup>67</sup> States with existing family planning waivers are allowed to convert them to the state plan option. As of April 21, 2011, four states that had active Section 1115 demonstration waivers—California, New Mexico, South Carolina, and Wisconsin—converted their waivers to the state plan option; and one state that did not previously have a waiver—Ohio—has submitted an SPA to take up the option.<sup>68</sup>

Recent state-by-state analysis of the fiscal impact of taking up the new family planning coverage option shows that it will lead to significant savings for most states. Among the 28 states that do not currently have a family planning waiver that serves people based on income, 19 would potentially avert 1,500 unintended pregnancies and save \$2.3 million each in state funds in a single year. The

remaining nine states would potentially avert 7,500 unintended pregnancies and save an estimated \$17.4 million each.<sup>69</sup>

The outlook is also positive for states that have expanded access to services through waivers. Among the 22 states with waivers, 11 would potentially avert 1,300 unintended pregnancies and save an additional \$1.7 million.<sup>70</sup>

Although all states stand to benefit financially from taking up the family planning SPA option, clearly states that do not now provide these services through a waiver have the most to gain. This outlook for savings is especially positive in states that have robust provider capacity and employ aggressive outreach and education strategies.

### **Taking up the State Option to Implement Freestanding Birthing Centers**

A birthing center is a nonhospital, primary health care facility that provides the midwifery mode of women's health and uncomplicated childbirth services to women who are at low risk for obstetrical complications.<sup>71</sup> These centers are not required to be supervised by a licensed physician, and are often managed by nurse midwives. According to a *New England Journal of Medicine* study of more than 17,000 women registered for birthing center care in 1989, "few innovations in health service promise lower cost, greater availability, and a high degree of satisfaction with a comparable degree of safety than do birthing centers."<sup>72,73</sup> Prior to the enactment of the ACA, Medicaid programs were only authorized to pay for maternity services to hospitals and other facilities operated by and under the supervision of a physician. States now have the option to cover state-licensed freestanding birthing centers, effective March 23, 2010. Support for this shift in policy came from the American College of Nurse-

Midwives, the American College of Obstetricians and Gynecologists, the American Nurses Association, and many consumer organizations. Currently, only nine states—Idaho, Louisiana, Maine, Montana, Michigan, North Carolina, North Dakota, Virginia, and Wisconsin—do *not* have regulations for licensing birthing centers.<sup>74</sup> As of April 25, 2011, three states—Minnesota, Texas, and Washington—had taken up the freestanding birthing center option.<sup>75</sup>

Medicaid is a key source of health coverage for pregnant women, financing more than one in three of the more than 4.3 million births annually in the United States.<sup>76</sup> In 2003, Medicaid paid for 50 percent or more of births in 11 states—Alaska, Arizona, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Texas, and West Virginia<sup>77</sup>—at average inpatient charges ranging from \$9,000 for an uncomplicated hospital birth to \$20,000 for a cesarean with complication<sup>78</sup> (excluding newborn, physician, and anesthesia charges).<sup>79</sup>

Women who deliver in birthing centers usually stay for a shorter time, use alternative measures for pain relief, and have fewer medical interventions than they would in inpatient hospitals, incurring, on average, about a one-third to one-half less in costs.<sup>80,81</sup> Therefore, providing medically low-risk women with an alternative to inpatient hospital labor and delivery could potentially yield significant savings on hospital charges and physician fees in states with large numbers of Medicaid-financed births.

In deciding whether this is a promising option, states need to consider whether their legislatures will be inclined to pass legislation (if necessary) to approve Medicaid payments for birthing centers. In addition, states should review their administrative data to determine whether they have high percentages of low-risk deliveries or inordinately high percentages

of uncomplicated caesarean deliveries that could potentially be diverted to birthing centers. States also need to consider availability of providers; whether there is a sufficient infrastructure to support birth centers; and whether women will be given a choice between delivering their babies in hospitals or at birthing centers.

### **Participating in the Medicaid Emergency Psychiatric Demonstration**

Section 2707 of the ACA appropriates \$75 million from 2011 through December 31, 2015, for states to conduct demonstration projects—the Medicaid emergency psychiatric demonstrations—that allow them to reimburse institutions for mental diseases (IMDs) for services provided to Medicaid beneficiaries between ages 21 and 65 to stabilize an emergency psychiatric medical condition. Prior to this provision of law, the IMD exclusion prohibited states from receiving federal matching payments for inpatient psychiatric services provided to persons in that age range.

Through this demonstration, states will be allowed to cover patients receiving care in nongovernment, freestanding psychiatric hospitals and receive federal Medicaid matching payments. States will have to contribute their own matching share of funds. This demonstration project will—

- Evaluate the role of inpatient psychiatric care in the continuum of community-based mental health care
- Help to determine ways to address timely access to behavioral health services
- Focus on the cost-effectiveness of inpatient psychiatric care and the efficiency of the delivery of psychiatric care
- Focus on discharge planning and aftercare to help reduce unnecessary hospitalization

This demonstration opportunity could represent significant cost savings for states, depending on how much the state was paying for emergency and acute inpatient hospital care for this population out of state and local general funds and on how states structure the care going forward (e.g., establishing care delivery systems and care management strategies that are effective at avoiding expensive hospital care).

### **Implementing Medicaid Program Integrity Initiatives**

Medicaid fraud represents a substantial financial loss and threatens to undermine public confidence in the program. To address this problem, the ACA gives states a number of new tools to combat Medicaid fraud and abuse and to realize savings. Medicaid-specific provisions would—<sup>82</sup>

- Require states to terminate providers who have been terminated by Medicare or another state’s Medicaid program (Section 6501)
- Require Medicaid to exclude providers who own, control, or manage an entity that (a) has failed to repay overpayments for a specified period; (b) is suspended, excluded, or terminated from participating in any Medicaid program; or (c) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation (Section 6502)
- Require entities that submit provider claims to register with the state and the secretary of HHS (Section 6503)
- Require states and managed care organizations to provide Medicaid Management Information Systems (MMIS) data related to program integrity to the Secretary of HHS (Section 6504)
- Bar Medicaid agencies from paying providers located outside of the United States (Section 6505)

- Require states to make their MMIS methodologies compatible with Medicare’s national correct coding initiative, which promotes correct coding and controls improper coding (Section 6507)

Aggressive implementation and enforcement of federal policies to clamp down on program fraud should yield savings for both states and the federal government. To maximize savings, states should allocate sufficient human resources to monitor their programs.

### New Opportunities for Medicaid Home and Community-Based Long-Term Services and Supports

The ACA also includes opportunities to increase access to home and community-based services (HCBS). This section discusses the funding of Medicaid long-term services and supports (LTSS) and the ACA programs that provide new federal dollars to shift more Medicaid funding toward HCBS (see appendix A for a grid describing each of these HCBS options). The following are opportunities for states to realize long-term savings and receive new federal funding:

- Applying for the Money Follows the Person Rebalancing Demonstration Program
- Taking up the Community First Choice Option
- Applying for the State Balancing Incentive Payments Program

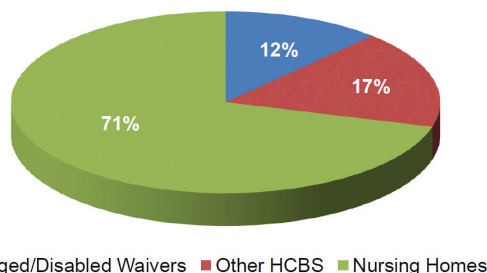
### Medicaid Funding for Long-Term Services and Supports

Medicaid is the largest payer for LTSS. In 2009, Medicaid spending for LTSS was more than \$114 billion.<sup>83</sup> More than 3 million people, or 7 percent of

Medicaid recipients, receive LTSS, which can include a wide range of services, such as nursing home care, personal care, and skilled home health care.<sup>84</sup>

Despite three decades of growth in Medicaid-funded HCBS, most states’ Medicaid LTSS spending for older Americans and adults with physical disabilities is “out of balance,” with roughly 7 out of 10 dollars going toward nursing homes (see figure 1).<sup>85</sup>

**Figure 1**  
Medicaid Long-Term Services and Supports Spending for Older People and Adults with Physical Disabilities in the United States, 2009



Source: AARP Public Policy Institute analysis based on data from Steve Eiken, Kate Sredl, Brian Burwell, and Lisa Gold, *Medicaid Long Term Care Expenditures FY 2009* (Cambridge, MA: Thomson Reuters, 2010).

During the current recession, most states temporarily maintained Medicaid LTSS because of the MOE requirements of ARRA.<sup>86</sup> However, by July 2011, the ARRA funds and its associated MOE requirement will expire.

The ACA provides a number of financial incentives—both enhanced federal Medicaid matching rates and grants—for states to expand Medicaid HCBS and to balance their array of services to better meet the needs of consumers, most of whom prefer to live at home and in the community. A key characteristic of a high-performing LTSS system is choice of care setting. State policymakers can use the HCBS provisions of the ACA to meet this goal.<sup>87</sup>

### **Applying for the Money Follows the Person Rebalancing Demonstration Program**

Section 2403 of the ACA extended and modified the Money Follows the Person (MFP) program. The purpose of the program is to provide transition funding for Medicaid beneficiaries leaving nursing homes for community settings and to fund initiatives that improve the opportunities for people to choose HCBS instead of institutional services.<sup>88</sup>

Between FY 2007 and FY 2011, the federal government awarded enhanced matching grants of \$1.75 billion to 29 states plus the District of Columbia to implement MFP programs. The program was slated to expire in FY 2011, but the ACA extended it and provided \$2.25 billion in additional funding from FY 2011 to FY 2016, totaling \$4 billion since FY 2007. In February 2011, CMS announced 13 new state grantees, totaling 43 grantees since 2007.<sup>89</sup> The 30 existing grantees must submit written requests for continued participation to CMS. Renewals are expected in summer 2011.

These grantees receive an enhanced federal match for services provided to Medicaid beneficiaries for the first year after beneficiaries leave nursing homes for community settings. The MFP beneficiary must first be in the nursing home for 90 days, excluding Medicare Skilled Nursing Facility days. Prior to the ACA, the minimum institutional requirement was six months.

The vast majority of existing MFP grantees are expected to renew.<sup>90</sup> The MFP grants allow for great flexibility and present few to no downsides. They can be used for a wide range of balancing activities, such as nursing home diversions and funding for staff who work on balancing initiatives. The funds can help states meet the balancing requirements of other ACA HCBS provisions, such as developing single points of entry, uniform

assessment tools, and conflict-free case management systems.

### **Taking up the Community First Choice Option**

Section 2401 of the ACA created the Medicaid Community First Choice (CFC) Option to allow states to provide home and community-based attendant services and supports using an SPA. States would fund an individual's person-centered care plan, and the individual could hire any qualified persons, including family members, to provide services and supports.

Effective October 2011, states that implement the CFC Option will receive a six percentage point FMAP increase for expenditures related to this option. The proposed rule estimates the potential new payments for services to be \$1.585 billion in FY 2012.<sup>91</sup> There is no end date associated with this option.

During the first full fiscal year in which the SPA is implemented, the state must maintain or exceed the level of state Medicaid expenditures for services provided to older Americans or individuals with disabilities in the previous fiscal year. The rationale for this requirement is maintenance of effort.

Under the CFC Option, there are three pathways to eligibility. States can provide attendant services and supports, for individuals who are eligible for medical assistance under the state plan, to:

1. People whose income does not exceed 150 percent of the FPL who do not meet institutional level of care standards;
2. People with income above 150 percent of the FPL who meet the state's institutional level of care criteria; and

3. People who qualify for Medicaid under the special home and community-based waiver eligibility group and who are receiving at least one HCBS waiver service per month.

State policymakers will have to assess the following criteria to determine whether to take part in this option:

- **The cost and entitlement.** States may be concerned about the costs associated with this program because once it is adopted, qualifying individuals are entitled to receive benefits statewide as long as the state participates in the CFC Option. When a state opts to cover personal care services as part of its state Medicaid plan, it becomes an entitlement. In contrast, states that offer personal care services under Medicaid waivers can limit populations covered, geographic coverage, and the amount and duration of services. States can also choose to maintain waiting lists for waiver services, but they cannot do so for personal care services under the state Medicaid plan since it is an entitlement. States will need to assess whether the increased federal matching funds will exceed what they may need to spend for people who were not previously eligible for these or similar services.
- **Enhanced federal matching funds.** States that already provide personal care under the Medicaid state plan option may be interested in providing expanded services because of the enhanced federal matching payments.
- **Nursing home diversions and transitions.** States that do not cover personal care under their Medicaid state plan might be interested in taking this option to help divert people from going into nursing homes and to get people out of

nursing homes. However, there could be short-term, upfront costs before longer-term savings are realized.

### Applying for the State Balancing Incentive Payments Program

Section 10202 of the ACA created the State Balancing Incentive Payments Program (BIPP), a competitive grant program to encourage states to balance their Medicaid spending toward more HCBS. Effective October 2011, CMS will award grants to states of up to \$3 billion total. The grant period will end by October 2015.

Qualifying states will receive enhanced federal matching funds. The amount of the enhanced FMAP will depend on how much of the state's Medicaid spending goes toward HCBS. There are two categories of states for this program:

- States with less than 25 percent of their Medicaid LTSS spending going toward HCBS can receive a five percentage point federal matching increase and must raise HCBS spending to 25 percent by October 2015.
- States with 25 to 50 percent of their Medicaid LTSS spending going toward HCBS can receive a two percentage point federal matching increase and must raise HCBS spending to 50 percent by October 2015.

States that spend more than 50 percent of their Medicaid LTSS spending on HCBS are not eligible for this program.

In addition to expanding Medicaid HCBS spending, qualifying states must agree to make the following structural changes within six months:

- A statewide “no wrong door” single point of entry system to enable consumers to access LTSS through an agency, coordinated network, or portal;

- Conflict-free case management to develop a care plan, arrange for LTSS, and conduct monitoring; and
- Core standardized assessment instruments for determining eligibility for LTSS and other services as well as a care plan.

States must also agree to collect quality, services, and outcomes data. They cannot apply more restrictive eligibility standards, methodologies, or procedures than those in effect on December 31, 2010, for all services for which they will receive the enhanced federal match. As of this writing, state policymakers are waiting for federal guidance to decide whether to apply for BIPP funding. It is difficult for state policymakers to determine the costs and benefits of this option because many questions remain about state eligibility and the infrastructure change requirements.

### Making the Business Case for Balancing

In addition to heightened consumer satisfaction, states can make a business case for balancing in that they can serve more people in the community and can better contain costs over time. On average, Medicaid can pay for nearly three people in the community for every person in a nursing home<sup>92</sup> (see figure 2).

State Medicaid programs that reduce reliance on nursing homes experience a positive financial impact over time. Expansion of HCBS incurs a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings.<sup>93</sup>

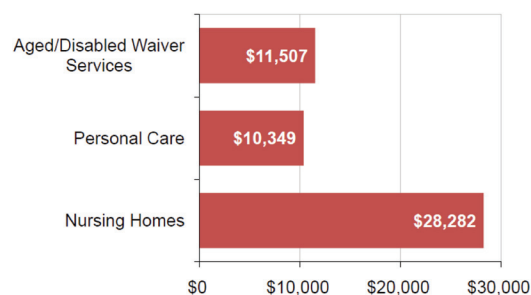
### Conclusion

For many states, it may truly be “the best of times and the worst of times.” State officials confront a myriad of choices that have the potential to

generate significant Medicaid savings and/or bring in extra federal dollars at a time when they are least able to take advantage of those choices. Budget shortfalls have caused many states to impose furloughs on state workers, institute hiring freezes, and in some cases, lay off workers.

According to the Center on Budget and Policy Priorities, at least 44 states and the District of Columbia plan to eliminate or not fill some state jobs, impose mandatory furloughs (time off without pay), or make other cuts that impact the ability of the state workforce to meet the needs of citizens attempting to access state-funded services.<sup>94</sup> In addition, states are under pressure to upgrade their coding systems for how diseases are classified for billing purposes by October 1, 2013. This activity will also be a pull on scarce state resources.<sup>95</sup> Despite these daunting challenges, states should carefully consider the options presented in this paper, understand the requirements, evaluate the cost-effectiveness, and direct their resources to those that will both improve health outcomes and services and realize cost savings or efficiencies.

**Figure 2**  
Average Medicaid Spending per Person Served in the United States, by Type of Long-Term Care Service, 2007



Source: AARP Public Policy Institute analysis based on data from Terence Ng and Charlene Harrington and Jhamirah Howard, *Medicaid Home and Community-Based Service Programs: Data Update* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 2011); and CMS, *Medicare & Medicaid Statistical Supplement 2009*, table 13.27, accessed March 2011.



### Other Related Affordable Care Act Provisions

A number of other ACA provisions also provide “carrots” to states to improve the lives of people with LTSS needs:

- **Aging and Disability Resource Centers.** From FY 2010 through 2014, the ACA provides \$10 million per year in grants to states for their “no wrong door” single point of entry systems to help consumers and their families access services. Although most states have Aging and Disability Resource Centers, this additional funding will help with geographic and service expansions.
- **Section 1915(i) State Option.** States can provide HCBS under a Medicaid state plan to individuals whose income does not exceed 300 percent of Supplemental Security Income. States can place limits on the type, amount, duration, population, and scope of services, but the services must be offered statewide. This provision is not included in the above discussion because it does not offer new enhanced federal funds, but it does allow states to offer these limited HCBS without Medicaid waivers.
- **Health homes** (as discussed above). Within the context of LTSS, the U.S. Centers for Medicare & Medicaid Services expects states that provide this optional benefit and health home providers to have a “whole person” philosophy that provides linkages to long-term community care services and supports as well as social and family services.<sup>96</sup>
- **Dual eligibles** (as discussed above). One of the goals of the new Federal Coordinated Health Care Office is to improve the quality of health and long-term services for dual-eligible individuals.

**Appendix A. Home and Community-Based Services “Balancing” Options within the Affordable Care Act**

	<b>Purpose</b>	<b>Total Funding</b>	<b>Enhanced Medicaid Funding</b>	<b>State Participation</b>	<b>Timing</b>	<b>Key Issues</b>
<b>Money Follows the Person</b>	To provide transition funding for Medicaid beneficiaries leaving nursing homes for community settings and to fund initiatives that improve the balance of funding for HCBS	\$2.25 billion appropriated by the ACA through FY 2016, totaling \$4 billion	For first 12 months after a Medicaid beneficiary goes back into the community; and federal matching available for a wide range of balancing activities such as nursing home diversion and staff; leverage for other ACA tasks	43 states total; 29 plus D.C. existing grantees and 13 new states	FY 2011–FY 2016	Expansion: Matching available for people leaving institution in 90 days (it was 180 days before the ACA)
<b>Community First Choice</b>	To enhance HCBS attendant services and supports under a Medicaid state plan option	Estimates of \$1.585–\$3.7 billion, depending on the number of states and people receiving services under this option	Funds HCBS attendant services and supports at 6% enhanced federal Medicaid match	Possibly states with existing Medicaid personal care plan options	October 2011–future; it is not time limited	Entitlement: statewide; no enrollment ceilings or service caps.  Maintenance of effort: during the first year, states must maintain level of state Medicaid expenditures for HCBS attendant services and supports

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	<b>Purpose</b>	<b>Total Funding</b>	<b>Enhanced Medicaid Funding</b>	<b>State Participation</b>	<b>Timing</b>	<b>Key Issues</b>
<b>Balancing Incentive Payments Program</b>	To encourage states to balance their Medicaid spending on LTSS toward HCBS	Up to \$3 billion in competitive grants	<ul style="list-style-type: none"> <li>■ States with less than 25% of Medicaid LTSS spending going toward HCBS = 5% federal matching increase to raise HCBS spending to 25% by Oct. 2015</li> <li>■ States with 25%-50% of Medicaid LTSS spending going toward HCBS = 2% federal matching increase to raise HCBS spending to 50% by Oct. 2015</li> </ul>		October 2011–October 2015	Delivery system changes required within 6 months: <ol style="list-style-type: none"> <li>1. Single point of entry</li> <li>2. Conflict-free case management</li> <li>3. Statewide core standardized assessment instrument for determining eligibility</li> </ol>

ACA = Affordable Care Act

HCBS = home and community-based services

LTSS = long-term services and supports

## Endnotes

- <sup>1</sup> E. McNichol, P. Oliff, and N. Johnson, *States Continue to Feel Recession's Impact* (Washington, DC: Center on Budget and Policy Priorities, updated January 21, 2011).
- <sup>2</sup> Public Law 111-148, enacted March 23, 2010.
- <sup>3</sup> Public Law 111-5, enacted February 17, 2009.
- <sup>4</sup> Public Law 111-226, enacted August 10, 2010.
- <sup>5</sup> Centers for Medicare & Medicaid Services (CMS), *American Recovery and Reinvestment Act of 2009: Section 5001: Increased Federal Medical Assistance Percentage Fact Sheet*, <http://ccf.georgetown.edu/index/cms-filesystem-action?file=statistics/guidance%20on%20arra%20fmap.pdf>.
- <sup>6</sup> Section 2001 of the ACA.
- <sup>7</sup> CMS, Center for Medicaid, CHIP and Survey & Certification, Dear State Medicaid Director letter: Maintenance of Effort, SMDL#11-001 and ACA#14 (February 25, 2011).
- <sup>8</sup> The state would be required to submit a State Plan Amendment (or amend an existing waiver) indicating this change in eligibility.
- <sup>9</sup> On August 10, President Obama signed H.R. 1586, containing a six-month extension of an enhanced match for the Medicaid (FMAP) and Title IV-E programs. The legislation provides states \$16.1 billion through a phased-down enhanced match—3.2 percent beginning the first calendar quarter of fiscal year 2011, then dropping to 1.2 percent in the second calendar quarter. This includes an extension of the additional relief based on increased unemployment, as well as the hold harmless clause.
- <sup>10</sup> The governor says that this action is necessary because the state is facing a \$763.6 million deficit in the current fiscal year and a \$1.15 million deficit in FY 2012. G. Rough, “Brewer Submits Request for Medicaid Waiver,” *Arizona Republic*, January, 25, 2011, <http://www.azcentral.com/news/election/azelections/articles/2011/01/25/20110125-arizona-submits-medicaid-waiver.html>.
- <sup>11</sup> U.S. Department of Health and Human Services, Dear Governor letter (February 3, 2011).
- <sup>12</sup> *Ibid.*
- <sup>13</sup> *Ibid.*
- <sup>14</sup> Not all of these categories are discrete, and some can overlap into long-term services and supports.
- <sup>15</sup> Federal law does not require states to offer the full Medicaid benefit package to the medically needy.
- <sup>16</sup> J. Hadley and J. Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2004), <http://www.kff.org/uninsured/upload/The-Cost-of-Care-for-the-Uninsured-What-Do-We-Spend-Who-Pays-and-What-Would-Full-Coverage-Add-to-Medical-Spending.pdf>.
- <sup>17</sup> Other portions of DSH funds are used to compensate hospitals for low Medicaid payments.
- <sup>18</sup> Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2002).
- <sup>19</sup> J. Hadley et al., *Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2008).
- <sup>20</sup> J. Holahan and B. Garrett, *The Cost of Uncompensated Care with and without Insurance* (Washington, DC: The Urban Institute, March 2010).
- <sup>21</sup> The authors estimated state and local government spending on uncompensated care by excluding all state payments financed through provider taxes or intergovernmental transfers. They also subtracted out hospital payments used to compensate for shortfalls in Medicaid reimbursement rates. J. Hadley, et al., “Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs,” *Health Affairs*; 27, no. 5 (September 2008):w399–w415.
- <sup>22</sup> Using the 6 percent increase in annual per capital health spending estimated by the CMS Office of the Actuary, researchers at the Urban Institute projected the amount forward to 2014–2019. S. Dorn and M. Buettgens, *Net Effects of the Affordable Care Act on State Budgets* (Washington, DC: The Urban Institute, December 2010).
- <sup>23</sup> *Ibid.*
- <sup>24</sup> A State Plan is the officially recognized document describing the nature and scope of a state’s Medicaid program as required under Section 1902 of the Social Security Act. The

state submits plan changes to HHS as State Plan Amendments (SPAs). Through CMS, HHS reviews each SPA to determine whether it meets federal requirements and policies. The State Plan is updated when CMS issues final approval of the SPA.

<sup>25</sup> States that implement health homes are required to track avoidable hospital readmissions, emergency room visits, and skilled nursing home admissions; identify savings resulting from improved care coordination; and monitor how health information technology improves care delivery and coordination. Department of Health and Human Services, CMS, Dear State Medicaid Director and Dear State Health Official Letter, SMDL# 10-024 and ACA#12, Re: Health Homes for Enrollees with Chronic Conditions (November 16, 2010).

<sup>26</sup> States are required to consult and coordinate with the Substance Abuse and Mental Health Services Administration in addressing issues of prevention and treatment of mental illness and substance use disorder. *Ibid.*

<sup>27</sup> Association of Maternal & Child Health Programs, *Health Reform: What's in It to Promote the Medical Home?* (Washington, DC: Association of Maternal & Child Health Programs, October 2010), <http://www.amchp.org/Advocacy/health-reform/Documents/Medical-Homes-ACA-Fact-Sheet.pdf>.

<sup>28</sup> States may request planning funds in excess of the \$500,000 if they need to. Department of Health and Human Services, CMS, Dear State Medicaid Director and Dear State Health Official Letter.

<sup>29</sup> E-mail communication from Mary Pat Farkas, Health Insurance Specialist, Division Integrated Health Systems, Disabled and Elderly Health Program Group, Center for Medicaid, CHIP and Survey & Certification (Wednesday, May 25, 2011, 3:07 p.m.).

<sup>30</sup> One example is Section 646 of the Medicare Modernization Act of 2003, which established the Section 646 Medicare Health Care Quality Demonstration Program. The demonstration will test providers' ability to improve the quality of care and services delivered to Medicare beneficiaries through a major system redesign. Goals of the 646 demonstration are to improve patient safety, enhance quality, increase efficiency, and/or reduce unwarranted variation in medical practices and costs. The legislation states that goals will be achieved in large part by adopting and using decision support tools such as best practice guidelines and shared decision-making programs. Networks that participate in the demonstration will be able to test innovative strategies to improve care

for Medicare beneficiaries and will receive a share of the Medicare savings and impact Medicare policy. Community Care of the Sandhills, *646 Medicare Demonstration Project*, <http://www.communitycare-sandhills.org/focused-initiatives>.

<sup>31</sup> Practices that have been shown to reduce hospital and emergency room admissions include care transition programs, care coordination, and improving the ability of patients and family members to manage post-hospital care.

<sup>32</sup> CMS, Center for Strategic Planning, Medicaid Incentives for Prevention of Chronic Diseases, *Initial Announcement, Funding Opportunity CMS-1B1-11-001* (February, 23, 2011), [http://www.cms.gov/MIPCD/Downloads/HHS\\_ACA\\_S4108\\_Solicitation.pdf](http://www.cms.gov/MIPCD/Downloads/HHS_ACA_S4108_Solicitation.pdf).

<sup>33</sup> *Ibid.*

<sup>34</sup> *Ibid.*

<sup>35</sup> *Ibid.*

<sup>36</sup> *Ibid.*

<sup>37</sup> *Ibid.*

<sup>38</sup> *Ibid.*

<sup>39</sup> Kaiser Family Foundation, Kaiser State Health Facts, *Dual Eligibles as a Percent of Total Medicaid Enrollees, 2007*, <http://statehealthfacts.org/comparemaptable.jsp?ind=305&cat=6&sub=76>; *Dual Eligibles Share of Medicaid Spending in Millions, 2007*, Accessed at <http://www.kff.org/medicaid/upload/7846-02.pdf>.

<sup>40</sup> CMS, Federal Business Opportunities, *State Demonstrations to Integrate Care for Dual Eligible Individuals* (November 16, 2010; Modified November 18, 2010), [https://www.fbo.gov/index?s=opportunity&mode=form&id=819095ab34a418a0dc90f754db01faae&tab=core&\\_cview=1](https://www.fbo.gov/index?s=opportunity&mode=form&id=819095ab34a418a0dc90f754db01faae&tab=core&_cview=1).

<sup>41</sup> *Ibid.*

<sup>42</sup> Medicare Payment Advisory Commission (Medpac). *Report to the Congress* (Washington, DC: Medpac, June 2010).

<sup>43</sup> G.P. Guy, "The Effects of Cost Sharing on Access to Care among Childless Adults," *Health Services Research* 45, no. 6, Part 1 (December 2010).

<sup>44</sup> States can make available without cost sharing only immunizations that have been recommended by the Advisory Committee on Immunization Practices—the federally approved body with authority to make national recommendations for vaccination. The screening tests that states can make available without cost sharing are those that have an A- or

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B- recommendation from the United States Preventive Services Task Force (USPSTF)—the federally approved body with authority to rate health screenings.

<sup>45</sup> The USPSTF gives an A- rating to screening for colon cancer beginning at age 50.

<sup>46</sup> T. S. Jordan, *Colorectal Cancer Treatment Costs*, [http://www.ehow.com/way\\_5553222\\_colorectal-cancer-treatment-costs.html#ixzz1DZWDg96C](http://www.ehow.com/way_5553222_colorectal-cancer-treatment-costs.html#ixzz1DZWDg96C).

<sup>47</sup> E-mail communication from Kathleen Teixeira, American Gastroenterological Association. June, 20, 2011 at 3:45 pm.

<sup>48</sup> CMS, “Medicaid Program; Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions”: Proposed Rule, *Federal Register*, 76, no. 33 (Thursday, February 17, 2011):9283–94.

<sup>49</sup> Public Law 109-171, enacted February 8, 2006.

<sup>50</sup> CMS included 10 categories of conditions for the HAC payment provision: Foreign Object Retained After Surgery; Air Embolism; Blood Incompatibility; Stage III and IV Pressure Ulcers; Falls and Trauma; Manifestations of Poor Glycemic Control; Catheter-Associated Urinary Tract Infection (UTI); Vascular Catheter-Associated Infection; and Surgical Site Infection Following; Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE). Note: Under the Medicare HAC policy, hospitals are not allowed to balance-bill beneficiaries. U.S. Department of Health and Human Services, CMS, *Hospital-Acquired Conditions*, [http://www.cms.gov/HospitalAcqCond/06\\_Hospital-Acquired\\_Conditions.asp](http://www.cms.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp).

<sup>51</sup> National Conference of State Legislatures, *Medicare Non-Payment for Medical Errors* (Washington, DC: National Conference of State Legislatures, August 2008), <http://www.ncsl.org/Portals/1/documents/health/MCHAC.pdf>.

<sup>52</sup> Department of Health and Human Services, Center for Medicaid and State Operations, Dear State Medicaid Director Letter, SMDL #08-004 (July 31, 2008), <http://www.cms.gov/SMDL/downloads/SMD073108.pdf>.

<sup>53</sup> CMS, “Medicaid Program; Payment Adjustment for Provider-Preventable Conditions.”

<sup>54</sup> *Ibid.*, 9283–95.

<sup>55</sup> *Ibid.*

<sup>56</sup> M. S. Kearney and Phillip B. Levine, *Reducing Unplanned Pregnancies through Medicaid Family Planning Services* (Washington, DC:

Brookings Center on Children and Families, July 2008).

<sup>57</sup> R. Gold, C. Richards, U. Ranji, and A. Salganicoff, *Medicaid’s Role in Family Planning*, Issue Brief (Menlo Park, CA: Kaiser Family Foundation; and New York, NY: Guttmacher Institute, October 2007), [http://www.kff.org/womenshealth/upload/7064\\_03.pdf](http://www.kff.org/womenshealth/upload/7064_03.pdf).

<sup>58</sup> Before this time, providing family planning services was a state option in Medicaid.

<sup>59</sup> Gold, Richards, Ranji, and Salganicoff, *Medicaid’s Role in Family Planning*.

<sup>60</sup> Department of Health and Human Services, CMS, Dear State Health Official Letter. SMDL#10-13, ACA#4, Re: Family Planning Services Option and New Benefit Rules for Benchmark Plans (July 2, 2010).

<sup>61</sup> *Ibid.*

<sup>62</sup> U. Ranji and A. Salganicoff (The Kaiser Family Foundation), and A. Steward, M. Cox, and L. Doamekpor (George Washington University Medical Center), *State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings* (Washington, DC: The Kaiser Family Foundation and George Washington University Medical Center, November 2009).

<sup>63</sup> Department of Health and Human Services, CMS, Dear State Health Official Letter. SMDL#10-13, ACA#4, Re: Family Planning Services Option and New Benefit Rules for Benchmark Plans (July 2, 2010).

<sup>64</sup> Department of Health and Human Services, CMS, Dear State Health Official Letter, SMDL#10-13, ACA#4, Re: Family Planning Services Option and New Benefit Rules for Benchmark Plans (July 2, 2010).

<sup>65</sup> A. Sonfield, J. J. Frost, and R. B. Gold, *Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services: 2011 Update* (New York, NY: Guttmacher Institute, January 2011). <http://www.guttmacher.org/pubs/Medicaid-Family-Planning-2011.pdf>. This report contains estimates of savings for every state.

<sup>66</sup> *Ibid.*

<sup>67</sup> Section 2303(b) of the ACA, creating a new Section 1920C of the Social Security Act.

<sup>68</sup> E-mail communication with CMS official Linda Peltz, Director, Division of Benefits and Coverage, Disabled and Elderly Health Programs Group, Center for Medicaid, CHIP and Survey and Certification, Centers for Medicare and Medicaid Services (April 25, 2011, 4:26 p.m.).

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<sup>69</sup> Sonfield, Frost, and Gold, *Estimating the Impact of Expanding Medicaid Eligibility*.

<sup>70</sup> Sonfield, Frost, and Gold, *Estimating the Impact of Expanding Medicaid Eligibility*.

<sup>71</sup> High-risk situations that are not appropriate for out-of-hospital birth include women who are pregnant with twins; vaginal breech deliveries or vaginal birth after cesarean; women with chronic high blood pressure or diabetes requiring insulin; women who have placenta previa (the placenta is over the cervix); women with pregnancy-induced hypertension/preeclampsia (aka toxemia); and women who are carrying a child with a known medical problem (e.g., heart defect) that will require special care. The Birth Center, Wilmington, DE: ND), <http://www.thebirthcenter.com/ShowPage.asp?id=152#LowHighRisk>.

<sup>72</sup> The National Birth Center Study was designed to respond to the recommendation of the Institute of Medicine committee that studies be conducted to provide reliable information about the relative safety and efficacy of all birth settings. J. P. Rooks et al., "Outcomes of Care in Birth Centers: The National Birth Center Study," *The New England Journal of Medicine*, 321, no. 26 (December 28, 1989):1804–09.

<sup>73</sup> A research team in California compared women who planned to give birth attended by midwives in a freestanding birthing center with similar women who chose to give birth in the hospital with doctors. Women choosing hospital birth were twice as likely to have cesarean surgery and more than twice as likely to have forceps- or vacuum-assisted vaginal births. Women planning birthing center births were much more likely to eat or drink, use a tub or shower, and walk around during labor. They were much less likely to need medicine to speed up labor and also much less likely to have episiotomies (a surgical incision to make the vaginal opening larger when the baby is born). The babies born in the birthing center group were just as healthy as those in the hospital group. D. J. Jackson, J. M. Lang, W. H. Swartz, et al., "Outcomes, safety, and resource utilization in a collaborative care birth center program compared with traditional physician-based perinatal care," *American Journal of Public Health*, 93, no. 6 (2003):999–1006.

<sup>74</sup> American Association of Birth Centers, *Birth Center Regulation Map* (Perkiomenville, PA: American Association of Birth Centers, 2011). As of 2011, the following states were exploring regulations or had draft regulations: Maine, Montana, Michigan, Virginia, and Wisconsin.

<sup>75</sup> E-mail communication with Linda Peltz.

<sup>76</sup> The Henry J. Kaiser Family Foundation, *Medicaid: A Primer. Key Information on the Nation's Health Program for Low-Income People January 2009*, <http://www.kff.org/medicaid/upload/7334-03.pdf>.

<sup>77</sup> Kaiser Commission on Medicaid and the Uninsured, *State Health Facts. Number of Births Financed by Medicaid, 2009* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2009), <http://statehealthfacts.org/comparemaptable.jsp?ind=222&cat=4>.

<sup>78</sup> American Association of Birth Centers (AABC), Birth Center Savings (unpublished data) from AABC Uniform Data Set. U.S. Agency for Healthcare Research and Quality, HCUPnet, Healthcare Cost and Utilization Project. 2008 data.

<sup>79</sup> E-mail communication from Eunice K. M. Ernst, Mary Breckinridge Chair of Midwifery, Frontier Nursing University, Coordinator of AABC Consulting Group, American Association of Birth Centers (May 13, 2011).

<sup>80</sup> Birth Centers: Alternatives to Hospitals, reviewed by the BabyCenter Medical Advisory Board, last updated September 2008, [http://www.babycenter.com/0\\_birth-centers-alternatives-to-hospitals\\_2007.bc](http://www.babycenter.com/0_birth-centers-alternatives-to-hospitals_2007.bc).

<sup>81</sup> E-mail communication from Eunice K. M. Ernst.

<sup>82</sup> There are a number of antifraud provisions that relate to Medicare, Medicaid, and CHIP. They may be found in Sections 6401, 6402, 6403, 6601, 6602, 6603, 6604, 6605, 6606, and 6607 of the ACA.

<sup>83</sup> Steve Eiken et al., *Medicaid Long-Term Care Expenditures in FY 2009* (Cambridge, MA: Thomson Reuters, August 17, 2010).

<sup>84</sup> Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Long-Term Care Services and Supports* (Washington, DC: The Henry J. Kaiser Family Foundation, March 2011).

<sup>85</sup> Enid Kassner, et al., *A Balancing Act: State Long-Term Care Reform* (Washington, DC: AARP Public Policy Institute, July 2008).

<sup>86</sup> Jenna Walls et al., *Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, January 2011).

<sup>87</sup> Susan C. Reinhard, Enid Kassner, and Ari Houser, "How the Affordable Care Act Can Help Move States Toward a High Performing System of Long-Term Services and Supports," *Health Affairs*, 30 (2011):447–53.

## Health Reform Law Creates New Opportunities for States to Save Medicaid Dollars

<sup>88</sup> Texas pioneered the MFP program by first authorizing the program through “riders” or amendments to state appropriations bills.

<sup>89</sup> HHS Press Release, “Affordable Care Act Supports States in Strengthening Community Living” (Washington, DC: U.S. Department of Health and Human Services. February 22, 2011).

<sup>90</sup> Walls et al., *Weathering the Storm*.

<sup>91</sup> CMS, Proposed Rule on the Community First Choice Option [42 CFS Part 441; file code CMS-2337-P] (February 25, 2011).

<sup>92</sup> Kassner et al., *A Balancing Act*.

<sup>93</sup> H. S. Kaye, M. P. LaPlante, and C. Harrington, “Do Non-institutional Long-Term Care Services Reduce Medicaid Spending?” *Health Affairs*, 28, no. 1 (2009):262–72.

<sup>94</sup> N. Johnson, P. Oliff, and E. Williams, *At Least 46 State Have Imposed Cuts that Hurt Vulnerable Residents and the Economy* (Washington, DC: Center on Budget and Policy Priorities, February 9, 2011).

<sup>95</sup> “ICD-10 codes must be used on all HIPAA [Health Insurance Portability and Accountability Act of 1996] transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2013. Otherwise, claims and other transactions may be rejected, and require a need to resubmit with the ICD-10 codes. This could result in delays and may impact your reimbursements, so it is important to start now to prepare for the

changeover to ICD-10 codes.” CMS, *ICD-10 Overview*, <http://www.cms.gov/ICD10/>.

<sup>96</sup> CMS, “Health Homes for Enrollees with Chronic Conditions,” State Medicaid Director Letter #10-024 (November 16, 2010).

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