Report on Health Reform Implementation

JHPPL Workshop on Medicaid Fiscal and Governance Issues: Objectives and Themes

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Editor's Note: Thanks to funding from the Blue Shield of California Foundation and the Robert Wood Johnson Foundation, JHPPL *has begun the coordination of an Engaged State Health Reform Research Network to bring together people from different backgrounds (practitioners, stakeholders, and researchers) involved in state-level health reform implementation to inform and extend health reform across the United States. A network website will document implementation projects across the country, workshops will be held, and* JHPPL *will publish essays under this new section based on findings emerging from network participants. All essays in the section will be published open access.*
—Colleen M. Grogan

Abstract At a November 2012 workshop, state health policy officials, other Medicaid and insurance exchange practitioners, and health policy researchers discussed issues surrounding the implementation and sustainability of Medicaid expansion and insurance exchange coordination under the Patient Protection and Affordable Care Act (PPACA). Foremost were concerns about (1) intergovernmental relations (states experiencing uncertain information, lack of coordination among federal agencies, and limited resources to take on new responsibilities under the PPACA), and (2) policy design (new issues such as Medicaid exchange coordination on top of preexisting Medicaid challenges). *JHPPL* has proposed the creation of a research network to develop policy options and share strategies and best practices.

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In November 2012, the *Journal of Health Politics, Policy and Law* convened a workshop on Medicaid fiscal and governance issues. Sponsored by Blue Shield of California Foundation, with additional support from the Center for Health Administration Studies at the University of Chicago, and the Robert Wood Johnson Foundation, the workshop brought together senior state health policy officials, other practitioners involved in Medicaid policy and the development of state exchanges, and researchers from academia and think tanks. The workshop had several goals: (1) to provide an opportunity for peer learning among state Medicaid leaders, policy practitioners, and policy researchers with respect to the implementation and sustainability of Medicaid expansion-related policies; (2) to discuss and document opportunities and challenges for states as they implement the Medicaid expansion under the Patient Protection and Affordable Care Act (PPACA); (3) to explore how a *JHPPL*-led practitioner-scholar network could add value; and (4) to identify strategies for disseminating information and findings to states and networks of policy makers and analysts.

To set the context for the discussion, several researchers presented on key issues related to Medicaid and the implementation of the PPACA. John Holahan of the Urban Institute began the workshop by presenting recent research estimating the effects of the PPACA on state Medicaid costs, Medicaid enrollment, and remaining number of uninsured by state. He concluded that although there was variability by state and region, overall the Medicaid expansions provided significant benefits for states relative to their investments. Katherine Swartz, a Harvard health economist, shared her research on the long-term sustainability of Medicaid given broad socio-economic, demographic, and health care trends. She concluded that Medicaid would require major changes over time. Sara Rosenbaum of the George Washington University laid out a series of opportunities for state flexibility in program design related to implementing the PPACA. Finally, Larry Jacobs, a political scientist at University of Minnesota, shared early results from a new project analyzing the key factors associated with PPACA implementation trajectories. He found that state administrative capacity and previous policy experience were more predictive of implementation success than was the partisan composition of state political leadership.

Each presentation was followed by commentary and reflections from a senior state health official, who shared his or her perspectives on the issues identified. Several themes emerged from the reactors and discussion following the presentations:

- There was consensus that Medicaid expansion under the PPACA would be financially beneficial to states with 100 percent federal match in the near term across a number of dimensions, including the infusion of federal funds, job creation, access improvements, and viability of safety net health care providers.
- There were consistent concerns among the participants about the long-term financial sustainability of Medicaid and its pressure on state budgets. Most participants accepted that the health care system will move from paying for volume of services to paying for value created.
- Notably, health officials in states led by conservative and progressive elected officials shared similar practical and structural concerns about Medicaid. Where they differed is in the order of action: progressive states are moving forward with the implementation of PPACA first and then plan to deal with these fundamental issues, while conservative state leaders are looking for action around the fundamental issues before they move forward with full implementation.
- There are fundamental differences in state and federal perceptions of what constitutes flexibility in Medicaid. The current federal perspective focuses on ways to expand eligibility and access to care for beneficiaries, while the state perspective typically focuses on budgetary relief.

The workshop participants then focused on two major issues that emerged during the discussion, intergovernmental relations and policy design.

The first set of issues concerned federal-state relations, in particular the states' role and voice in PPACA rule making and their ability to access the information they need for implementation. There is a long history of strained intergovernmental relations over Medicaid, but these tensions have been amplified both by the extensive scope of the PPACA and by the fiscal environment in which it is being implemented. In brief, states are being asked to take on new responsibilities and tasks at a time of reduced administrative capacity because of severe budget cuts. As one state Medicaid official characterized the capacity challenge, "Yes, we have an Office of Health Reform, and you are talking to him."

Medicaid officials from both red and blue states recounted an extensive list of difficulties, especially lack of information, lack of coordination, and uncertainty. Some aspects of the legislation came as a surprise: states were distressed by the maintenance of effort requirements in the PPACA, which limited a crucial budget tool, the ability not to cover optional groups. Overall, states are nervous precisely because they do not know what budget tools

are available to them. For example, the Centers for Medicare and Medicaid Services (CMS) have prevented even small increases in cost sharing.

State officials cited a lack of coordination among federal agencies as another issue, with states receiving mixed messages from different federal agencies. CMS issues a rule, but then the state gets audited by the Office of the Inspector General, which has a different reading of the rule. States' efforts are also hampered by uncertainty. Some regulations have been slow in coming, undermining states' ability to plan. Uncertainty also arises from the way the legislation has been implemented. For example, states do not know the requirements for establishing a Basic Health Plan (BHP). So despite interest from a number of states in creating a BHP, it has proved to be a distraction because it is not viable in the near term.

The lack of information, coordination, and certainty undermines trust between the states and the federal government. State officials also resent federal judges who rule that states cannot do X or Y—judges who do not have to balance budgets. At the most basic level, state officials are concerned about states' ability to negotiate and to manage the federal-state partnership, and tensions between the two have come to a head with the PPACA's complexity and scope.

The second major set of issues concerns policy design—both the larger issue of Medicaid's place in the health care system and more specific PPACA-related design issues on coordination between Medicaid and the exchanges. The PPACA expands Medicaid's size and scope without fundamentally reforming it. Therefore preexisting problems remain: the fact that the sickest and most expensive patients, the dual eligibles, are split across Medicaid and Medicare without sufficient coordination; the fact that because of variation in coverage of optional populations and services, identical individuals can be eligible in some states but not in others; the fact that Medicaid rolls are expanding because of job loss during the Great Recession, and threaten to continue to grow in the future because of stagnant wages and declines in wealth among lower-income groups, posing a risk to state budgets.

To these existing problems the PPACA adds a host of new difficulties. Medicaid already represents a growing burden on state budgets; with optional expansion under the PPACA, the program would grow dramatically in the poorest states with the lowest fiscal capacity (e.g., poor states could go from covering one in five poor childless adults to covering all of them). Do these states have the administrative capacity to handle all the new enrollees? Will they have the fiscal capacity to cover these new populations once the federal match drops to 90 percent in 2017?

States also have new tasks under the PPACA. For example, before the reform, when an individual left Medicaid, he or she often entered the uninsured population, dropping out of state purview and into the hands of cities or counties, which handle the bulk of the uninsured problem. Under the PPACA, individuals who leave Medicaid may now enter other insurance coverage such as a state or federal health benefits exchange. Thus state health officials must coordinate coverage and delivery systems across health insurance platforms. This will be difficult to do, since the culture and goals of these different institutions and programs vary greatly. Beyond these coordination issues are policy design issues: How will movement between Medicaid and exchanges function in terms of financing, delivery systems, and the individuals' experiences? For example, will patients who change coverage have to change their providers? What happens in the case of a woman at 150 percent of the federal poverty level who has been insured through a health exchange who becomes pregnant, and her state's Medicaid program covers pregnant women up to 185 percent of poverty level. Will she be required to enroll in Medicaid? Medicaid and exchange alignment issues are new, important, and complex, since each has a different financing source.

In this environment, *JHPPL* has proposed convening a research network that would conduct policy-relevant research, formulate recommendations for improving federal-state coordination, and develop policy designs for Medicaid exchange alignment and safety net integration. Its primary objective would be to nurture policy ideas and share feasible strategies and best practices as they emerge.