

ACA Implementation—Monitoring and Tracking

Cross-Cutting Issues:

Progress in Implementing Selected Medicaid Provisions
of the Affordable Care Act: A 10-State Analysis

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia to help states, researchers and policy-makers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. In addition, state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

INTRODUCTION

Even in the wake of the June 2012 Supreme Court ruling that made the Affordable Care Act's (ACA) Medicaid expansion provision voluntary for states, Medicaid remains a centerpiece in the law's effort to expand health insurance coverage and reform the nation's health care system. In addition to the now-optional Medicaid expansion to individuals with incomes up to 138 percent of the federal poverty level (FPL) in 2014,¹ the ACA includes many other Medicaid-related provisions, such as the option to expand Medicaid early (before 2014), the requirement to modernize program eligibility and enrollment systems, and testing of new delivery systems. A related provision gives states the option to create a Basic Health Program (BHP), which can be structured as a Medicaid-like program for low-income individuals who are ineligible for Medicaid. Given that Medicaid is administered through a federal-state partnership, much of the responsibility for implementing these parts of the ACA resides with the states. While the law presents a host of opportunities, it also poses many challenges to states. Quick and nimble decision-making by policymakers is essential, as is rapid-fire program design and implementation. At the same time, states are experiencing exceptionally tough fiscal times, with many enacting significant cuts to their Medicaid programs.

In this brief, we draw on the experiences of 10 states (Alabama, Colorado, Maryland, Michigan, Minnesota,

New Mexico, New York, Oregon, Rhode Island and Virginia) participating in the Robert Wood Johnson Foundation's State Health Reform Assistance Network and the related health reform implementation monitoring and tracking project. We describe health care stakeholders' perceptions of the costs and savings related to the ACA Medicaid provisions, as well as state decisions about implementing selected major Medicaid provisions available under the 2010 federal health reform law. In particular, we examine state action on or consideration of modernizing Medicaid eligibility and enrollment systems, pursuing integrated financing models for Medicaid beneficiaries who are also covered by Medicare (also known as dual-eligible beneficiaries), expanding Medicaid early, and implementing the Basic Health Program.

The information in this brief is based on site-visit interviews conducted with key health care stakeholders in each of the 10 states between September 2011 and April 2012, as well as review of state documents and the published and gray literatures.

For context we begin with a brief overview of Medicaid eligibility standards in the 10 study states just before the ACA became law. Then we discuss the potential impact of the ACA Medicaid expansion on the states. These two factors have a substantial influence on how states view the savings and costs of the ACA Medicaid provisions.

DIFFERENT STARTING POINTS: PRE-ACA MEDICAID ELIGIBILITY STANDARDS

Reflecting the design and nature of Medicaid, the breadth of study states' eligibility standards for the program varied considerably when the ACA became law. In Table 1 we show selected Medicaid eligibility standards for the 10 states in 2009, just before the ACA was enacted. The first two columns display state income limits for nonworking parents² and nondisabled adults without dependent children—the two populations that stand to gain the most under the ACA's Medicaid provisions.³ Across the states, there was nearly a 20-fold

difference in eligibility standards for parents (states must cover parents under Medicaid but have flexibility in income standards) ranging from 11 percent of FPL in Alabama to 215 percent of FPL in Minnesota. An even greater disparity is observed in Medicaid coverage of nondisabled adults without dependents; before the ACA, states could not cover this group without first securing a waiver. Only New York, as part of its long-standing Partnership Plan waiver, provided full Medicaid benefits to this population before enactment of federal reform.

Table 1. Pre-ACA Eligibility and Enrollment Levels and Potential ACA-Related Enrollment Increases for 10 Study States

	Pre-ACA Medicaid Eligibility Standards, Full Benefits (2009)		Pre-ACA Medicaid Eligibility Standards, Limited Benefits (2009)		Percent Increase in Medicaid Enrollment Assuming Full ACA Implementation in 2011 ³
	Jobless Parents ¹	Adults without Dependents ²	Jobless Parents ¹	Adults without Dependents ²	
Alabama	11%	N/A	N/A	N/A	45%
Colorado	60% ⁴	N/A ⁴	N/A	N/A	48%
Maryland	116%	N/A	N/A	116%	38%
Michigan	37%	N/A	N/A	35% ⁵	30%
Minnesota	215%	N/A	275%	250%	14%
New Mexico	29%	N/A	200% ⁵	200% ⁵	37%
New York	150%	100%	N/A	N/A	13% ⁶
Oregon	32%	N/A	100%/185% ^{5,7}	100%/185% ^{5,7}	67%
Rhode Island	175%	N/A	N/A	N/A	21%
Virginia	23%	N/A	N/A	N/A	51% ⁸

1. Cohen Ross et. al., “A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009”, http://www.kff.org/medicaid/upload/8028_T.pdf.
2. For all states except Minnesota, eligibility information is from: Kaiser Family Foundation, “Expanding Health Coverage for Low-Income Adults: Filling the Gaps in Medicaid Eligibility”, May 2009, <http://www.kff.org/medicaid/upload/7900.pdf>. For Minnesota, eligibility information is from: Chun, R., Minnesota House of Representatives' Research Department, MinnesotaCare Information Brief, October 2011, <http://www.house.leg.state.mn.us/hrd/pubs/mncare.pdf>
3. Blavin F, Buettgens M and J Roth, “State progress toward health reform implementation: Slower moving states have much to gain. RWJF, Timely Analysis of Immediate Health Policy Issues” (Washington, DC: The Urban Institute, January 2012).
4. Colorado passed legislation expanding Medicaid and CHIP in 2009 (House Bill 09-1293, the 2009 Health Care Affordability Act). Specifically, the state expanded CHIP coverage for children and pregnant women with incomes up to 250 percent of FPL and Medicaid for parents and adults without dependents up to 100 percent of FPL. Though the expansion was signed into law before passage of the ACA, it did not take effect until after the federal health reform law was passed. The coverage expansion for children, pregnant women, and parents became effective in May 2010; for adults without dependents, a scaled-down expansion (up to 10 percent of FPL) became effective in April 2012.
5. Enrollment closed.
6. Blavin F, Blumberg L, Buettgens M and J Roth, “The coverage and cost effects of implementation of the Affordable Care Act in New York State” (Washington DC: The Urban Institute, March 2012).
7. In Oregon, limited waiver coverage is available for parents and childless adults with incomes up to 100 percent of FPL; a premium assistance program is available to parents and childless adults up to 185 percent of FPL.
8. Estimates for Virginia from the Health Insurance Policy Simulation Model (HIPSM).

Short of offering full Medicaid benefits, states also can provide limited Medicaid coverage (e.g., a benefit package limited to primary or outpatient care only) to parents and adults without dependents. The third and fourth columns in Table 1 indicate which of the 10 states offered this type of coverage in 2009. Again, wide variation is observed. Four states (Alabama, Colorado, Rhode Island and Virginia) offered no such coverage to parents or to adults without dependents.⁴ Each of the rest provided coverage to at least one group, though the income limits vary widely, ranging from Michigan's coverage of adults without dependents with incomes up to 35 percent of FPL to Minnesota's coverage of parents

Factors that affect a state's expected Medicaid enrollment growth also include the availability of other insurance options (such as employer-sponsored insurance) in the state, the share of the state's current Medicaid eligibles enrolled in the program, and its underlying poverty rates.

with incomes up to 275 percent of FPL. Notably, in several of the states (Michigan, New Mexico and Oregon), enrollment in limited-benefit Medicaid programs is closed (and, in some cases, has been for several years), making effective coverage of these state programs very limited. Only in Maryland and Minnesota is enrollment for limited Medicaid benefits currently open to new enrollees. Medicaid enrollees that are receiving limited benefits now will be considered "new eligibles" in 2014, at which point they will begin receiving more comprehensive benefits and states will receive higher federal matching funds for their coverage.

Pre-ACA Medicaid eligibility standards, particularly for parents and adults without dependents, greatly affect the level of increase in Medicaid enrollment that a state can expect if it opts to expand the program in 2014. All else equal, states with more limited Medicaid eligibility thresholds would experience larger enrollment increases under the ACA than states with higher thresholds. Additional factors also affect a state's expected growth, including the availability of other insurance options (such as employer-sponsored insurance) in the state, the share of the state's current Medicaid eligibles enrolled in the program, and its underlying poverty rates.⁵

The potential impact of the ACA Medicaid expansion on each of the 10 states is displayed in Table 1's last column, which shows expected Medicaid enrollment increase assuming that each state fully implemented the Medicaid expansion in 2011. The projected enrollment includes individuals made newly eligible for Medicaid under reform as well as individuals currently eligible for Medicaid but not enrolled.

New York is predicted to have the lowest percent increase (13%) in its Medicaid enrollment, followed by Minnesota (14%) and Rhode Island (21%). In large measure this reflects these states' comparatively generous core Medicaid eligibility standards. At the other extreme, several states are projected to experience significant increases in enrollment, most notably Oregon (67%), Virginia (51%) and Colorado (48%). Low Medicaid eligibility standards explain much of these states' higher expected ACA enrollment increases, but a state's uninsurance rate for low-income individuals is another important factor. For example, nationally 34 percent of individuals under 139 percent of FPL are uninsured, but in Oregon the rate is 39 percent.⁶

SAVINGS AND COSTS OF THE ACA'S MEDICAID PROVISIONS

Unsurprisingly, states held a variety of perspectives on the savings and costs related to the ACA's Medicaid provisions. While a state's political environment certainly played an important role, its current Medicaid eligibility standards and general program features were also critical in shaping how the 10 states viewed both mandatory and optional Medicaid reforms.

A major source of savings for several of the states will be the ACA's higher federal match (100% for 2014–16 and then gradually declining to 90 percent in 2019 and beyond)⁷ for populations under 139 percent of FPL that they already provide limited Medicaid coverage to or currently cover in state-only financed health programs. As to the former, Oregon expects to save considerable state Medicaid funds for the some 70,000 enrollees that

are currently receiving limited benefits. At present Oregon receives its Medicaid standard match of about 63 percent for this group, but the state will begin receiving the higher match designated for “new eligibles” in 2014. Maryland, Michigan and New Mexico stand to realize similar, albeit smaller, savings related to the limited benefit Medicaid coverage they currently provide.

New York similarly anticipates substantial savings by receiving enhanced Medicaid matching funds for the 1 million-plus adult-without-dependents enrollees for which it currently provides full Medicaid coverage. The ACA includes a specific provision for “expansion states,”

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or those states that already provided full Medicaid benefits to parents and/or adults without dependents with incomes up to 100 percent of FPL (or higher) when federal health reform was enacted. Seven states appear to meet this definition, including one study state, New York.⁸ Expansion states will receive a phased-in increase in their federal Medicaid match rate for adults without dependents that by 2019 will equal the higher matching rate available for newly eligible adults.

Some states noted that they expect savings because of reductions in spending for health care services and programs that are now financed with state-only dollars but that under reform would be shifted to Medicaid with the benefit of federal matching dollars. Maryland, for example, projects \$423 million in reductions in state funding for public health programs, mental health administration, and alcohol and drug abuse administration. New Mexico officials suggested their state might also benefit from reductions in state funding for behavioral health services, but thought this would depend on the contents of the Essential Health Benefit package that states must include in their benchmark benefit set for new 2014 Medicaid enrollees. At the same time, other states (e.g., Oregon and New York) did not see much opportunity to roll more state-only financed services into Medicaid. As one New York

official explained, “New York has made an art form out of Medicaid-izing services.”

Several states also mentioned the potential to save Medicaid funds by transitioning existing Medicaid enrollees with incomes above 138 percent of FPL into federally subsidized private coverage provided through the state’s health insurance exchange (exchange). Each of the 10 states covers at least some children above this level, either through Medicaid or the Children’s Health Insurance Program (CHIP). The ACA requires states to maintain Medicaid and CHIP eligibility levels for children until 2019, after which point they can choose to transfer these enrollees to exchange-based coverage. Each of the 10 states except Alabama also covers pregnant women above 138 percent of FPL and can transfer these enrollees to the exchange beginning in 2014. In addition, to varying degrees several states (e.g., New York, Minnesota, New Mexico and Rhode Island) have the option to make a similar shift for other populations (e.g., the medically needy or parents) with incomes above 138 percent of FPL that they currently cover. While states indicated that these types of transitions are under consideration, none had reached any decision about such a change at the time of the site visit interviews. Indeed, some state officials acknowledged that to “roll back” Medicaid eligibility is not an easy task, especially in states that have nurtured a “culture of coverage.”

More immediately, several states have already realized savings under the ACA. Perhaps the primary example among our states is Minnesota. As will be described in more detail below, Minnesota took up the ACA’s early Medicaid expansion option and began receiving federal matching funds for a health coverage program that had been funded solely through state dollars, a move expected to save the state an estimated \$1.7 billion between 2011 and 2015. Also factoring into this estimate is the higher federal match rate that Minnesota will begin receiving for early expansion enrollees’ coverage beginning in 2014, since these enrollees will be considered “new eligibles” at that time. Another early source of savings that several states (e.g., Minnesota, Michigan and New York) have already taken advantage of is the ACA authorization of prescription drug rebates for Medicaid managed care plans. Before the new law, states had only been allowed to take these rebates for drugs paid for on a fee-for-service basis.

Although most of the states appreciate that considerable savings are available to them under the ACA, officials in some states were also worried about their ability to finance their Medicaid programs in the future. In

particular, they expressed concern about how they would pay for expansion to new ACA enrollees once federal funding for this group begins to decline in 2016. Moreover, some states (e.g., Alabama, New Mexico and Virginia) are worried about the costs associated with the “woodwork effect” of ACA-related coverage expansions—that is, the cost of covering currently Medicaid-eligible but not enrolled individuals who decide to enroll when the ACA coverage expansions become effective, a group for which the state would only receive its standard Medicaid match. A surge in enrollment

among currently eligible but not enrolled Medicaid individuals is a relevant concern even for those states that choose not to expand Medicaid eligibility in 2014, given the ACA’s individual mandate, the availability of both a new enrollment portal and subsidies in exchanges, the connection between exchanges and state Medicaid programs, and other factors. States must plan for these new costs at a time when rising Medicaid expenditures continue to be a major source of fiscal pressure, a problem that will likely persist in the future due to rising health care costs and an aging population.

MODERNIZING MEDICAID ELIGIBILITY AND ENROLLMENT SYSTEMS

To date, much of the work to implement the ACA’s Medicaid provisions in our study states has focused on modernizing eligibility and enrollment systems, which all 10 states have pursued. The ACA calls for major changes in the way these systems operate by requiring states to rely on electronic rather than paper-based processes, make eligibility decisions in “real time,” and provide self-service (e.g., online, telephone) enrollment

states in our study, all but two (Colorado and Michigan) are using decades-old “legacy” Medicaid eligibility and enrollment systems. Though states have long recognized the need for modernization, the high cost of technology and budget constraints prevented them from pursuing large-scale overhauls and upgrades. With the passage of the ACA, however, came a significant increase in federal financial support for system investments. States can receive enhanced federal Medicaid matching funds (a 90% match, often called the 90/10 funding) through 2015 for designing and developing new eligibility systems.⁹

The ACA’s vision of highly automated, user-friendly eligibility and enrollment Medicaid systems is a sea change for the 10 study states.

and renewal options. Eligibility and enrollment processes must also be coordinated across Medicaid, CHIP and the exchange, so consumers can transition seamlessly between programs. In addition to providing a “first-class” enrollment experience for customers and improving program efficiency, changes in Medicaid enrollment and eligibility processes are essential to ensuring that state Medicaid programs can handle the expected increase in application volume associated with the 2014 ACA coverage expansions.

The ACA’s vision of highly automated, user-friendly eligibility and enrollment Medicaid systems is a sea change for the 10 study states. Their current systems rely heavily on paper-based processes, are expensive to maintain, and were not designed to share information with other state and federal databases, which will be required once the ACA is fully implemented. Of the

Given federal health reform’s imperative to modernize Medicaid eligibility systems in a very short time frame, the influx of temporary federal funding, and the archaic condition of existing state systems, it is unsurprising that in the initial years of ACA implementation our study states prioritized system modernization over other Medicaid-related provisions. It is also significant that compared to other parts of the ACA, investing in information technology has widespread support among policy-makers, who may view system modernization as a way to reduce bureaucratic red tape and increase the efficiency of government programs. Minnesota’s state legislature, for example, remained bitterly divided over exchange establishment, but it still appropriated the state funding necessary to draw down the enhanced 90/10 federal match for system modernization. In Virginia, a state that challenged the constitutionality of the ACA in the June 2012 Supreme Court case, informants said that policy-makers backed the state’s ACA-related eligibility system overhaul and thought system modernization was “still a good investment, regardless of the outcome of the court decision.”

As shown in Table 2, all 10 states responded to the 90/10 incentive Medicaid match and were in various stages of pursuing the funds at the time of our site visits. Further, four study states—Maryland, New York, Oregon and Rhode Island—received “Early Innovator” grants to develop integrated eligibility and enrollment systems for Medicaid and the exchange using components that can be easily modified and adopted by other states. Typical modernization activities across the study states included developing online application forms that consumers can use for self-service enrollment and renewal, replacing or upgrading eligibility rules engines (i.e., the “brains” of the eligibility determination process), and creating electronic interfaces so different state and federal databases can share the information needed to process an applicant’s eligibility (e.g., data on income, residency, and citizenship) and make real-time determinations.

Every study state planned to or already had contracted with an external vendor to implement modernized systems. Informants generally agreed that outsourcing was necessary both because of time constraints and lack of specific in-house expertise. Most reported that they planned to or had already procured “commercial off-the-shelf” system components that the vendor would configure specifically for their state, as compared to creating a custom-built system that would require more resources and may force the state to rely on the vendor, in perpetuity, for future coding and programming needs. Using an off-the-shelf product marks a notable departure from previous state efforts to upgrade or overhaul Medicaid eligibility and enrollment systems, which were generally custom built.

Table 2. Eligibility and Enrollment System Modernization in 10 States, July 2012

State	Using Enhanced Federal (90/10) Match			Received Early Innovator Grant	Status of Procurement	
	Received Approval	Submitted Plans	Will Submit Plans		RFP Released	Contract in Place
Alabama	✓				✓	
Colorado			✓			✓ ¹
Maryland	✓			✓		✓
Michigan			✓			
Minnesota		✓				✓
New Mexico	✓					✓ ²
New York			✓	✓		✓
Oregon	✓			✓		✓
Rhode Island	✓			✓	✓	
Virginia			✓		✓	

1. In Colorado, the Exchange and Medicaid eligibility systems will be interoperable but not fully integrated. The Colorado Health Benefits Exchange selected CGI Technologies and Systems to develop its system in May 2012. The Colorado Medicaid program procured a commercial off-the-shelf (COTS) rules engine in 2012 and will work primarily with its existing Medicaid system vendor (Deloitte) to configure its system, with the potential for smaller procurements (with other vendors) later as part of its system replacement project.
2. In New Mexico, it is not yet clear whether the Exchange and Medicaid will share a single fully-integrated eligibility system. The state began its Medicaid modernization project prior to passage of the ACA, and contracted with Deloitte to replace its legacy system. An RFP for an exchange system was released in early 2012 but subsequently canceled; the state has since contracted with Leavitt Partners to analyze system requirements and work on creating a new RFP.

Table 2 shows the status of system procurements as of July 2012. Contracts to replace or upgrade Medicaid systems are in place in six states: Colorado, Maryland, Minnesota, New Mexico, New York and Oregon. Three additional states (Alabama, Rhode Island and Virginia) have released RFPs but have not yet awarded contracts;

in Alabama’s case, an award notice was issued in March 2012 but subsequently retracted, with no action since. One state—Michigan—has not yet released an RFP but plans to do so in the coming year.

Without exception, informants described the ACA’s aggressive timeline as the biggest challenge to

implementing modernized eligibility and enrollment systems. The federal government will perform a readiness test of state eligibility and enrollment systems for the exchange in July 2013, and ACA-compliant eligibility systems for Medicaid and the exchange must be in place by October 2013, when open enrollment for the 2014 health plan year begins. State officials worried about whether they would be able to meet these deadlines. One state official said that because of the compressed time frame, eligibility and enrollment system development was “without question, the single most stressful piece of health care reform.” In another state, an official joked, “I’m pretty sure we’re already out of time!”

Another challenge related to modernization involves uncertainty about specific federal requirements for eligibility and enrollment systems. For example, at the time of our site visits states had very little information about how their new systems must interface with the promised “federal data hub” that will allow them to access eligibility information from federal agencies like the Internal Revenue Service and the Department of Homeland Security. Because of the ACA’s tight

implementation timeline, states had no choice but to begin their modernization activities before receiving complete federal guidance. As a New Mexico official aptly noted, “We’re building the car as we’re driving down the road.” To address this uncertainty, several states emphasized the need for flexibility in their requests for proposals and placed a high value on this when making procurement decisions. New York also built supplements into its system development contract that allow the vendor to respond to future federal guidance. Similarly, New Mexico officials set aside \$1 million of the state’s exchange establishment grant funding to respond to new (or changing) federal guidance in system requirements.

Finally, to date, states are more focused on the “back-end” processes related to eligibility and enrollment such as the eligibility rules engine and electronic data interfaces. Respondents noted that they will separately pursue “front-end” solutions—which are expected to be less complicated, implementation-wise—including the web site through which consumers will access online applications or compare health plans.

FINANCIAL ALIGNMENT MODEL FOR DUAL ELIGIBLES

Another major ACA Medicaid initiative that is almost as popular as eligibility system modernization among our study states involves designing and implementing delivery and payment models that integrate care for Medicaid beneficiaries who are also covered by Medicare—the so-called dual eligibles, one of the costliest groups served by the Medicaid program. The goal behind the initiative, commonly referred to as the Financial Alignment or FA demonstration, is to test person-centered care models that align the financing and delivery of care to dual eligibles by fully integrating medical, behavioral health and long-term care services. The expectation is that by combining Medicaid and Medicare funding and integrating across the full care

spectrum, states (and the federal government) will save money while improving the quality of care delivered to dual eligibles. Two basic models are to be tried: capitated integration and managed fee-for-service (FFS) integration.

In April 2011, the federal government awarded 15 states with up to \$1 million in federal funding to support the design and development of integrated health programs for dual eligibles. Five of our study states (Colorado, Michigan, Minnesota, New York and Oregon) were selected to receive one of the 15 planning grants (Table 3). Since then, the federal government has sought full demonstration proposals from the 15 FA planning grant states and invited other interested states to submit proposals.

Table 3. Financial Alignment (FA) Demonstration for Duals in 10 States, July 2012

State	Received FA Planning Grant	Submitted FA Proposal to CMS	Model Type ¹
Alabama	No	No	—
Colorado	Yes	Yes	FFS
Maryland	No	No	—
Michigan	Yes	Yes	Capitated
Minnesota	Yes	Yes	Capitated
New Mexico	No	Yes	Capitated
New York	Yes	Yes	FFS/Capitated
Oregon	Yes	Yes	Capitated
Rhode Island	No	Yes	FFS/Capitated
Virginia	No	Yes	FFS/Capitated

1. FFS—fee for service

As of July 2012, 25 states have submitted FA demonstration proposals, including eight of the 10 study states. Only Alabama and Maryland are not pursuing the initiative. Reflecting their current dominant model of Medicaid health care service delivery, Michigan, Minnesota, New Mexico and Oregon have proposed capitated approaches, while New York, Rhode Island and Virginia have proposed testing both capitated and FFS models. Only Colorado has proposed an FFS-only model of integrated care for dual eligibles.

Most FA proposals envision a statewide demonstration that would include the vast majority of the study states' dually eligible populations. New York and Virginia are exceptions in that their proposed models would operate only in certain regions and cover about half of their respective dual eligibles. Implementation dates for the demonstrations vary: most study states expect to begin demonstration enrollment in early 2014, though Colorado and Minnesota hope to implement in early 2013, subject to CMS approval.

Several study states have proposed FA demonstrations that would be integrated into broader Medicaid delivery system reform efforts. Colorado's demonstration, for example, would be part of the state's newly established Accountable Care Collaborative effort, which officials compared to a primary care case management program, "but with more players." New York's proposed FFS FA model would build on its Health Home initiative, an ACA-authorized effort under which the state is receiving temporary enhanced federal funding for health home services (e.g., care management and coordination, transitional care, referrals for social services) for Medicaid beneficiaries with chronic conditions. And Oregon's demonstration would be rooted in the state's recently launched effort to serve Medicaid beneficiaries through Coordinated Care Organizations, which are community partnerships of providers, community members and risk-bearing entities.

EARLY MEDICAID EXPANSION OPTIONS

The ACA created new opportunities for states to cover low-income adults in advance of the 2014 Medicaid expansion. Specifically, the law includes a new Medicaid state plan option to cover adults with incomes up to 133 percent of FPL and a related provision that allows states to cover low-income adults through a Medicaid Section 1115 waiver but without meeting the budget neutrality typically required under a waiver.¹⁰ The costs of these

early expansion options are shared with the federal government at the state's regular federal matching rate,¹¹ and in 2014 they will be eligible for the higher federal matching funds provided for newly eligible enrollees in the ACA. Across the country, seven states and the District of Columbia have taken advantage of one or both of these ACA early expansion provisions, including two states in our study—Colorado and Minnesota.¹² Both

Colorado and Minnesota counted the early Medicaid expansion among their initial successes in implementing the ACA, and the provision was supported by an array of stakeholders. Other study states such as Michigan and New York reported considering early Medicaid expansion but ultimately decided that their current budget could not support such a move.

Colorado received a Section 1115 waiver to implement a small-scope expansion to adults without dependents with incomes up to 10 percent of FPL, effective April 2012 and capped at 10,000 beneficiaries. Even before the ACA was enacted, Colorado was planning to expand coverage, and on a much larger scale, to low-income adults without dependents as part of a broader state health reform effort.¹³ Budget constraints prevented Colorado from implementing the full-scale expansion that was originally envisioned, however, and instead the state opted to cover a subset of the population under the ACA early Medicaid expansion provision. Colorado officials reasoned that, in addition to providing full Medicaid benefits to previously uninsured adults living in extreme poverty, this incremental expansion approach would provide the state with valuable experience covering the population that will be newly eligible for the program in 2014. For instance, they expected the early expansion to help with identifying outreach and enrollment strategies for the new eligibles and with creating a benefit package that would fit their needs. Given the state's current fiscal environment, officials did not expect to expand Medicaid to additional

low-income adults (beyond 10 percent of FPL or 10,000 beneficiaries) before 2014.

Minnesota, on the other hand, used both the ACA's early expansion provisions to secure federal Medicaid financing for health insurance programs that were previously funded entirely with state dollars. Under the ACA state plan expansion option, Minnesota transferred more than 80,000 adults without dependents with incomes up to 75 percent of FPL from Minnesota's long-standing state-funded, limited-benefit General Assistance Medicaid (GAMC) program into federally matched Medicaid with standard Medicaid benefits. In addition, using the Section 1115 waiver process, Minnesota is now receiving federal Medicaid funds to finance coverage for over 41,000 adults without dependents who have incomes between 75 and 250 percent of FPL who had been enrolled in the state-only financed MinnesotaCare program.¹⁴ These adults continue to receive a benefit package that is more limited than Medicaid.¹⁵ Implementing this combination of early expansion provisions was a fiscally advantageous move for Minnesota (the state is expected to save an estimated \$1.7 billion between 2011 and 2015) and provides a more stable funding base for the state's coverage of adults without dependents. Moreover, the lowest-income of these beneficiaries—those previously in the GAMC program—now receive a more comprehensive benefit package.

BASIC HEALTH PROGRAM

The BHP is an optional program available to states under the ACA. Although the BHP statute permits states to offer any coverage that is at least as comprehensive and affordable as subsidized exchange coverage, the BHP has generally been envisioned as a Medicaid or CHIP-like set of benefits with modest cost-sharing, targeted at individuals with incomes above the ACA Medicaid income thresholds but still low enough that the amounts charged in the exchange could make coverage or care unaffordable. Specifically, the BHP covers adults with incomes between 133 and 200 percent of FPL, and lawfully present immigrants below 133 percent of FPL who are ineligible for Medicaid (such as adults whose lawful residence status was approved within the past five years). BHP-eligible individuals must enroll in the BHP and may not receive subsidized private insurance through the exchange. States that choose to

create a BHP will receive 95 percent of what the federal government would have spent on exchange-based tax credits and either 95 or 100 percent of what would have been spent on cost-sharing subsidies, depending on how CMS interprets the BHP statute.

At the time of our site visit interviews, none of the 10 study states had made an official decision about whether to create a BHP, which is not unexpected given the complete absence (so far) of any federal guidance about the program. Most reported that they were considering and seriously studying the BHP, though in a handful of states—including Alabama, Colorado and Virginia—there had not been much discussion of the BHP, and informants indicated that its creation was very unlikely. In one study state—Michigan—a bill was introduced to

create a BHP in 2011, but there had been little activity related to it in the state legislature.

A determinative factor in the decision about whether to implement the BHP is the state costs of administering the program, of which there is still a great deal of uncertainty. Informants in several states expressed concern that federal BHP payments could come up short and expose the state to new expenditures, particularly if (on average) the BHP population is sicker and costlier than the average exchange enrollee. The ACA specifies that the federal government's contribution to a state's BHP will be based on the cost of exchange tax credits and other subsidies that BHP consumers would have received, but the subsidies themselves are based on the premium for the second-lowest cost "silver" plan offered in the exchange. If such plans resemble currently available commercial coverage, federal BHP payments should exceed the cost of providing BHP adults with

A determinative factor in the decision about whether to implement the BHP is the state costs of administering the program, of which there is still a great deal of uncertainty.

coverage like that offered by Medicaid or CHIP.¹⁶ However, premium costs in exchanges are unknown at this time and could vary substantially depending on the competition level in an exchange, complicating state efforts to evaluate whether federal funds are enough to support the BHP.

Several states had commissioned studies on the BHP at the time of our site visits, and the few that had received results shared mixed findings on program costs. New York's external analysis found many potential positive effects of a BHP and estimated that, even while paying providers more than Medicaid and offering much lower cost-sharing options than exchange-based coverage, program operations would not require additional state funds.¹⁷ The analysis suggested that New York could realize significant budget savings by moving beneficiaries from state-funded coverage programs (including legally residing immigrants currently ineligible for federally matched Medicaid) into the BHP, where subsidies would be entirely funded with federal dollars. In Minnesota, on the other hand, an external analysis of the BHP option reported that federal funds would likely not cover the

costs of a program. Some Minnesota observers, however, questioned the study results.¹⁸

Informants recognized the potential advantages of the BHP. Advocacy-oriented informants—among the option's biggest proponents—reasoned that the BHP would help smooth enrollee transitions between Medicaid and other insurance, primarily the exchange. Since BHPs can be structured to use the same managed care plans and health care provider networks as Medicaid, enrollees who move from one program into the other (e.g., due to an increase/decrease in income or family size) could remain in the same plan and continue seeing the same providers. Informants thought this level of continuity would be less likely in transitions between Medicaid and the exchange. Some informants also suggested that BHP coverage could be more affordable for low-income consumers than subsidized exchange coverage, but others were unsure about this given the considerable state flexibility permitted for BHPs.

If structured to build on current Medicaid or CHIP programs, the BHP also has distinct advantages for Medicaid managed care plans. Informants suggested that the option could make these plans more viable because it offers them a way to increase their enrollment without needing to become part of the exchange-based market, which would require certification as a Qualified Health Plan and enrolling a (higher-income, privately insured) population that the plans may not be accustomed to serving. Indeed, in each of the study states with risk-based Medicaid managed care that was still considering a BHP (Maryland, Michigan, Minnesota, New York, Oregon and Rhode Island), Medicaid plans were major supporters of the BHP option. Managed care plans that participate solely in the commercial market, on the other hand, were described in some states as opposing the option, presumably because a BHP would mean less business in the exchange for these commercial plans.

On the downside, a primary concern about the BHP across the study states was that it might compromise the exchange's integrity. For instance, a state's BHP would divert covered lives from the exchange and—depending on the risk profile of those individuals—premiums for exchange enrollees could be higher than they would have been otherwise. A few informants noted that a state could mitigate this effect by including the BHP in exchange risk adjustment and reinsurance or by combining risk across the markets, but most states were still in the early stages of determining how these risk-leveling mechanisms would work and they had not factored much into BHP discussions. In addition, a BHP could decrease the

exchange's enrollment potential to a point that might jeopardize health plans' interest in participating in the exchange. These concerns were particularly prominent in less-populous states such as Colorado, Oregon and New Mexico but were also shared by officials in larger states such as New York. Urban Institute research suggests that—at any given time in the average state—the BHP would cover one-third of consumers who otherwise would qualify for subsidies in the exchange.¹⁹ Taking into account exchange participation by small group plans and unsubsidized individual enrollees, however, an average of 8.2 percent of nonelderly residents would still be covered through exchanges with BHP (down from 9.6% without BHP).²⁰

Health care providers in some states were also hesitant to support the BHP because of the assumption that the

program's reimbursement rates would be similar to those in Medicaid, which are generally considered inadequate. Similarly, informants in a few states suggested that policy-makers might oppose the BHP because they see it as a “quasi-Medicaid expansion” and have negative views of that program.

For many states, overlaying all these concerns was the sense that they did not have the internal capacity to establish and administer a new program at this time, given all their other ACA-related responsibilities. As one informant noted, “With the timeline, I don't see how we could add the BHP to our load of work.” Others suggested that, as permitted by the ACA, states may choose to create a BHP at a later point, once the crush of preparation for the 2014 expansions has passed.

CONCLUSIONS

At this juncture in ACA implementation, our review of 10 state Medicaid programs shows that states are assiduously working on many different fronts to prepare for the 2014 coverage expansions while also taking advantage of various ACA-related opportunities to save costs and improve their programs. In particular, all the states are taking advantage of enhanced federal match to upgrade their Medicaid enrollment and eligibility systems, and eight are pursuing the financial alignment demonstration for dual eligibles, a major initiative under the ACA.

At the same time, only two states elected to expand Medicaid before 2014, which is consistent with the limited response of other states to this ACA option. While some of our study states considered expanding Medicaid early, their budget climates prevented them from going forward. Informants in all 10 states readily acknowledged that the nation's deep and protracted economic slowdown has seriously squeezed state Medicaid resources, directly affecting state decisions on early Medicaid expansion and whether to pursue the BHP, among others. Indeed, states expressed concern about financing their Medicaid programs if their budget situation further deteriorates. One Oregon official questioned how they were going to be able to “limp” along until 2014, when most of the ACA funding becomes available. In addition, officials in several (but not all) states worried about being able to finance

their share of the ACA eligibility expansion once the 100 percent federal match is reduced beginning in 2017. Equally worrisome to states was their ability to finance their share of Medicaid coverage for individuals who are currently eligible for Medicaid are not enrolled—the so-called “woodwork” enrollees.

As implementation of the ACA continues to unfold, states will need to make a host of critical decisions pertaining to the Medicaid provisions of the law. Clearly, the biggest decision states must make with regard to the ACA's Medicaid provisions still lies ahead: Will states take up or decline the Medicaid expansion? Our site visit interviews occurred before the Supreme Court's ruling that made the 2014 Medicaid expansion optional for states, and thus we do not have information on states' perspectives on this major decision. In addition, states will face decisions about how and to what extent they are going to pursue outreach and enrollment assistance, how they are going to structure benchmark benefits, and how care will be delivered to newly eligibles. Even states that decide against the Medicaid expansion will likely experience enrollment increases because of the woodwork effect and must continue to prepare their programs to handle the influx of applications come 2014. For each of these decision points and many others, states will calculate the benefits versus the costs and then make their choices, all the while building the foundation for Medicaid reform.

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ENDNOTES

1. Nominally, the ACA's Medicaid expansion is limited to adults with incomes up to 133 percent of FPL. However, 5 FPL percentage points are subtracted from income (i.e., an income disregard), so all adults with gross income at or below 138 percent of FPL will qualify.
 2. Slightly higher income eligibility thresholds typically apply to employed parents.
 3. Though not shown, each of the 10 states' Medicaid and CHIP eligibility levels for children and pregnant women already meet, and in most cases far surpass, the expansion of Medicaid to 133 percent of FPL allowed under the ACA.
 4. Technically, New York is in this group, but, importantly, as shown in the first two columns of Table 1, it offered full Medicaid benefits to jobless parents and adults without dependents.
 5. Buettgens M, Holahan J, and Carroll C. 2011. "Health reform across the states: increased insurance coverage and federal spending on the exchanges and Medicaid." Prepared for Robert Wood Johnson Foundation, Timely Analysis of Immediate Health Policy Issues, <http://www.urban.org/UploadedPDF/412310-Health-Reform-Across-the-States.pdf>.
 6. Kaiser Family Foundation, State Health Facts, "Health Insurance Coverage of the Nonelderly (0–64) with Incomes up to 139% Federal Poverty Level (FPL), states (2009–2010), U.S. (2010)," <http://statehealthfacts.org/comparetable.jsp?ind=849&cat=3>.
 7. This is the same federal matching level states opting to expand Medicaid in 2014 will receive for newly eligible enrollees who were not covered at all previously.
 8. Though the U.S. Department of Health and Human Services will make the official determination, the list of states meeting ACA's "expansion state" criteria of covering nonelderly, non-pregnant adults to at least 100 percent of FPL appears to include Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont.
 9. States must meet certain conditions, including seamless coordination with the exchanges, to qualify for the enhanced match rate. They are also eligible for an enhanced 75 percent matching rate for system maintenance and operations. The 90 percent matching rate is available for eligibility systems until December 31, 2015, and the 75 percent match is available beyond that date, assuming the conditions continue to be met. More information can be found at <http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf>.
- For states choosing to create a single integrated eligibility system for Medicaid and the exchange, other critical sources of funding include exchange planning and establishment grants (available 2010–13) and the Early Innovator grants awarded to a handful of states in 2011. As of July 2012, six study states—Maryland, Michigan, Minnesota, New York, Rhode Island and Oregon—were planning to create single, integrated systems.
10. Before the ACA, states could use 1115 waivers to expand Medicaid coverage to low-income adults, but these expansions had to be budget neutral to the federal government—that is, the state had to demonstrate that the expansion would not cost the federal government more than it would have paid in the absence of the waiver. The ACA allows states to cover low-income adults through 1115 waivers but waives the budget neutrality rules.
 11. The federal share of Medicaid spending, known as the Federal Medical Assistance Percentage (FMAP), is 50 percent on average but there is considerable state-by-state variation. FY 2013 FMAPs varied from a low of 50 percent (in Alaska, California, Colorado, and 11 other states) to a high of 73 percent (in Mississippi).
 12. Kaiser Family Foundation, 2012. "Quick Take: States Getting a Jump Start on Health Reform's Medicaid Expansion," http://www.kff.org/medicaid/quicktake_medicaid_expansion.cfm.
 13. This expansion was part of the state's 2009 *Health Care Affordability Act* (House Bill 09-1293), which expanded CHIP coverage for children and pregnant women with incomes up to 250 percent of FPL and Medicaid for parents and adults without dependents up to 100 percent of FPL. Legislative text can be found at http://www.leg.state.co.us/Clitics/CLICS2009A/csl.nsf/fsbillcont3/D71C48DD229F80CD872575540079F3A0?Open&file=1293_enr.pdf.

14. Before the ACA, Minnesota had received federal funding to help finance MinnesotaCare coverage for children, pregnant women, and parents.
15. Kaiser Family Foundation, 2012. "States Getting a Jump Start on Health Reform's Medicaid Expansion (Quick Take)," http://www.kff.org/medicaid/quicktake_medicaid_expansion.cfm.
16. Dorn S, Buettgens M, and Carroll C. 2011. "Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States," <http://www.urban.org/UploadedPDF/412412-Using-the-Basic-Health-Program-to-Make-Coverage-More-Affordable-to-Low-Income-Households.pdf>.
17. Benjamin ER and Slagle A. 2011. "Covering More New Yorkers while Easing the State's Budget Burden—Bridging the Gap: Exploring the Basic Health Insurance Option for New York." New York: Community Service Society of New York, http://www.healthcarereform.ny.gov/research_and_resources/docs/bridging_the_gap_exploring_basic_health_insurance_option.pdf.
18. Gruber J and Gorman B. 2011. "Coverage and Financial Impacts of Insurance Market Reforms in Minnesota," <http://mn.gov/commerce/insurance/images/Gruber-Gorman-Slides-11-17-11.pdf>.
19. Buettgens M, Nichols A, and Dorn S. 2012. "Churning under the ACA and State Policy Options for Mitigation." Prepared for Robert Wood Johnson Foundation, Timely Analysis of Immediate Health Policy Issues, <http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf>.
20. Dorn et al.