



The future of Medicaid in Colorado: Impacts of U.S. Supreme Court ruling

A discussion paper by and for Colorado physicians
by Joan Henneberry

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Optional Medicaid expansion

On June 28, 2012, the United States Supreme Court ruled on various provisions in the Affordable Care Act (ACA), including a mandatory expansion of the Medicaid program to cover all individuals living in families below 133% of the federal poverty level (in 2012, \$30,657 for a family of four) beginning January 2014. The Court ruled against that provision, primarily because the law gave HHS the authority to withdraw all federal matching funds if a state did not expand Medicaid - "a gun to the head" - threatening a state's entire Medicaid program. Now the decision about expanding Medicaid as part of the ACA will be made state-by-state. Several Governors have stated they intend to expand Medicaid by the 2014 target date, while several others have stated they do not plan to expand. Most, including Colorado, have either been silent or are studying the implications of expansion. It should be noted that when the Medicaid expansion was expected to be mandatory, most states were already planning for and analyzing the implications of the expansion. It is expected that all states will implement at least some portions of the ACA even if they do not expand Medicaid.



Recent Colorado Medicaid expansion

Since early 2007 Colorado Medicaid has been reforming and transforming, first as part of the state's health reform agenda and later to prepare for implementation of the ACA. These

reforms included myriad initiatives that started with: adopting medical homes for children in Medicaid and CHP+; expanding Medicaid eligibility for pregnant women and children; increasing reimbursements to pediatricians and other primary care providers; implementing new models of care for individuals with chronic conditions and high cost claims (now known as "hot spotters"); developing loan repayment programs; and instituting quality incentive payments for nursing homes.

With the support and collaboration of provider organizations including the Colorado Medical Society, Colorado took further steps to expand coverage, develop new models of service delivery, and initiate payment reforms. The capstone of the state's agenda was the passage of HB-1293 in 2009. The bill created a financing mechanism to expand Medicaid for the first time in Colorado to additional populations, including adults without dependent children, through a hospital provider fee. Simultaneously the state had been working on new service models, moving away from fee-for-service. The Colorado Medical Society strongly supported the development of a hybrid plan for Colorado that took the best ideas from other states. These efforts culminated in the creation of the Accountable Care Collaborative (ACC) that is now the foundation of the Medicaid service delivery system. The policy choices and models used by Colorado prior to the ACA set up the state nicely to implement key provisions in the ACA including further eligibility expansions, payment and service delivery reform, and changes in reimbursements to primary care providers.

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Key data assumptions

The Congressional Budget Offices (CBO) makes the following assumptions about the optional Medicaid expansion under the ACA:

- Of those patients newly eligible for Medicaid under ACA, one-third have incomes between 100% and 138% of FPL; two-thirds have incomes below 100% FPL.
- One-third of new Medicaid clients will be in states that will fully implement expansion; one-third in states that will delay expansion to 2015; one-third in states that will delay longer than a year.
- If a state expands in 2014 they will expand to 138% FPL. States that postpone will also seek to expand to more limited populations.
- Of the 6 million people who will remain uninsured in 2022 (living in a state that did not expand), three-quarters would have been eligible for the new Medicaid expansion; one-quarter were actually eligible for Medicaid pre-ACA but not enrolled.



Key choices and decisions for the state

Now that the decision to expand Medicaid is voluntary, it is assumed that Colorado will need enabling legislation to do so. In order to expand on January 1, 2014 per the ACA, a bill would need to be passed in the 2013 session of the Colorado Legislature and signed by Governor Hickenlooper. Until further guidance or interpretation of the Court's decision are issued by HHS, it is assumed that state options are:

- Expand Medicaid as outlined in the ACA, to 138% (133% plus disregards) of FPL for all non-elderly legal residents.
- Expand Medicaid but propose doing so in phases, i.e. up to 100% FPL by 2014, 125% FPL in 2015, to 138% FPL in 2016. Or expand to specific populations such as non-elderly dually eligible individuals.
- Examine the use of a Basic Health Plan (BHP) for individuals up to 200% FPL. The ACA gives states the option to put adults between 133 and 200 percent of FPL into a health plan with minimum essential benefits versus sending those individuals to the exchange for subsidies. States would receive 95% of what the federal government would have spent in the exchange, and the state would use those funds to pay the premiums of the BHP.
- Fully implement hospital provider fee expansion (from 10% FPL to 100% FPL) but have individuals above 100% FPL go to the exchange with subsidies. The state has authority now to expand Medicaid to adults without dependent children up to 100% FPL, prior to 2014. However, the state has limited this enrollment to 10,000 people and is not expected to expand eligibility prior to 2014 because this is a new population and could be more costly than originally expected.
- Agree to expand eligibility under ACA but postpone the implementation date from 2014 to 2015 or later.
- Expand eligibility while the federal government's share of costs is 100% (2014-2016), then roll back eligibility when the state has to provide match beginning in 2017.
- Request a waiver (prior to 2017) to cover everyone with a state-designed approach instead of ACA models. The federal Health and Human Services (HHS) secretary has authority to allow a state to develop their own coverage model if it achieves the same coverage and financial goals of the ACA.

Many of these options would require federal approval through a state plan amendment or waiver and it is not clear if the HHS secretary would have the authority (or willingness) to grant waivers for all of these options.

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Required and recommended state analysis

Since the passage of the ACA states have been concerned about their ability to complete all of the planning, system changes and IT adoption, and programmatic changes necessary to be ready on January 1, 2014. HHS and states acknowledge that even though federal funds will pay the full cost of medical care for newly eligible individuals in 2014, states will have additional administrative costs associated with eligibility and enrollment, promulgation of rules and regulations, program integrity requirements, and managing client appeals. States were not given any new administrative funds to implement general provisions of the ACA. There were, and still are, numerous grant-funding opportunities to make changes to Medicaid, but those grants have specific purposes, require someone to write and administer the grant, and come with new reporting requirements. In addition, states like Colorado are also analyzing the impact of the ACA on current initiatives underway such as the uses of the hospital provider fee, ACC rollout and expansion, current waiver programs, and reform of long-term care. Specifically Colorado should:

- Use recent analysis done for the health insurance exchange, and the data from the Colorado Health Institute and the household survey to: update information on the uninsured; project take-up rates for Medicaid and the exchange; map out current Medicaid provider participation rates; and analyze how many of those who enroll in Medicaid beginning in 2014 would be “newly eligible” (fully federally funded) and how many new enrollees were eligible under previous rules (state pays 50% of costs).
- Review studies regarding the benefit of Medicaid to improved health status and reduction in the burden of disease (Oregon Study, NEJM, 8/25/11; Mortality & Access Study, NEJM, 7/25/12)
- Forecast the amount of matching funds needed for out years when the state will be required to provide a portion of the costs (5% in 2017, 6% in 2018, 7% in 2019 and 10% in 2020).
- Calculate general fund savings that could be realized in other state or county agencies such as Department of Corrections, local public safety, behavioral health, human services and public health.
- Calculate the general fund or other financing savings from state-only programs that could be eliminated or significantly reduced after individuals receive coverage through either Medicaid or a health insurance exchange. If the state is serving optional populations and they become “new eligibles” calculate the benefit of enhanced match versus the current 50/50 match.
- Determine what the practical and funding implications for expanding a state’s Medicaid population through a waiver versus a state plan amendment.
- Since the ACA has been upheld with the exception of part of the Medicaid expansion, hospitals will be facing Disproportionate Share Hospital (DSH) allotment reductions totaling \$14.1 billion in FFY 2014 through FFY 2019, plus an additional \$4 billion in FFY 2020. For states that choose to forego participation in the Medicaid expansion, these hospitals will not only continue to see the uninsured/medically indigent, they will also be losing funds that have traditionally been directed to these hospitals that treat the uninsured. The pending DSH cuts will have deeper impact in states that do not expand their Medicaid program and policymakers will need to consider these fiscal issues.

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“Physicians who serve the very people impacted the most by that policy choice should have a seat at the table, and offer their knowledge, experience and quantifiable data to inform the policy deliberation.”

Issues of greatest interest to Colorado physicians and Colorado Medical Society



Perhaps the overarching challenge in the aftermath of the Court decision is whether to recalibrate policy and programmatic efforts designed to achieve the goal of everyone having insurance. If elected officials from either branch of government decide not to expand Medicaid eligibility by 2014, what impact might that have on these current efforts and goals? Physicians have always been concerned about the effects of everyone having coverage, both the positive and potentially negative impacts. Key questions for physicians are:

- How will the health status and outcomes of Coloradans be impacted by a Medicaid expansion to more individuals?
- How does the state plan to address the current concerns about access to primary and specialty care; will those access problems increase with an expansion and what are the solutions being considered to ensure access to care?
- Will the reimbursement rates to physicians be enough to entice them to serve new Medicaid clients and continue to participate in the existing program?
- How will the state implement the Medicaid primary care rate increase to parity with Medicare in 2013-2014? Is the state considering a way to continue that rate increase beyond 2015?
- Is the state considering other reimbursement changes in order to ensure access to specialists? Is there a unique impact on hospital-based specialties?
- What are the physician reimbursement rates going to be from health plans sold in the health insurance exchange? Will they use rates closer to commercial reimbursements or closer to public insurance programs?
- How will the coordination between the exchange and Medicaid help to reduce “churn” and improve continuity of care for new populations?
- What are the impacts from an SGR fix (or no fix) to providers’ willingness to serve Medicare and Medicaid clients?
- Will there be an attempt to roll back Medicaid eligibility once the maintenance-of-effort requirements (2014) are lifted?
- If the medical society takes a position against the Medicaid expansion in Colorado, is there an alternative being developed to propose to the state? Will the medical society take a position on block grants to states, or new “super” waiver authority should a new administration propose such an alternative?
- If the medical society takes a position in support of the expansion, is it prepared to condition its position with “asks” not otherwise associated with the state’s decision to participate in the expansion?

Generally Governors and other elected officials advocate for flexibility and state choice when it comes to health policy and financing decisions, but the unexpected ruling from the Court that gives states the choice of whether to expand Medicaid came as a surprise to most. Embedded in that choice are moral, financial, and political factors that will resonate for years regardless of the policy choice made by elected officials. Physicians who serve the very people impacted the most by that policy choice should have a seat at the table, and offer their knowledge, experience, and quantifiable data to inform the policy deliberation.