AHCCCS AND KIDSCARE

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The Patient Protection and Affordable Care Act (Act) envisions a healthcare system where nearly everyone has health insurance. Insurance is available four ways – through an employer, a health insurance exchange, a private health insurer or through public (federal and state funded) health insurance, such as Medicaid (called AHCCCS in Arizona), CHIP (called KidsCare in our state) or Medicare.

To help realize this vision of near-universal coverage through one of four means, the Act greatly expands and strengthens the role that AHCCCS and KidsCare will play in providing coverage to Arizonans. The Act expands eligibility, incentivizes quality and encourages states to conduct outreach to enroll more eligible people in coverage. It also requires coordination with health insurance exchanges, making it easier for those people seeking coverage to identify affordable health coverage options and enroll in health coverage.

While the Act contains many features that will benefit Arizonans, healthcare reform poses numerous challenges. Expanded eligibility will conflict with Arizona policy makers' inclination to limit costs through constraints on enrollment. In addition, resources will be needed to alter and enhance eligibility systems. Finally, concerted efforts will be needed to plan and implement changes, coordinate systems, expand partnerships and leverage opportunities to improve quality and service delivery. Fortunately, the Act also commits significant new federal dollars to support these efforts in future years.

HEALTH COVERAGE GAINS, BUDGET IMPACT

Healthcare reform will dramatically expand the number of people receiving publicly financed health insurance in our state. It will raise eligibility levels for non-elderly adults (not including unqualified immigrants) to 133 percent of the Federal

KEY REFORM CHANGES

- **Expands Medicaid eligibility to 133 percent of poverty in 2014.**
- **Requires states to continue current eligibility and enrollment practices existing as of March 23, 2010. States reducing or limiting eligibility lose all federal dollars for Medicaid. Requirements for adults exist until 2014; for children, they extend through 2019.**
- **Increases the federal Medicaid match for those newly eligible. Also increases the federal match for non-pregnant childless adults enrolled in Medicaid over time.**
- **Shifts CHIP coverage for children ages 6-19 whose families earn between 100-133 percent of poverty to Medicaid in 2014.**
- **Increases in the federal CHIP match rate beginning in October 2015.**
- **Establishes new methodology for determining eligibility based on adjusted gross income (with some exceptions).**
- **Extends and increases federal funding for enrollment and renewal activities.**
- **Provides for a benefit package for newly eligible Medicaid enrollees equivalent to the exchange.**
- **Requires coordination with state exchanges, including a state-overseen website where people can apply for coverage.**
- **Augments provider oversight to protect against fraud.**
- **Allows for innovation opportunities to improve quality, reduce cost and improve care coordination.**

Poverty Level (about $29,000 a year for a family of four). Eligibility levels currently vary, although for most Arizona adults, eligibility is set at 100 percent of poverty. Nationally, half of those who are expected to gain coverage through healthcare reform will obtain coverage through Medicaid expansion.[1] In Arizona, an additional 76,400 adults and children will receive coverage through AHCCCS in 2014.[2] The federal government will pay most of the cost for those who are newly covered.

Healthcare reform will also dramatically expand the number of enrollees who are already eligible for coverage yet not currently enrolled. (This will likely occur as public awareness increases as a result of the Medicaid expansion.) AHCCCS estimates that 123,000 non-elderly adults and children would gain coverage by 2014, representing half of those who would be eligible but uninsured.[3]

The Act also increases the amount the federal government will pay for coverage for many individuals currently enrolled in AHCCCS in future years. Those billions of additional federal dollars will add Arizona jobs, strengthening the economy.[4] However, in the short run, reform does nothing to address Arizona's economic woes.

Over the long term, healthcare reform may reduce state costs. Because the federal match for many of those currently eligible will increase, Arizona's total obligation for Medicaid and CHIP may actually decrease over the next 10 years. The Joint Legislative Budget Committee estimates that General Fund costs over the next 10 years (2011-2020) will be reduced by $2.3 billion under the 2010 baseline.[5] However, the budgetary impact of past expansions has varied wildly from predictions, so the ultimate effect is yet to be seen.

State Response to Budget Deficit

Arizona, like many other states, was struggling with how to pay for Medicaid and CHIP before healthcare reform was enacted. Enrollment in the program has increased rapidly in recent years, responding to growth in unemployment and the economic downturn. Arizona's Medicaid program has had the largest enrollment growth rate in the country in recent years.[6]

In an effort to control the state's rising tab for Medicaid and address the state's budget deficit, the Arizona Legislature eliminated KidsCare and coverage for nearly one quarter of the AHCCCS population (310,500 people) during the past legislative session. However, before the session ended, the Legislature reinstated KidsCare (keeping an existing enrollment cap in place) and maintained existing AHCCCS eligibility levels through the end of the state's fiscal year contingent upon the receipt of additional federal stimulus dollars.

The Legislature's change of heart – resulting in continued coverage for hundreds of thousands of Arizonans – was a practical decision. When healthcare reform became law last March, states were required to maintain existing eligibility levels. States reducing eligibility levels existing at the time the healthcare reform law was signed jeopardized losing all federal support for their Medicaid programs. In Arizona, that amounted to a potential loss of over $7 billion annually – a whopping amount that is nearly the size of the state's entire general fund.

As noted above, the Legislature's "quick fix" to maintain eligibility and meet new federal maintenance of effort requirements was contingent upon the federal government continuing the flow of enhanced federal stimulus funding for Medicaid past December 2010. Recently, the federal government did indeed extend the enhanced federal funding for Medicaid for six months, but not at the level policy makers assumed when they passed the FY 2011 budget. As a result, Arizona must still reconcile a $150 million budget gap in AHCCCS funding for FY 2011.

KEY TAKEAWAYS:

- Healthcare reform will result in hundreds of thousands of Arizonans maintaining or gaining coverage through AHCCCS.
- Arizona may need to identify additional revenue for it to continue current AHCCCS eligibility levels until 2014 to meet new federal maintenance of effort requirements.
- New revenue or additional budget cuts will have to be identified to address a $150 million shortfall for FY 2011 due to enhanced federal funding for Medicaid not meeting state budget assumptions.
- Because the federal government will pick up a bigger share of the costs for covering some existing populations receiving Medicaid, state costs for AHCCCS may decrease over the next 10 years.
- Healthcare reform will eventually bring billions of additional federal dollars to the state, strengthening the economy and creating more jobs.

PUTTING OUT THE WELCOME MAT: OUTREACH AND STREAMLINED ENROLLMENT

The Act contains provisions designed to encourage states to implement outreach and streamlined application and enrollment strategies. As noted above, the expanded role of Medicaid in achieving near-universal coverage is integral to reform. Thus, efforts to support and expand outreach and streamline eligibility and enrollment practices are important to successful implementation.

The Act includes an extension and an additional $40 million in CHIP Reauthorization (CHIPRA) outreach grants to support the enrollment of children, as well as a new program to create "navigators" to assist with public education and enrollment more generally starting in 2014. It also creates an option for hospitals and other providers to play a role in enrollment.

Historically, Arizona's outreach efforts have been limited. For example, while the state provided some (mostly media-related) outreach efforts when KidsCare was first created in 1998, the state soon devoted little to no resources to outreach.[7] Many other states have had more robust and sustained commitments to outreach, paying for activities including media, community-based or school-based application assistance or toll-free hotlines.[8] Such outreach efforts may be more needed today than ever, with many people losing their jobs – and their health insurance – for the first time.

Several recent outreach and enrollment assistance efforts could be expanded as part of healthcare reform implementation. The federal government awarded a two-year grant in 2009 as part of CHIP reauthorization to a coalition led by the Pima Community Access Program coalition for outreach and enrollment assistance.[9] In recent months, First Things First (the state's early childhood health and education agency) also awarded grants to community-based organizations to conduct outreach and enrollment/renewal assistance for families with young children eligible for Medicaid and CHIP. Such efforts could potentially be built upon in the future, and the state could submit for federal matching dollars to expand state-funded efforts even further. In addition, the state may be able to loosen current restrictions placed on contracted health plans in marketing their products, allowing them to play a greater role in encouraging enrollment.

Arizona Online Application Is a Plus

The Act also contains new requirements aimed at streamlining enrollment in Medicaid and CHIP. In some instances, Arizona is ahead of other states in meeting these requirements. For example, Arizona has implemented an online, joint application for Medicaid and CHIP. The new law requires such an online application. In other instances, the state will have to implement changes outlined in the new law, such as creating an electronic match with Treasury to facilitate enrollment in Medicaid, CHIP and the exchange.

To further meet the intended outcome of streamlining enrollment in Medicaid and CHIP, the state could implement additional practices already adopted by other states aimed at diminishing enrollment and renewal barriers and increasing administrative efficiencies. Numerous states have implemented such changes in recent years.[10] Nine states were awarded bonuses by the federal government last December for implementing certain policies known to increase enrollment and retention and achieving specific enrollment targets.[11]

Of course, both outreach and streamlined enrollment and renewal practices will result in more people enrolled in Medicaid and CHIP. Once again, this is where the "culture of coverage" envisioned through healthcare reform collides with our state's current political culture of cost containment. Rather than expanding coverage, our state is currently reducing it. Indeed, the current cap on KidsCare has resulted in over 17,000 fewer children enrolled in KidsCare since January.[12]

KEY TAKEAWAYS:

- Successful implementation of healthcare reform requires a "culture of coverage" that conflicts with Arizona's current political priority of cost containment.
- There are a number of resources and opportunities that exist to promote coverage for those who are eligible but not yet covered.

ELIGIBILITY SYSTEM CHANGES AND INTEGRATION AMONG SYSTEMS

The Act also creates new methodology that states must use to determine income eligibility for Medicaid, CHIP and subsidized coverage available through the exchange. The new standards will create some efficiencies by requiring the state to use existing tax income data as part of eligibility processes. However, these changes will also require substantial alterations of existing information systems.

Arizona's current information systems for Medicaid and CHIP are quite old. For example, the eligibility system administered by the Arizona Department of Economic Security (DES) and used for Medicaid and other public benefits dates back to 1986. AHCCCS staff interviewed expressed skepticism that the current systems could be easily (or cost-effectively) modified. However, they did note that the state's web-based application system for Medicaid, CHIP and other public benefits (Health E-Application) might be modified to meet the new requirements.

Altering these eligibility systems will take years and require a commitment of additional (currently unquantified) state dollars. (The federal government will pay part – but not all – of the expense for these required modifications.) Specifications for the new systems still need to be determined as details of required eligibility changes are fleshed out by the federal government. The requirements will ultimately depend on how the new or modified systems are integrated with other information systems, including the health insurance exchange.

The Act explicitly requires individuals seeking coverage through an exchange, Medicaid or CHIP to be able to apply through any program, screened for eligibility through all programs and referred for enrollment in the program for which they are eligible. The law also provides that the exchange may be able to screen for Medicaid eligibility and that any determinations of Medicaid eligibility made by the exchange can prevail for state agencies. States are required to oversee a single website where consumers can go to find information on health insurance options and enrollment. Massachusetts has developed such a site (a web portal) called the Health Connector. Undoubtedly, these requirements will necessitate coordination between exchange planning and changes to state eligibility systems.

Close linkage between public health coverage and private, subsidized insurance offered through the exchange would benefit consumers and reflect the reality that some families may end up receiving coverage from a variety of sources. It may also provide flexibility in preparing for potential future coverage shifts.

Changes in Enrollment and Public Education

As Arizona plans for eligibility changes and coordination among coverage programs, it may want to re-examine how it conducts its current eligibility and enrollment processes for public health insurance programs. Arizona generally administers eligibility for its KidsCare and AHCCCS programs separately. AHCCCS processes applications for KidsCare using one eligibility system. The Arizona Department of Economic Security (DES) processes applications for Medicaid using another eligibility system. Evidence suggests that aligning or combining eligibility, enrollment and renewal for the two programs reduces the amount of fragmentation, resulting in fewer children unnecessarily losing health coverage as family income changes and their income eligibility changes.[13] Closer alignment between the two programs may ultimately require not only changes to information systems, but also changes to rules and state law.[14]

Arizona may also want to reconsider how it informs the public about its health coverage programs. When KidsCare began in 1998, it was given a different name to appeal to families with higher incomes than those typically served by AHCCCS. The separate naming reflected a national trend to decouple publicly financed health coverage from welfare to avoid some of its stigma. With the advent of healthcare reform, Arizona may wish to look at the branding of its public health coverage programs again as eligibility for adults expands and children (ages 6-19 whose families earn between 100-133 percent of the Federal Poverty Level) are shifted from CHIP to Medicaid in 2014. The state could brand all coverage for children the same regardless of whether it is received through Medicaid or CHIP (similar to states such as Vermont). Or it could rebrand all coverage for children and adults with the same name, again making Medicaid coverage more appealing to working families.

Recent DES and KidsCare office closures attributed to state budget cuts may also provide impetus for additional system redesign. While an increasing number of Medicaid and CHIP applicants apply online, there will likely continue to be a need for offices where people can submit documentation or applications. Community partners could play a greater role in this area in the future, making it easier for working families to receive application assistance and relieving overburdened state welfare offices.[15] Of course, if such partners are given authority to deem people eligible, AHCCCS will have to monitor eligibility determinations to ensure program integrity.

While the deadline for implementing changes to eligibility systems is not until 2014, states have begun moving forward with implementation, noting that the 2014 deadline is not that far away. For example, Wisconsin recently released a request for proposals calling on bidders to provide "maintenance, operation, modification and enhancement" services to its eligibility system and an automated system that would support the creation of an exchange for that state.[16]

KEY TAKEAWAYS:

- Arizona needs to begin planning for changes to eligibility systems immediately. As part of that effort, Arizona should look for opportunities to better coordinate existing coverage programs and partner with the community. It should also begin to identify new sources of revenue for such enhancements.
- Changes to eligibility systems and potential system redesign should occur in conjunction with planning for healthcare exchanges. Eligibility and enrollment for publicly funded insurance and insurance offered through the exchange will need to be coordinated. An integrated web portal should be created.

BENEFITS

As part of healthcare reform, states will have to define the array of services available to those newly eligible. The state could make coverage for newly eligible adults narrower than the standard comprehensive Medicaid package. The new law minimally calls for "benchmark" or equivalent coverage based on private health insurance plans in each state, or federally approved coverage. The state could choose not to include some services available currently to those who receive services under Medicaid or CHIP, such as some services needed by persons with serious mental illnesses.[17] (See Behavioral Health Services and Coverage section of this report.)

KEY TAKEAWAY:

- The state will need to determine the benefit package for those newly eligible for Medicaid. This will be a critical (and likely contentious) task that will have profound access and cost implications.

PROVIDERS

As more people are enrolled in Medicaid and CHIP, the number of contracted providers needed to provide health services will increase. The Act includes provisions that address and incentivize provider expansion, including a modest two-year increase in Medicaid provider rates for primary care. However, the effect of these provisions may be thwarted by recent and potential future rate cuts. While there has been no reduction yet in the overall number of providers, it is unclear whether prolonged cuts – or additional cuts resulting from further budget reductions – might affect service provision to an expanded Medicaid population.

The Act will also result in AHCCCS having to negotiate new contracts and new capitation rates with its contracted health plans. Determining these new rates may be challenging, given the uncertainty of how many additional people might be enrolled, their health status, and their health care utilization. While it is possible that this risk might affect the number of health plans participating, this uncertainty may be ameliorated by AHCCCS limiting health plans' risk exposure (as it has done in the past with expansion populations). It is also possible that there may be greater health plan participation due to the potential increase in Medicaid enrollees.

Enhanced provider oversight may also affect the number of providers. Healthcare reform includes new efforts and requirements aimed at protecting against fraud. These include expansion of provider audits and mandated provider compliance programs. The new requirements also include screening processes, with accompanying fees, for providers and suppliers to complete when enrolling or getting revalidated for Medicaid participation. While such efforts may reduce fraud or the risk of fraud, they may also reduce the number of participating providers and increase the amount of time it takes for providers to be included as part of a health plan's network.[18] These new (and other recent) requirements will also result in new demands on AHCCCS to monitor providers, potentially requiring additional state dollars.[19]

KEY TAKEAWAY:

- Enrollment may drive increased need for healthcare providers. However, budget cuts, risk, and regulatory requirements may stymie efforts to expand the number of providers.

ADDITIONAL OPPORTUNITIES TO INNOVATE, IMPROVE QUALITY

As noted in another section of this report, healthcare reform provides opportunities and incentives to innovate, improve quality and reduce costs. (See section on Quality and Efficiency.) The state also has flexibility under its 1115 waiver[20] (which it must periodically renew and which the federal government must approve) to introduce new innovations and reforms (with certain limitations). At the time this was written, AHCCCS was drafting its new waiver, adding proposed language that would allow the state to adopt new payment methods that incentivize quality.

Other provisions contained in the Act also provide the state with the opportunity to innovate. Section 1332 of the Act allows states to create and administer what could be considered an additional public coverage option. States may elect to provide health coverage through managed care plans, rather than through the exchange, for adults between 133 percent and 200 percent of poverty. Coverage must meet certain cost-sharing standards. Funding for the program would equal 95 percent of what would have been spent on the exchange for the population. Depending on the benefit design, this option might be particularly attractive to adults with health problems if the benefit package is made more generous than that offered through an exchange. It might also allow people who churn on and off of Medicaid due to fluctuations in income to maintain their coverage, or allow families whose children are enrolled in KidsCare to all be on the same health insurance plan, resulting in administrative efficiencies and more consistent care for consumers.

KEY TAKEAWAY:

- Healthcare reform will provide opportunities for our state to further innovate and improve the quality of care delivered through AHCCCS.
- New public health coverage options provide opportunities for our state to reduce the amount of "churning," allow more families to share the same insurance plan, or provide greater access to care for people with special health needs.

AHCCCS INFRASTRUCTURE

Implementation of healthcare reform will add to AHCCCS' responsibilities, present new implementation challenges and provide new opportunities for what AHCCCS does so well – innovate. Efforts will be needed to plan for and implement required programmatic changes, manage enrollment growth and leverage opportunities.

AHCCCS has long enjoyed a national reputation for innovation and effective and efficient management of our state's Medicaid program.[21] However, budget cuts have reduced AHCCCS' staff by 30 percent in recent years. In lieu of increased staffing, public and private sector support and partnerships (including support from foundations and businesses) may be needed to ensure that needed expertise is garnered and system capacity is strengthened.

The state may also wish to explore partnerships with the private sector (including health plans and insurers) to augment the state's administrative capability. However, the state should approach delegation of required tasks with caution and plan for appropriate oversight of contractors. States have experienced wide ranging experiences with contractors in administering various functions of Medicaid and CHIP programs, including some well-publicized disasters.[22]

KEY TAKEAWAY:

- Staffing cuts may weaken AHCCCS' ability to implement reform changes. Public and private support and partnerships may be needed to bolster chances for success.

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