Insight

Administrative Cuts to Medicaid Will Not Solve HHS Problem

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During an April 10th Senate Finance Committee hearing, Department of Health and Human Services (HHS) Secretary Kathleen Sebelius informed committee members that some states may see cuts to Medicaid funding. According to Secretary Sebelius, some states are unable to receive Medicaid applications from the federally facilitated exchange (FFE), and are left sifting through applications for individuals awaiting their Medicaid eligibility approval. In order to encourage states to move through their backlogged applications more quickly, the Centers for Medicare and Medicaid (CMS) may decrease the federal matching rate for Medicaid – with the cut expected to come in the form of reductions to administrative Medicaid funding.[1] States that are still reporting an inability to connect with the federal marketplace, and are therefore seeing applications back-up in the determination process, are subject to these cuts.

Secretary Sebelius rationalizes this funding threat as an incentive. However, reducing administrative reimbursement to states already crammed with backlogged applications will only lead to additional staffing pressures and slowdowns.

BACKGROUND

The backlog discussed by Secretary Sebelius originated in the faulty technology developed at the federal level. Initially, the FFE was not able to transfer Medicaid applications from the exchange website to state Medicaid systems. The federal government took months to improve systems enough to begin transferring applications one state at a time – sometimes in batches of 10 or fewer.[2]

This disconnect created thousands of backlogged cases where individuals were informed by the exchange that they were eligible for Medicaid benefits, but the state could not verify the individual's information, and therefore could not add the individual to Medicaid rolls. Slowly, HHS worked to develop connections between healthcare.gov and each unique state system. Not only are states working through this technical "account transfer" challenge, the staff are revamping eligibly requirements, answering calls from confused beneficiaries, and working through other Affordable Care Act (ACA) changes. These competing priorities would be strained further should funding decrease.

STATE BURDENS

States are bringing their eligibility systems up to date and hiring new staff to handle the additional beneficiary volume. Decreasing funding for administration of the program will force states to scale back on the current pace of progress. The funding for services rendered to Medicaid beneficiaries is a combination of state and federal funding. Unlike the funding for clinical services which is assessed on a sliding scale based on per capita income, the amount of federal funding issued to assist states in the administrative tasks of running the program is set at 50 percent of federal dollars and 50 percent of state dollars. The funding for administrative services covers the overhead costs of running an agency, including the eligibility determinations process.[3] Decreasing the funding

for the administrative portion of the program will not accomplish Secretary Sebelius' goal of faster state compliance to eligibility standards, it will create the opposite impact – slowing application assessment and placing additional pressure on strained staff.

In a January meeting of the Medicaid and CHIP Access and Payment Commission, state personnel were asked to comment on the current status of the administrative challenges in Medicaid. Darin Gordon of TennCare (Tennessee Medicaid), Chuck Milligan of Maryland Medicaid, and Eileen Griffin of the University of Southern Maine all stressed to the Commission the increased pressure placed on state staff by the ACA and the complications occurring in their states. Griffin indicated during her testimony that administrative budgets have not kept up with the increased demands on the Medicaid program.[4]

POPULATION IMPACTED

The population of individuals stuck in coverage limbo is difficult to identify. However, many of these individuals will still be able to access medical services through Medicaid while they are waiting on an official Medicaid eligibility determination. The presumptive eligibility (PE) expansion in the ACA allows for hospital staff to complete a preliminary Medicaid application for patients granting temporary Medicaid eligibility.[5] Through the PE process, the state pays Medicaid claims while a formal eligibility determination is processed.

Further, individuals can receive retrospective Medicaid coverage for up to 90 days depending on the state.[6] For instance, an individual can receive emergency care and later be determined eligible for Medicaid coverage. Medicaid will pay the claims for three months prior to enrollment if the individual met eligibility requirements during that time.

However, it is an easier process to determine eligibility with an application, and the federal government should, if anything, provide additional help to states experiencing an influx of applications, rather than threaten funding cuts.

THE PATH FORWARD

CMS should continue to encourage states to work through their current systems challenges instead of imposing temporary cuts, halting progress. Every Medicaid program began reaching the newly imposed eligibility system requirements from a different place, and CMS has repeatedly acknowledged the complexities associated with the required updates. CMS should assist those states that are still working through their updates, rather than threaten them with decreased funding.

Eligibility regulations were written at a time when the administration envisioned a much more seamless and highly functioning data system. Though providing additional funding for the burden placed on states may not be a solution at this time, CMS should not intensify the backlog by further reducing funding for increased requirements for state agencies.

For those individuals that are ultimately determined ineligible for Medicaid, a substantial coverage appeal process is in place for those seeking exchange coverage as well as Medicaid coverage. This process is established in the ACA, however the first year of implementation will likely bring growing pains in implementation. In the meantime, some states are advising individuals still awaiting a determination response to apply directly with the state agency which is required to make an eligibility determination within 45 days, rather

than through an exchange portal.[7]

[1] http://insidehealthpolicy.com/201404162467721/Health-Daily-News/Daily-News/sebelius-feds-may-cut-medicaid-pay-so-states-clear-enrollment-backlogs/menu-id-212.html