STRATEGIC HEALTH CARE

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KEY PROVIDER ISSUES IN HEALTH CARE REFORM

May 2010 **MEDICAID & CHIP PROVISIONS**

Medicaid Expansion

The Patient Protection and Affordable Care Act of 2010 (PPACA) will extend coverage to an additional 16 million low-income individuals by requiring states to expand coverage to those under the age of 65 with an income at or below 133 percent of the federal poverty level (FPL) ($14,404 for an individual or $29,326 for a family of four in 2009). States must implement this expansion on or before January 1, 2014. Currently only 11 states provide coverage to adults without dependent children. These early expansion states (AZ, DE, HI, ME, MA, MN, NY, PA, VT, WA, WI) will receive a higher federal matching rate for the coverage they already provide.

Medicaid Eligibility

The new law modifies how an individual's income will be calculated for Medicaid eligibility. Beginning in 2014, states will use modified adjusted gross income (MAGI) to determine income with no asset or resource test. An additional formula change effectively raises the income threshold from 133% to 138% of the FPL.

Presumptive Eligibility Determination: Under current law, *states* can choose to allow certain providers to make presumptive eligibility determinations for children, pregnant women, and women with breast and cervical cancer based if the applicant appears to meet enrollment criteria. Effective January 1, 2014, *Federal law* will permit hospitals to make presumptive eligibility determinations for all populations.

Financing for Medicaid Expansion

The federal government will pay the full cost of the Medicaid expansion for the first three years. Beginning in 2017, 5 percent of the expansion cost will shift to the states, increasing to 10 percent by 2020 (see below).

FMAP Payment for newly eligible Medicaid enrollees and transfer of responsibility to states [1]

	2014	2015	2016	2017	2018	2019	2020 +
All States	100%	100%	100%	95%	94%	93%	90%
Early Expansion States	FMAP+ transition (75-95%)	FMAP+ transition (80-92%)	FMAP+ transition (85-94%)	FMAP+ transition (86-92%)	FMAP+ transition (90-92.6%)	FMAP+ transition (93%)	FMAP+ transition (90%)

[1] CRS Report, Medicaid & CHIP: HCERA changes to PPACA

Medicaid Disproportionate Share Hospitals (DSH)

The Medicaid DSH program provides funding allotments to states as a means to subsidize hospitals for the unreimbursed costs incurred when treating uninsured and Medicaid patients. Beginning in 2014, the Secretary is required to make aggregate reductions in the Medicaid DSH allotments. These reductions are based on the assumption that the new law will expand insurance coverage and reduce uncompensated care. The largest reductions will take place in states that have the lowest percentage of uninsured individuals or states that fail to target DSH payments to hospitals with the highest volume of Medicaid patients and uncompensated care.

Overall Medicaid DSH Reductions

FY2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
$500 million	$500 million	$600 million	$1.8 billion	$5 billion	$5.6 billion	$4 billion

Prescription Drug Coverage

Under the current law, manufacturers must provide rebates to state Medicaid programs but drugs purchased through managed care organizations are not subject to the rebate program. The new law increases the Medicaid drug rebate percentage for brand name drugs from 15.1 percent to 23.1 percent and from 11-13 percent for multi-source, non-innovator and all other drugs. It also extends the drug rebate to Medicaid managed care plans with the exception of the 340B program.

Provider Payment Rates

Payment Increase: The law increases Medicaid payments to family medicine physicians, general internists and pediatricians for evaluation and management services and immunizations to Medicare rates in 2013 & 2014. The law also provides 100 percent federal funding for the incremental costs to states of meeting this requirement.

Medicaid and CHIP Payment and Access Commission (MACPAC): The law broadens the scope of the MACPAC Commission to include adult services and allows for the review of eligibility policies, enrollment and retention processes, quality of care, retention processes and interactions with Medicare and Medicaid.

The CMS Innovation Center: The law establishes an Innovation Center at the Centers for Medicare & Medicaid Services (CMS) to test new patient-centered payment models and evidence-based, coordinated care in Medicaid.

Children's Health Insurance Program (CHIP)

The new law provides a two year extension and funding for the CHIP program through 2015. States will receive a 23 percentage point increase in federal matching rates beginning FY2016 through FY2019 if the program is reauthorized prior to the end of FY2015. Children who are eligible for CHIP but are unable to enroll due to federal allotment caps will be eligible for tax credits on the state exchange.

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Additional Provisions

Community First Choice Option: Beginning on October 1, 2011 the Community First Choice Option will allow states to provide home and community-based attendants support and services to disabled persons at or below 150 percent of the FPL. Covered services under the program cover include services to facilitate activities of daily living, health-related tasks and expenditures for the transition of an individual from an institutional to a home or community-based setting. Participating states will receive an increase of 6 percent points in their FMAP.

The CLASS Act: The Community Living Assistance Services and Supports, also known as the CLASS Act, is an insurance program for individuals who need assistance but do not need more intensive services such as those provided by a nursing home. Funding is through voluntary premium payments and payroll withholding (not to exceed $30 a month) and is placed in a "National Independence Fund." All workers over the age of 18 will be automatically enrolled, though a worker may opt out of the program. Individuals who contribute to the program for a minimum of five years and are unable to perform two or more activities of daily living (ADL), such as feeding, dressing, bathing, toileting, or walking; or individuals who have an equivalent cognitive disability will be eligible to collect a benefit. Individuals will receive cash benefits based on the degree of disability or impairment, with a minimum of $50 to a beneficiary a day. Cash benefits can be used to purchase caregiver services such as transportation to a grocery store or meal preparation.

Incentives to Shift Medicaid Beneficiaries to Home-and Community- Based Services: The new law creates financial incentives for states to shift Medicaid recipients from assisted living facilities into home- and community-based services through increased FMAP matching funds.

Money Follows the Person Rebalancing Demonstration Project: The new law extended the current demonstration program for an additional 5 years. The project assists individuals with disabilities transition from an institution to home- and community-based settings. The law also amends the eligibility requirements by reducing the time an individual must reside in a facility from 6 months to 90 consecutive days.