Medicaid Provisions in the Affordable Care Act

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

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Medicaid Has Always Been a Cornerstone for Reform

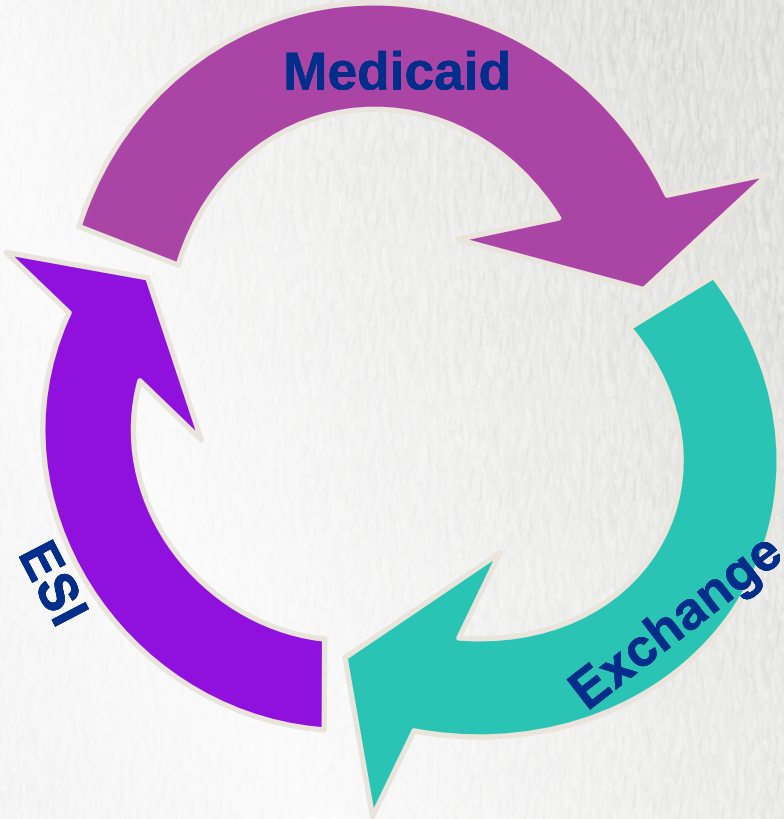
- States have continually relied on Medicaid to meet new demands and initiate reforms
  - Improving infant mortality rates
  - Significantly reducing uninsured rate among children
  - Providing coverage for children with special health needs
  - Providing coverage for those living with HIV/AIDS
  - Covering people with disabilities in the labor market and providing community based long-term care (LTC)
  - Developing new care coordination models
  - Initiating Electronic Health Records (EHRs)
  - And much more.

Access Key Provisions

- Expands Medicaid significantly (to 133% FPL)
- Maintains an employer-based system, with employer requirements
- Maintains private insurance market
- Requires most people to have insurance ("individual mandate")
- Creates temporary high-risk pools
- Requires creation of health insurance exchanges, with subsidies for many (up to 400% FPL)
- Requires plans to allow coverage for young adults on their parent's policy.
- Enacts health insurance reforms (e.g., no preexisting condition exclusions)
- Establishes a long-term care program (CLASS) -- community living assistance

A system of coverage per CMS

- Creating a *system* of coverage across Medicaid/Exchange/ESI
- Make "No Wrong Door" a reality



Comparative Data: 2008-2009

State	% uninsured	% < poverty uninsured (nonelderly)	% adults < poverty uninsured	% children < poverty uninsured	% firms that offer insurance
US	17	40	47	17	55
AZ	20	43	47	22	52.1
ID	15	36	50	17	45
NE	12	34	41	20	45.4
NV	20	38	57	30	55
NM	23	42	51	25	51
UT	14	32	40	25	46.4

Poverty Level In 2010: $10,830 for individual; $22,050 family of 4

Sources: Kaiser Family Foundation, State Health Facts, from the Census Bureau Current Population Survey

Medicaid Expansion

Establishes a national minimum eligibility level at 133% of federal poverty level (FPL). Effective level is 138% of the FPL with the 5% income disregard.

- In 2010: $14,941 for individual; $30,428 family of 3

Questions to ask:

- How many newly eligible individuals?
- How many are currently eligible but not enrolled?
- "How Would States Be Affected by Health Reform?" Jan. 2010, John Holohan and Linda Blumberg say:
  - 182,051 new eligibles or 11.1% pop (7.2%)
  - 99,407 eligible but not enrolled or 6.1% pop (8.9%)

Medicaid Expansion

- Eligibility based on Modified Adjusted Gross Income (MAGI) with no asset tests (exempt: SSI,* child welfare, SSDI,** medically needy, Medicare Savings Programs)
- Adds new mandatory categories of Medicaid-eligibles: (1)Single, childless adults who are not disabled;
- (2) Parents;
- (3) Former Foster Care Children (aged-out of foster care, up to age 26) effective 2014.

*SSI: federal Supplemental Security Income

**SSDI: federal Supplemental Disability Income

Coverage for new adults

- According to the law, "newly eligible" individuals will be those adults:
  - with incomes below 133 percent FPL (138% with the 5% income disregard)
  - not eligible for full benefits under the state plan or waiver programs;
  - not eligible for benchmark coverage or benchmark-equivalent coverage;
  - eligible but not enrolled (or were on a waiting list) for such benefits or coverage through a waiver under the plan that had capped or limited enrollment that was full.
  - Waiting on further guidance.
- Provides all "newly eligible" adults with a benchmark benefit package or benchmark-equivalent that meets the minimum essential health benefits available in the Exchange.

Coverage for foster children

- The ACA amends 42USC1396a and establishes a new mandatory eligibility category under Medicaid for former foster children up to age 26 who were in the foster care system when they became 18 years of age (or a higher age set by the state for ending foster care benefits) and were enrolled in Medicaid when they aged-out of the system. Children who qualify for Medicaid through this eligibility pathway will receive all benefits under Medicaid, including Early and Period Screening, Diagnostic and Treatment (EPSDT) benefits. This provision is effective January 1, 2014.

  While many states end eligibility for foster children at age 19, New Mexico has already expanded eligibility for foster care children up to the age of 21.

- How does the state identify former foster children for enrollment in Medicaid that have already aged out of the foster care system?

Enhanced FMAP for New Eligibles

Enhanced FMAP for Newly Eligible Enrollees 2014-2020

Year	Federal Match
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and thereafter	90%

There are special provisions for "expansion states"

Medicaid Expansion Features

Temporary Maintenance of Effort/Eligibility

- Prohibits eligibility changes that are more restrictive than those in place on date of enactment (March 23, 2010)
- Expires in 2014 when the health care exchanges become effective

State Financial Hardship Exemption from Maintenance of Effort

- Governor must certify that state is in deficit or will be in deficit to qualify for the hardship exemption (12/31/2010). No state has applied to date

Early Expansion

- Option for states to begin expansion for certain non-elderly individuals with incomes up to 133%of FPL effective April 1, 2010. Coverage would be reimbursed at the state's *regular* Medicaid FMAP (estimated to be 80.49% for 2010.)
  - Connecticut and Washington, D.C (WA just approved)

Changes for children receiving hospice care.

- The law amends 42USC1396d(o)(1) to allow children, as defined by the state, who are eligible for Medicaid or the Children's Health Insurance Program (CHIP), to receive hospice care without forgoing any other service to which the child is entitled under Medicaid or CHIP.

Family Planning Services & Tobacco Cessation

- ACA creates a state option to provide Medicaid coverage for family planning services through a state plan amendment to certain low-income people up to the highest level of eligibility for pregnant women upon enactment of the law.
- Effective Oct. 2010, requires Medicaid to cover counseling and pharmacotherapy for cessation of tobacco use by pregnant women. Prohibits cost-sharing.

Pediatric Accountable Care Demo Project

- The DHHS secretary must establish the Pediatric Accountable Care Organization Demonstration Project
- Allows state to recognize pediatric medical providers that meet specified requirements as accountable care organizations for purposes of receiving incentive payments.
- Participating states, in consultation with the DHHS secretary, will establish an annual minimal level of savings in expenditures for items and services covered under Medicaid and CHIP, which must be reached by an accountable care organization to receive an incentive payment.
- The demonstration project is to begin on January 1, 2012, and end on December 31, 2016. The section does not provide specific appropriations, rather authorizes the appropriation of such sums as may be necessary to carry out this section.

Other Medicaid Mandates/Changes

- Phase-in Medicare rates for primary care providers (100% federal match for increment above current rate) for 2013 and 2014 only
- Coverage of preventive services, no cost-sharing
- Reimbursement of Medicaid services provided by school-based health clinics
- Non-Payment for certain Health Care Acquired Conditions (mirrors Medicare provision)
- Background checks for direct patient access employees of long term care facilities and providers

Other Medicaid Mandates/Changes (cont.)

- Incentives for Coverage of Preventive Services
  - Add 1 percentage point to regular FMAP
- Incentive Grants for the Prevention of Chronic Diseases (1/1/2011) to promote healthy lifestyles
- Medical Home – State Option

Reduction in DSH Payments

Directs the HHS Secretary to reduce DSH payments to states by $14.1 billion between FY 2014-FY 2020

Fiscal Year	Reduction
2014	$500 million
2015	$600 million
2016	$600 million
2017	$1.8 billion
2018	$5 billion
2019	$5.6 billion
2020	$4 billion

Reductions will be made quarterly in equal installments

Reduction in DSH Payments

- Requires the Secretary to carry out the reductions using the "DSH Health Reform Methodology" that will impose the largest reductions on states that:
  - Have the lowest percentage of uninsured individuals (determined on the basis of: (1) data from the Bureau of the Census; (2) audited hospital reports; and (3) other information likely to yield accurate data) during the most recent year for which the data is available; or
  - Do not target their DSH payments to: (a) hospitals with high volumes of Medicaid inpatients; and (b) hospitals that have high levels of uncompensated care (excluding bad debt).
- Could affect access to health care for children and their parents who remain uncovered.

What Happens to CHIP?

- Extends the current CHIP authorization through 9/30/15.
- From FY 2016 to FY 2019, states will receive a 23 percentage point increase in the CHIP match rate, capped at 100 percent.
- CHIP-eligible children, who cannot enroll in CHIP due to federal allotment caps, will be deemed ineligible and will then be eligible for tax credits in the exchange.
- Requires states to maintain current income eligibility levels for CHIP through September 30, 2019.
  - Prohibits states from implementing eligibility standards, methodologies, or procedures that were more restrictive than those in place on the date of enactment (March 23, 2010), with the exception of waiting lists for enrolling children in CHIP.
  - Conditions future Medicaid payments on compliance with the maintenance of effort provision.

CHIP & the Exchange

CHIP and the Health Insurance Exchange

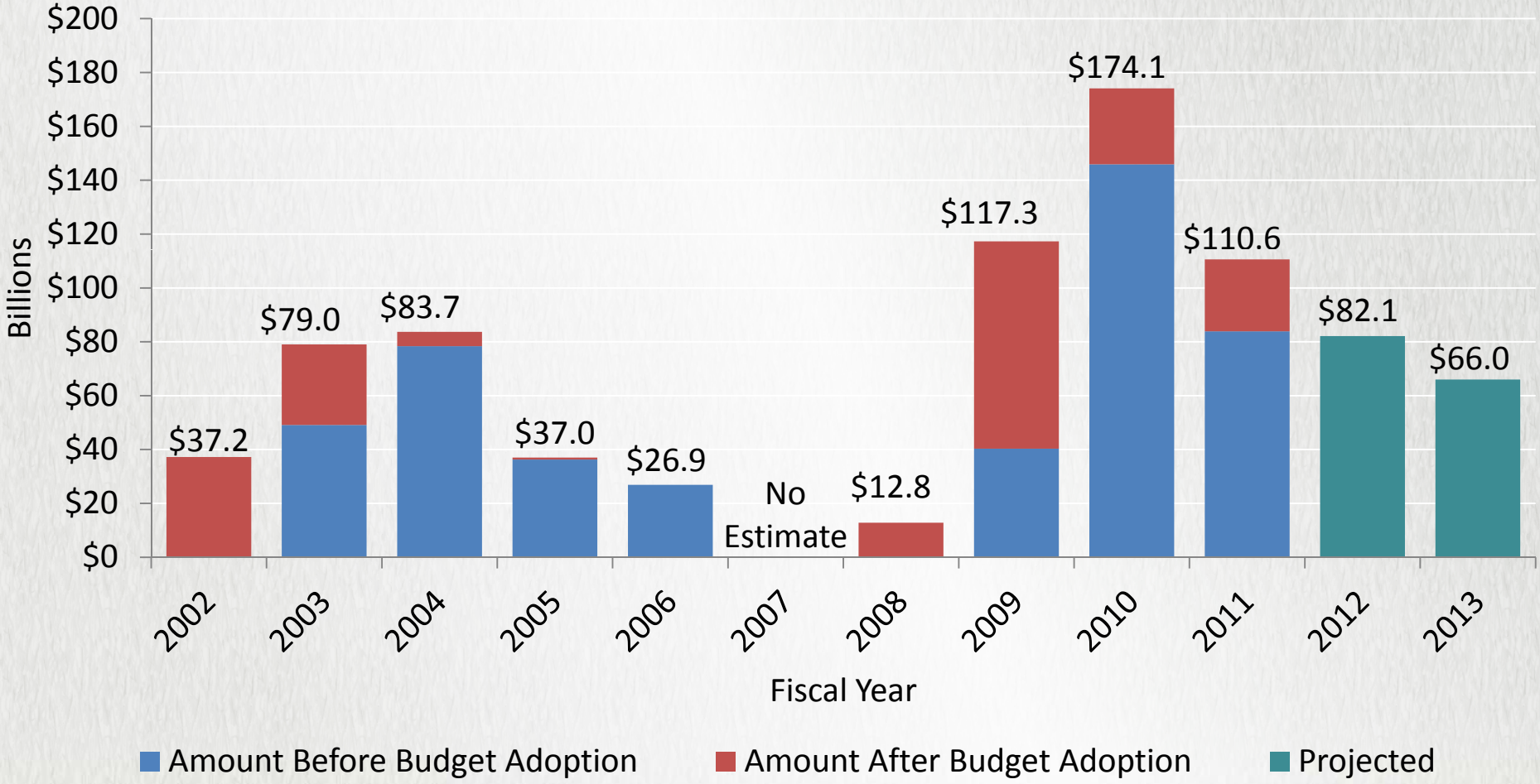
- Provides that after FY 2015 states may enroll targeted low-income children in qualified health plans that have been certified by the Secretary.
- Requires the Secretary to review in each state the benefits offered for children and the cost-sharing imposed by qualified health plans offered through a Health Insurance Exchange (no later than April 1, 2015).
- Requires the Secretary to certify plans that offer benefits for children and impose cost-sharing that the Secretary determines are at least comparable to the benefits and cost-sharing protections provided under the state CHIP (certification of comparability of pediatric coverage).

Some State Concerns

- Transformation left largely to the states
- Budget Issues
  - Underfunding of the underlying program
  - No coverage for undocumented immigrants
  - No statutory countercyclical trigger
  - Implications of reduction in federal assistance in the future
  - Long-term care
- Budget Impacts
  - Newly eligible and others who will "come out of the woodwork"
  - Systems upgrades for eligibility & interoperability with the Exchanges
  - Staffing: State and local government
  - Workforce/Infrastructure

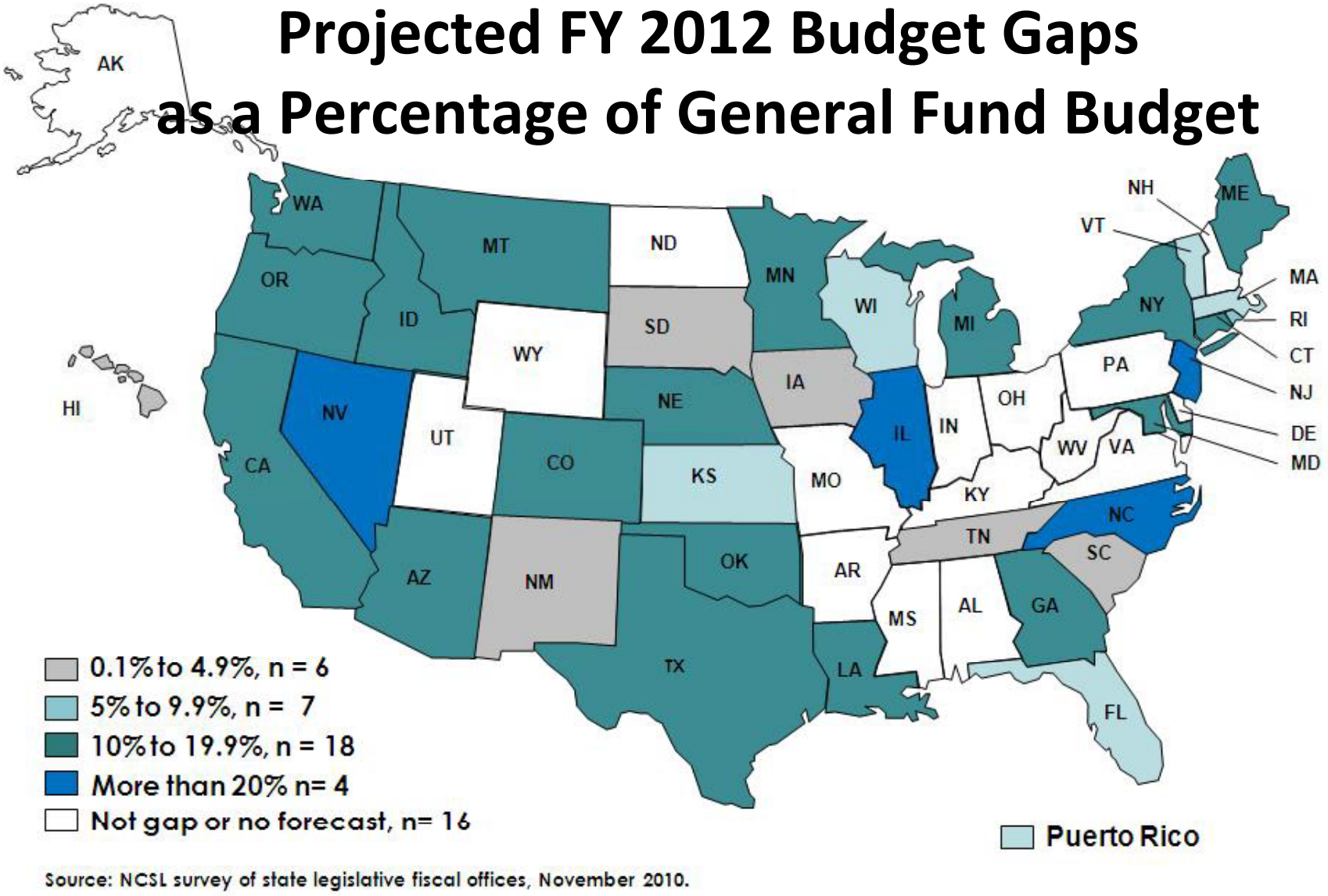
    Provider reimbursement; Training & recruitment
- Election turnover and steep learning curve
- Planning for effective public outreach to partners and the public
- System upgrades for Medicaid/Exchange interoperability
- Health care workforce shortages
- State flexibility

State Budget Gaps FY 2002-FY 2013 (projected)



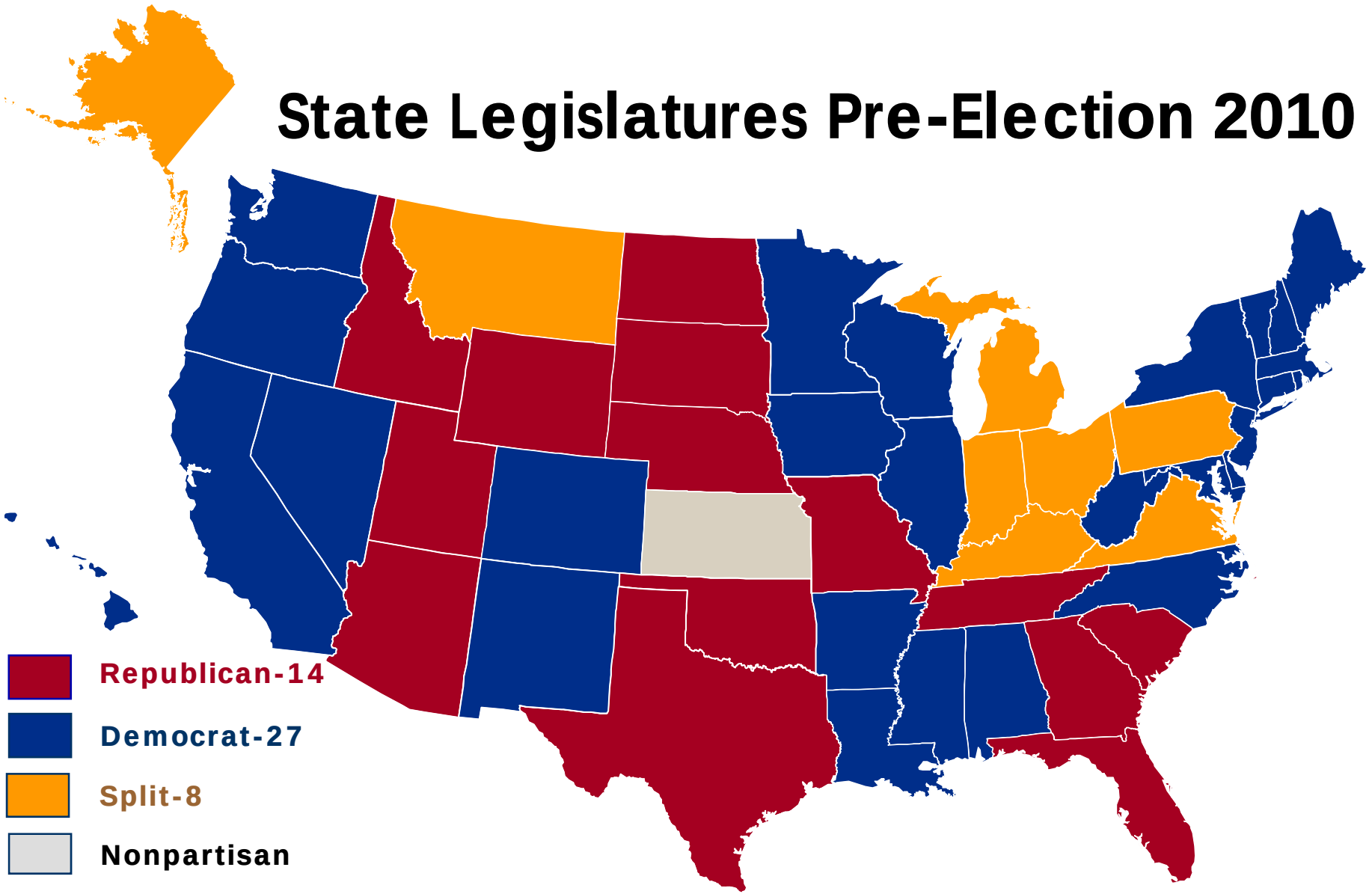
Source: NCSL survey of state legislative fiscal offices, various years.

Projected FY 2012 Budget Gaps as a Percentage of General Fund Budget

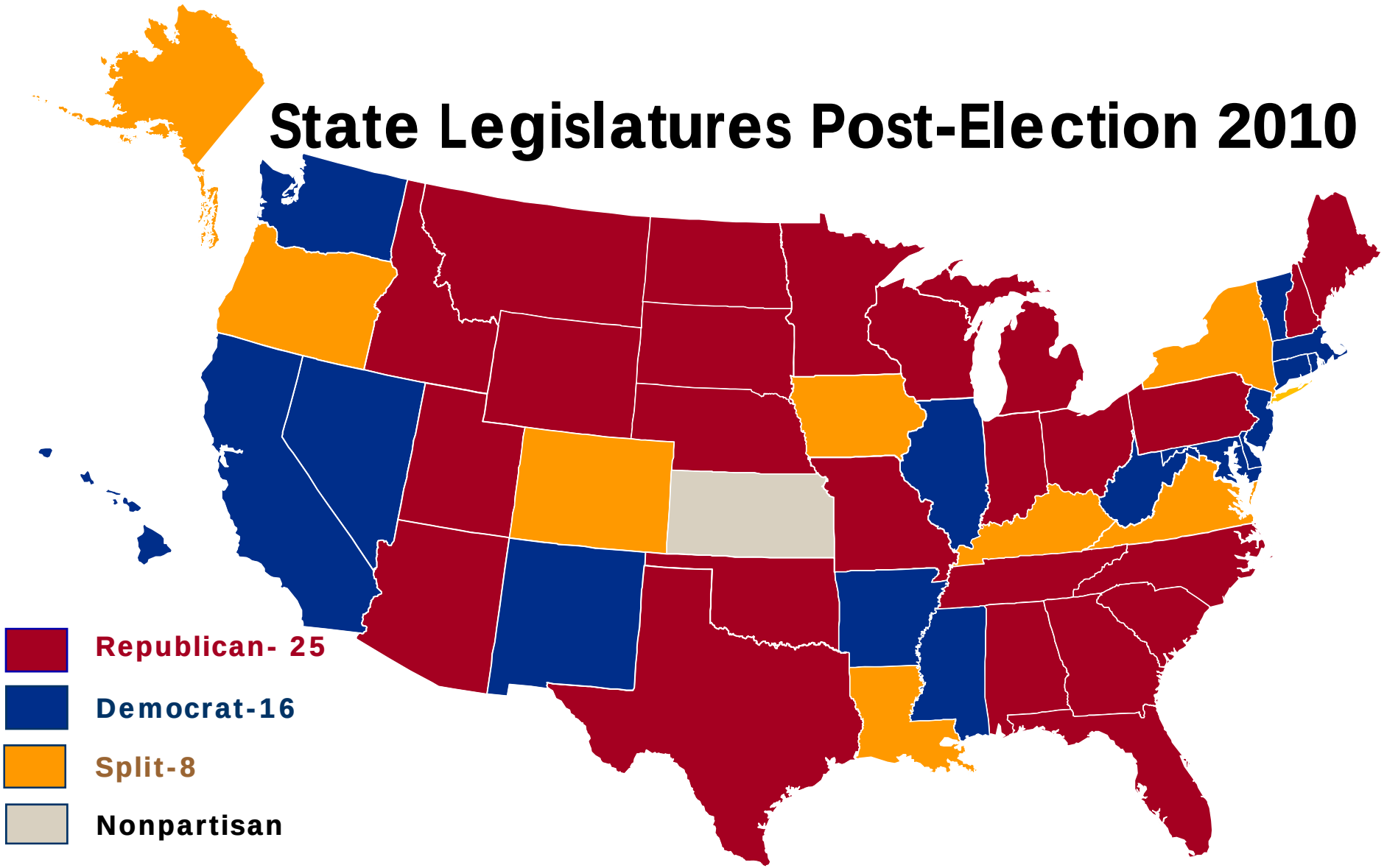


Source: NCSL survey of state legislative fiscal offices, November 2010.

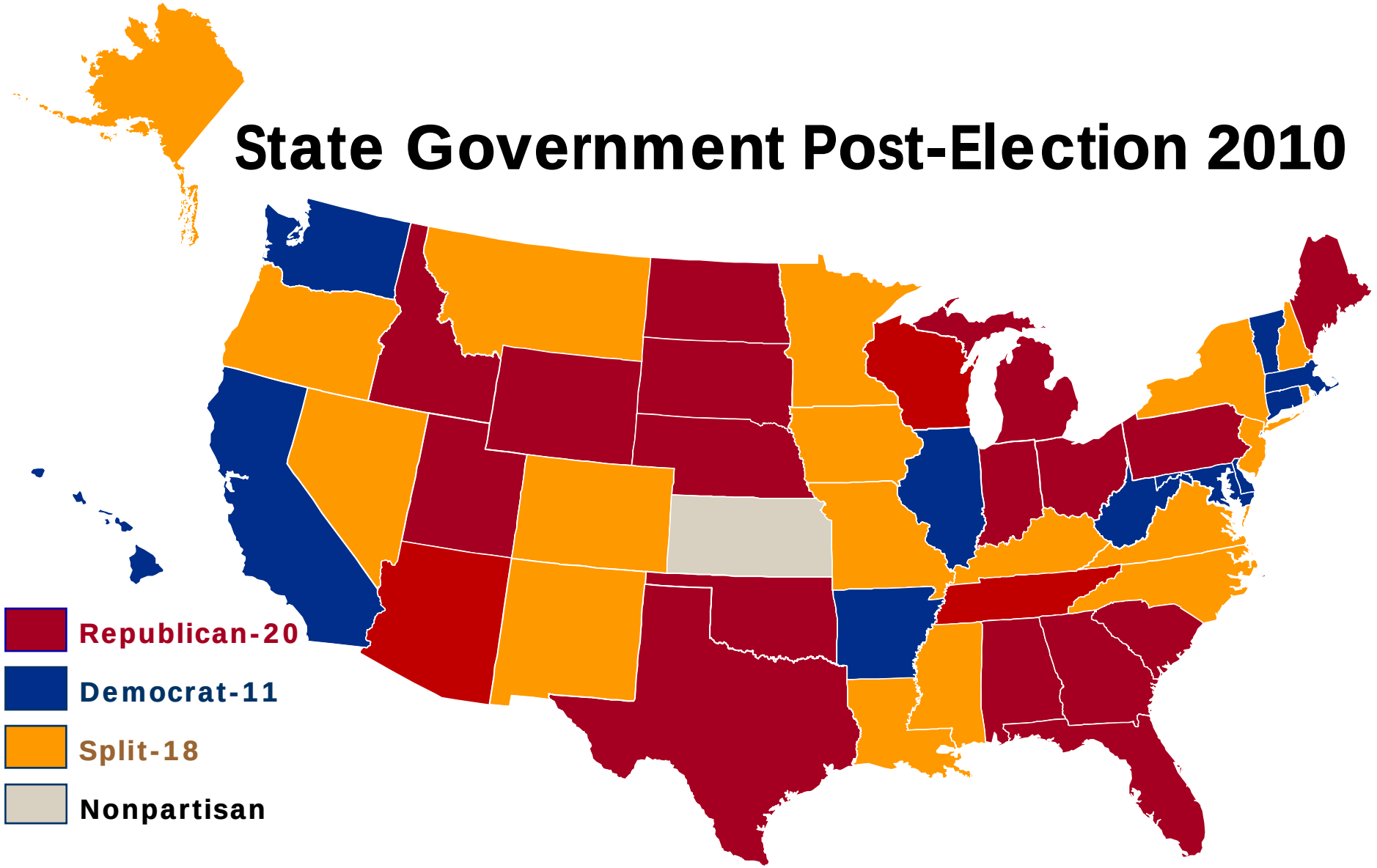
State Legislatures Pre-Election 2010



State Legislatures Post-Election 2010



State Government Post-Election 2010



Home Visiting Programs

Maternal, Infant, and Early Childhood Home Visiting Programs

- Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s).
- Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.
- Establishes competitive grants appropriated at $100 million in 2010, $250 million in 2011, $350 million in 2012, $400 million in 2013 & 2014
- A maintenance of effort (MOE) applies and prohibits grants from supplanting existing funding for these services.
- First grants were awarded on July 21, 2010 to 49 states, the District of Columbia, and five territories.

School Based Health Centers

The Act includes two provisions for school-based health centers:

- An emergency $200 million appropriation for SBHCs' construction and equipment needs. In FY 2011, DHHS will award $100 million in federal funding for construction, renovation, and/or equipment for SBHCs to build their infrastructure capacity to offer primary health care services. Section 4101(a) of the Affordable Care Act allows for SBHCs to access $200 million in competitive federal funds over the next four years. These funds cannot be used for personnel or health service provision.
- New Mexico awarded $26.4 million
- SBHCs became an authorized federal program in Section 4101(b) of the ACA with a federal $50 million authorization for operations. These funds have not yet been appropriated.

Preventing Childhood Obesity

- Authorizes $25 million in funding for the Childhood Obesity Demonstration project, which was established through the CHIP legislation. HHS will award grants to develop a comprehensive and systematic model for reducing childhood obesity.

Pregnancy Assistance Fund

- $250 million over 10 years to support pregnant and parenting teens and women in completing their education and combat violence against pregnant women.
  - Support for pregnant/parenting student services at institutions of higher education; including maternity coverage in student health plans, housing, child care, flexible/alternative academic scheduling, parenting education, material needs (requires match)
  - Support for pregnant/parenting teens at high schools and community service centers (no match)
  - Improving services for pregnant women who are victims of domestic violence, sexual violence, sexual assault, and stalking; including passing funds through to Attorneys General for technical assistance or for other state offices providing svcs. to victims
  - Increasing public awareness and education about the services available
- New Mexico awarded $1.3 million

Other Non-Medicaid Provisions that will affect children

- Prohibits health insurers from denying coverage to children with pre-existing conditions as of September 23, 2010. Beginning in 2014, the law applies this requirement to all covered people
- Extends health care coverage for young adult children under their parent's health plan up to the age of 26. 37 states had similar laws pre-reform including NM.
- Employers are required to provide a reasonable amount of time in an appropriate place for breastfeeding mothers to express milk. Some exemptions for small employers.

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Non-Medicaid Provisions, cont.

- Requires coverage of not only basic pediatric services under all new health plans, but also oral and vision needs, starting in 2014.
- Requires new plans to cover prevention and wellness benefits and exempts these benefits from deductibles and other cost-sharing requirements.
- Requires the creation of a health insurance exchange to serve as a health insurance marketplace and to facilitate enrollment in public programs.
- Prohibits lifetime limits.

NCSL Resources on Health Reform

- **Federal Health Reform Main Page**
  http://www.ncsl.org/healthreform
- **State Actions to Implement Reform**
  http://www.ncsl.org/?tabid=20231
- **State Reports and Research**
  http://www.ncsl.org/?TabId=21448
- **State Actions to Implement Health Benefit Exchanges**
  http://www.ncsl.org/?TabId=21388
- **States Challenging Health Reform**
  http://www.ncsl.org/?TabId=18906