

## Overview

### Eligibility

- Effective 2014, individuals under 65 with incomes below 133% of the Federal Poverty Level, or FPL, (currently \$14,400 per year for an individual and \$29,300 for a family of four in 2010) will be eligible for Medicaid. This includes non-pregnant childless adults.

### Timing

- States must enroll newly eligible Medicaid beneficiaries into the Medicaid program by January 2014 yet have the option to begin in 2011.

### Minimum Benefits

- All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits.

### Coordination with Exchanges

- Beginning in 2014, the new insurance Exchanges will be expected to provide information about Medicaid eligibility and programs to individuals purchasing health insurance.
- States must coordinate enrollment with the new Exchanges so that new enrollees are signed up for the most appropriate program—premium credits, Medicaid, and/or CHIP. The states must have a “no wrong door” approach under which applicants get signed up for the right program, no matter where they apply.

## Who Pays?

### Federal / State Percentages

- The federal government will pay the full cost of Medicaid expansion (for all newly eligible Medicaid enrollees) for the first 3 years. In 2017, the federal government will shift 5% of this cost to states. The states’ share of the cost of expansion will top out at 10% in 2019 and beyond:
  - 100% federal funding 2014 – 2016
  - 95% in 2017
  - 94% in 2018
  - 93% in 2019
  - 90% for 2020 and subsequent years

### States Who Expand Early

- States that have already expanded eligibility to non-pregnant childless adults with incomes up to 100% FPL will receive a phased-in increase in the Federal Medical Assistance Percentage (FMAP) so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020 and later).
- States that expand Medicaid eligibility to childless adults after April 1, 2010, will receive their regular FMAP until 2014.

### All States Treated Equally

- No state will receive favorable treatment with respect to the federal share of Medicaid costs.

## CHIP: Children's Health Insurance Program

### Eligibility

- CHIP currently covers over 6 million children who are not eligible for Medicaid, most in families with incomes between 100% and 200% FPL. Children currently covered by CHIP between 100% and 133% FPL would be transitioned to Medicaid coverage which provides a more comprehensive children's benefits package and lower cost-sharing limits.

### CHIP Funding

- CHIP was set to expire at the end of 2013 but will receive federal funding at current levels for an additional two years, through fiscal year 2015.
- Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. However, CHIP will need to be reauthorized by the end of fiscal year 2015 for this increase to occur.
- Beginning in 2014, if a state has exhausted its federal CHIP allotment, CHIP-eligible children will be eligible for tax credits to enroll in comparable coverage through the new Exchanges.

## Eligibility for Medicaid and CHIP

### Maintaining Eligibility Levels

- States must maintain the Medicaid and CHIP income eligibility levels that were in place on March 23, 2010. For children's coverage, this requirement extends until 2019. For adult coverage it extends until Exchanges are fully operational in 2014. States cannot implement any policies that make it more difficult to enroll in Medicaid or CHIP than existed on March 23, 2010, including premium increases, more frequent re-certifications, or additional documentation requirements.

### Income Counting Rules

- The law maintains existing income counting rules for the elderly and groups eligible through another program like foster care, low-income Medicare beneficiaries and Supplemental Security Income (SSI). Medicaid expansion group members will have eligibility determined based on their taxable income without income disregards currently applied in Medicaid, but will not be subject to an asset test.

## Provider Payment Changes

### Increases for Primary Care Providers

- Medicaid payments for primary care services provided by primary care doctors increase to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates for these two years.

### Chronic Conditions

- A new Medicaid state plan option will permit Medicaid enrollees with at least two chronic conditions to designate a provider as a health home. This will provide states with 90% FMAP for this coverage for two years effective January 1, 2011.

### Alternative Payment Structures and Demonstration Projects

- An Innovation Center within the Centers for Medicare and Medicaid Services will be created to test, evaluate, and expand alternative payment structures and methodologies in Medicare, Medicaid, and CHIP to reduce program expenditures while maintaining or improving quality of care.
- Several payment demonstrations projects will be undertaken, including:
  - Bundled payments for episodes of care that include hospitalizations (2012- 2016).
  - Pediatric medical providers organized as accountable care organizations will be able to share in cost-savings (effective 2012- 2016)
  - Payments to institutions for adult enrollees who require stabilization of an emergency mental health condition (effective 2011- 2015).

## Other Changes in Medicaid

### Prevention and Wellness

- Medicare and Medicaid beneficiaries will be given incentives to complete behavior modification programs effective January 1, 2011 or when program criteria are developed, whichever is first. These programs must run a minimum of three years and promote one of the following:
  - Ceasing use of tobacco products.
  - Controlling or reducing weight.
  - Lowering cholesterol and blood pressure.
  - Avoiding the onset of diabetes or improving the management of diabetes.
- Medicaid will cover tobacco cessation services for pregnant women effective October 1, 2010.

### Aging and Disability Funding

- Aging and Disability Resource Center initiatives will receive \$10 million per year for 2010 through 2014.

### Dual Eligibles

- Care coordination for dual eligibles will be improved by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office.

### Statewide Services

- States may not have waiting lists, program caps, or offer services less than statewide. States can elect to target services to specific populations and vary the services provided to those populations.

### Preventing Waste, Fraud and Abuse

- Federal payments to states for Medicaid services related to health-care-acquired conditions are prohibited effective July 1, 2011.
- In an effort to reduce waste, fraud, and abuse in public programs there will be provider screening and enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs. Medicare and Medicaid program providers and suppliers are required to establish compliance programs.
- A database will be developed to capture and share data across federal and state programs. Penalties will be increased for submitting false claims, standards for community mental health centers will be strengthened and funding for anti-fraud activities increased (effective dates vary).

## New or Extended Medicaid Programs

### Disproportionate Share Hospital Reductions Program

- Medicaid Disproportionate Share Hospital (DSH) allotments will be reduced by:
    - \$0.5 billion in 2014
    - \$0.6 billion in 2015
    - \$0.6 billion in 2016
    - \$1.8 billion in 2017
    - \$5 billion in 2018
    - \$5.6 billion in 2019
    - \$4 billion in 2020
  - The Secretary of Health and Human Services will have significant authority to develop a methodology targeting Medicaid DSH reductions across states based on:
    - Percentage of state population uninsured
    - If the state is targeting DSH funds to hospitals with high Medicaid patient loads and high uncompensated care costs (excluding bad debt)
  - “Low DSH” states will face smaller proportional reductions compared to “high DSH” states.
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## New or Extended Medicaid Programs (continued)

### State Balancing Incentives Payment Program

- This five-year \$3 billion program will provide qualifying states with federal matching payments.
- Some states will be eligible for FMAP (Federal Medical Assistance Percentages) increases to build home-based and community-based services capacity.
- To be eligible, states must have non-institutional care account for less than 50% of total Medicaid long-term care spending in 2009 and must submit to Health and Human Services an application that includes a detailed plan and budget for increasing the use of non-institutional care to target levels.
- The target level is either 25% or 50% of total Medicaid long-term care spending, depending on the state's spending level in 2009. The program will exist from October 1, 2011 through September 30, 2015.

### Community First Choice Program

- Starting October 1, 2011, states can begin a Community First Choice program to offer home-based and/or community-based attendant services through a Medicaid state plan amendment.
- Eligibility is limited to those in Medicaid with disabilities who require institutional level care and with incomes up to 150% FPL (can vary by state).
- Services will be statewide without program caps, and benefits cannot target specific populations.
- States will receive an enhanced federal matching rate of an additional six percentage points for reimbursing expenses.
- The program is designed to give states a strong incentive to significantly expand Medicaid home-based and community-based services and will sunset after five years.

### Money Follows the Person Extension

- The Money Follows the Person (MFP) rebalancing demonstration will be extended for five years, through 2016.
- This program provides states with enhanced federal funding for twelve months for each Medicaid beneficiary transitioned from an institution to the community during the demonstration period. MFP is designed to help states reduce reliance on institutional care for individuals needing long-term services and supports and expand options for individuals with disabilities and the elderly to receive services in the community.
- Eligible participants must reside in an institution for at least 90 consecutive days (the previous residency period was from six months to two years). Days that an individual resides in an institution for the purpose of receiving short-term rehabilitation under Medicare cannot count for the 90 day period required for MFP eligibility. The MFP amendments are effective as of April 22, 2010.

For more information on health care reform, visit [washington.mcc.org](http://washington.mcc.org)

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