Medicaid Expansion

Briefing for Medicaid Health Plans of America

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Webinar
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Agenda

1. **Medicaid Eligibility Expansion under PPACA**
2. **Financing of Medicaid Expansion**
3. **Implementation of Medicaid Expansion**
4. **Enrollment Projections**
5. **Preliminary Answers to MHPA Member Questions on Medicaid Expansion**

Caveat: Presentation is based on PPACA language, initial CMS guidance, and preliminary views regarding likely federal and state policies. Therefore, the following is subject to change based on subsequent federal and state decisions.

Medicaid Eligibility Expansion Under PPACA

- ✓New National Floor for Medicaid Coverage
- ✓New Medicaid Eligibility Group
- ✓New Income Test for Medicaid
- ✓State Optional Expansion in 2010 – 2013
- ✓Mandatory Expansion in 2014

New National Floor for Medicaid

- Law creates a new, uniform nationwide floor for Medicaid eligibility at 133% of Federal Poverty Level (FPL). Starting in 2014.
- **Virtually all persons <133% FPL** except those covered by Medicare and unauthorized immigrants.
- Objective is to fill in gaps in current complex maze of federal and state, mandatory and optional Medicaid and CHIP eligibility for those in 0% to 133% of FPL.
- **Individuals / families at or below 133% of FPL, covered by Medicaid.**
- **Children covered in CHIP between 100% and 133% FPL transitioned to Medicaid.**
- Individuals / families between 133% and 400% of FPL are eligible for subsidized coverage in an Exchange plan. Exchange plans also start in 2014.
- For uninsured childless adults between 133-200% FPL, state may create Basic Health Plan with premium subsidies (in lieu of Exchange plan for this population).

New Medicaid Eligibility Group

- Law creates a **new Medicaid eligibility group** for low-income individuals not otherwise eligible under an existing mandatory category in Medicaid.

- All persons up to **133% of FPL** who are **not**:
  - ✓ Age 65 or older
  - ✓ Pregnant
  - ✓ Eligible for Medicare Part A
  - ✓ Enrolled in Medicare Part B
  - ✓ SSI beneficiaries
  - ✓ Unauthorized immigrants

- At same 133% FPL threshold, includes **children age 6 to 19, parents, and childless adults**.

- **Optional from April 1, 2010 through December 31, 2013**. At standard, non-enhanced FMAP.

- Mandatory for all state Medicaid programs starting **January 1, 2014**.

State Optional Expansion from 2010-2013

- Starting April 1, 2010, states have **option to phase-in Medicaid coverage** for part or all of the new eligibility group.
- Key Examples: **Childless adults, parents, and disabled persons not eligible for SSI.**
- State may set income eligibility for new group at any level up to 133% of FPL (based on family size). No asset test. Lower income people must be covered first become higher income are covered.
- Prior to 2014, states encouraged to use SSI approach to determine income.
- Optional expansions made through the **State Plan Amendment (SPA)** process.
- The state's **normal federal matching rate (FMAP) applies** to any expansion eligibles during the optional years. Enhanced FMAP under Recovery Act (AARA) does not apply.

Mandatory Expansion in 2014

Effective January 1, 2014:

- State Medicaid programs must cover the expansion population:
  - ✓ **New uniform income rules, no asset or resource test**
  - ✓ **New federal matching rates for expansion population**
  - ✓ **Existing cost sharing and immigrant status rules continue**
  - ✓ **Parent not covered unless children are covered in Medicaid or other health insurance.**
- States must also extend Medicaid coverage to persons under age 26 who were in foster care at age 18. Includes EPSDT coverage.

New Income Test for Medicaid Eligibility

- Medicaid eligibility will be **based on income only**, with no asset or resource test.
- **Modified Adjusted Gross Income** (MAGI): Total income, interest income, and foreign earned income.
- Includes special income adjustment of 5 percentage points. **So 133% of FPL becomes effective level of 138%.**
- Effective for most Medicaid eligibles (new and re-determined) starting January 1, 2014.
- Existing income counting rules for seniors and persons eligible for other programs continue to apply: Foster children, Supplemental Security Income (SSI), and low-income Medicare beneficiaries.
- Transition to MAGI will require **massive systems and process changes** by states. Plus significant increase in state / local capacity to process millions of applications.

Financing Medicaid Expansion

- ✓Federal Matching for Expansion Population
- ✓Phase-In for Expansion States
- ✓Maintenance of Effort (MOE)

Federal Matching for Expansion Population

- Increased federal match (FMAP) for **new eligibles** under Medicaid expansion:

Year	FMAP
2014 – 2016	100%
2017	95%
2018	94%
2019	93%
2020 and After	90%

- Primarily applies to Medicaid spending for persons newly eligible under federal expansion who are above state's Medicaid income eligibility as of PPACA enactment (March 23, 2010).

FMAP = Federal Medical Assistance Percentage. Federal matching rate for Medicaid benefits.

Phase-In of Federal Funding for Expansion States

- **"Expansion States" will receive phase-in of higher FMAP** for current Medicaid coverage of non-pregnant adults so that these states receive same FMAP as other states by 2019.

- Phase-in to reach 93% FMAP in 2019 and 90% in 2020 and beyond.

- Expansion States = State that already cover adults (parents and childless adults) at or above 100% FPL in Medicaid or a state-funded program.

- Expansion States (likely): **Arizona, Delaware, District of Columbia, Hawaii, Maine, Massachusetts, Minnesota, Pennsylvania, Vermont, Washington, and Wisconsin.**

- Vermont qualifies for 2.2 percentage point increase in FMAP for persons not newly eligible up to 133% FPL.

Maintenance of Effort (MOE)

- For children in Medicaid and CHIP, **states must maintain income eligibility** in effect as of March 23, 2010 through September 30, 2019.
- For adults in Medicaid, states must maintain income eligibility in effect as of March 23, 2010 until the state's health insurance exchange is fully operational (likely through 2014).
- In 2011-2013, state exempt from MOE for non-disabled, non-pregnant adults with incomes **above 133% FPL** if state certifies a **budget deficit or projects budget deficit** for following year.
- In theory, state failing to meet MOE puts all federal Medicaid match at risk.
- **In sum, freezes eligibility at no less than current state levels for:**
  - ✓ **Parents and childless adults through 2014**
  - ✓ **Children through 2019**
- To generate non-federal share for expansion population, law caps state use of local share (e.g., counties) at December 31, 2009 levels.

Implementation of Medicad Expansion

- ✓State Plan Amendments and s. 1115 Waivers
- ✓Benefit Package for Expansion Population
- ✓Transition of Children's Health Insurance Program
- ✓Interaction with State Exchanges

State Plan Amendments and s. 1115 Waivers

- To implement the optional and mandatory Medicaid coverage expansion, states will use the **State Plan Amendment** (SPA) process.

- Since many states have s. 1115 waivers containing eligibility-related provisions, **revisions to many s. 1115 waivers** will be necessary to accommodate new federal minimum:

  - ✓ In some cases, PPACA may moot earlier s. 1115 waivers, at least in part.

  - ✓ States may move expansion eligible populations from waiver to State Plan.

- Starting in September 2010, CMS must create transparent process for s. 1115 waivers, including public comment. Rules forthcoming.

Benefit Package for Medicaid Expansion Population

- Unless otherwise exempt, newly eligible adults under Medicaid expansion receive a **benchmark benefit package** or actuarial equivalent.
- Benchmark equivalent must meet minimum **essential health benefits** available in Exchange, as defined by HHS Secretary.
- Essential benefits modeled after typical employer plan with prevention, wellness, prescription drug, and mental health benefits included.
- Populations currently exempt from mandatory enrollment in benchmark plans remain exempt: seniors, disabled, pregnant women, dual eligibles, special needs.
- Those exempt from benchmark package approach will receive full Medicaid benefit package (Medicaid mandatory services, plus optional services elected by state).
- Medicaid **EPSDT coverage continues** for all children, regardless.

Role of Children's Health Insurance Program (CHIP)

- **Children covered by CHIP between 100% and 133% of FPL transitioned to Medicaid.** So all children 0-133% of FPL in Medicaid starting ~2014. Specifics to be determined.
- Federal funding for CHIP extended by two years through 2015.
- Federal match for CHIP increased by 23 percentage points on October 1, 2015.
- States must maintain their current CHIP eligibility through 2019. CHIP now authorized through 2019.
- If state hits federal CHIP allotment cap and stops new enrollment of children, children must be screened for Medicaid eligibility. If not Medicaid eligible, then eligible for tax credit in a Exchange plan comparable to CHIP.
- Starting in 2010, new state option to extend CHIP coverage to children of low-income state employees. Special premium limits apply.

Interaction with State Health Insurance Exchanges

- Starting in 2014, considerable interface required between Medicaid, CHIP, and the new **State Health Insurance Exchanges**.

- States must:
  - ✓ Allow individuals to apply for Medicaid, CHIP, and Exchange plan coverage through a **single state-run website**.
  - ✓ Allow Medicaid applications and renewals **on the web, with electronic signatures**.
  - ✓ Conduct outreach to uninsured and underinsured.

- At state option, Exchange may determine eligibility for premium subsidies.

- Medicaid expansion, coupled with the new Exchanges, will require states to work out an **extraordinary array** of capacity, governance, enrollment, systems, data, contracting, staffing, educational, and program integrity issues.

- **MHPA is hosting a webinar on Exchanges on Tuesday, July 20, 2010.**

Enrollment Projections

- ✓Difficulty of Estimating Enrollment Increase
- ✓Congressional Budget Office Projection
- ✓Urban Institute Projection
- ✓Range of Estimates of New Medicaid Enrollees

Quote from Rick Foster, Chief Actuary at CMS

"The actual future impacts of the PPACA on health expenditures, insured status, individual decisions, and employer behavior are very uncertain. The legislation would result in numerous changes in the way health care insurance is provided and paid for in the US, and the scope and magnitude of these changes are such that few precedents exist for use in estimation."

Richard S. Foster, Chief Actuary
Centers for Medicare and Medicaid Services
Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended
April 2010

Difficulty Estimating Increase in Medicaid Enrollment

- For many reasons, **predicting the ultimate increased enrollment in Medicaid is extremely difficult.**
- PPACA involves a series of significant and highly complex changes to the health care system, including new plan offerings, Exchanges, subsidies for individuals, taxes and penalties.
- Arriving at enrollment estimate requires subjective assumptions about the **behavior of states, individuals, and employers.**
- No precedent to build solid assumptions. Must rely on assumptions based on past take-up rates for new federal benefits and subsidies, rough effectiveness of past outreach, economic projections.
- A variety of **practical factors** also apply, such as state processing of millions of applications, extent and effectiveness of outreach and enrollment efforts, success and timeliness of federal and state implementation, degree sign-up is streamlined on the web, effect of simplified eligibility on retention, etc.
- **Economic factors** also apply, including **crowd-out** of employer-sponsored and individual coverage, interaction with Exchange subsidies, **employment rates**, and economic conditions.

Congressional Budget Office Projection

- The Congressional Budget Office (CBO) projects Medicaid and CHIP to increase by a net of 16 million new enrollees by 2019:

2014	2015	2016	2017	2018	2019
10 million	15 million	17 million	16 million	16 million	16 million

- CBO assumes the take-up rate will build over time, especially over 2014-2015. Also that a large portion of individuals who qualify will not enroll (~40%).
- Difficult to estimate take-up rates based on prior expansions, especially given individual mandate, availability of Exchange plans and subsidies, simplified eligibility standards, web-based enrollment, and state variations.

Source: Congressional Budget Office. Letter to House Speaker. March 20, 2010.
www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf

Urban Institute Projection

- In an analysis for the Kaiser Family Foundation, the Urban Institute developed two **scenarios to estimate increased Medicaid enrollment in each state**.
- The Standard Scenario attempted to approximate CBO's national estimate of 16 million but with state specific estimates. This reflects moderate levels of participation (57%) by newly eligible uninsured by 2019.
- An **Enhanced Scenario assumes a more aggressive outreach and enrollment campaign** to increase participation by newly eligible uninsured to 75%. This scenario projects **22.8 million new Medicaid enrollees by 2019**.

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured. *Medicaid Coverage and Spending in Health Reform: National and State-By-State Results for Adults at or Below 133% FPL.* May 26, 2010. www.kff.org/healthreform/8076.cfm

Range of Projections of New Medicaid Enrollees

Projected New Medicaid Enrollees by 2019 in Millions

35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0

CBO	OMB / OACT	Urban Institute (Enhanced Scenario)	Upper Bound (w/o Crowd-Out)
16.0	20.0	22.8	30.3

Preliminary Answers to
MHPA Member Questions on
Medicaid Expansion Under PPACA

Effect of Expanded FMAP under ARRA

Question: What happens if Congress doesn't extend the higher FMAP under ARRA?

Answer:

- The temporary 6 percentage point increase in each state's FMAP enacted under the ARRA expires on December 31, 2010.
- States are seeking and Congress is debating a six-month extension through June 30, 2011.
- Six-month extension would provide states with an extra $24 billion and match timing of state fiscal years.
- Many states built budget projections on these dollars. If the funds are not extended, many states will face higher deficits and therefore prospect of further budget cuts.

Hardship Under Maintenance of Effort

Question: How will HHS/CMS define a budget hardship to waive a state's maintenance of effort?

Answer:

- The law specifies this based on a certification from state to the HHS Secretary.
- It appears waiver of MOE is automatic if Governor certifies budget deficit.
- HHS/CMS could try to make the process more difficult through rules defining what is required in the certification and what constitutes a deficit.
- Regardless, the MOE waiver for budget reasons only applies to state's ability to reduce Medicaid eligibility for non-disabled, non-pregnant adults above 133% of FPL.
- We expect considerable discussion on this point between the Administration and NGA, NCSL, NASBO, and NASMD.

Federal Match for Children Age 6-18 at 100-133% FPL

Question: What is the FMAP rate for children age 6-18 who are between 100% and 133% of FPL?

Answer:

- All children currently in CHIP who are between 100% and 133% of FPL will be transitioned to Medicaid.
- Once in Medicaid, the normal Medicaid FMAP rates will apply.
- The precise timing and process for this transition is unknown. CMS guidance needed.
- Congress' long-range intent appears to be phase-out of CHIP on or about 2019. Federal CHIP funding currently ends in 2015 and CHIP as law in 2019.
- Presumably, current CHIP will be phased-out with children above 133% FPL moving to Medicaid and subsidized Exchange plans.

Continued Use of Asset Tests

Question: Which groups will continue to have asset tests for Medicaid eligibility?

Answer:

- In 2014, asset tests are eliminated for the Medicaid expansion population.
- For most groups, states will then determine Medicaid eligibility solely on income using the Modified Adjusted Gross Income (MAGI) method and family size.
- Asset tests will continue only for those population groups eligible for Medicaid through another program which has an asset test (most notably, SSI) and Medicaid medically needy (spend-down) population.
- Also important is the special income adjustment of 5 percentage points. With this, 133% of FPL becomes effective level of 138%.
- Implementing these changes will present states with major technical and practical challenges – in addition to challenge of processing huge volume of applications.

Effect of Standardizing Income Counting Rules

Question: What are the implications of a uniform Modified Adjusted Gross Income standard?

Answer:

- This change is likely significant, both because of the elimination of asset or resource testing but also because of simplified approach to counting income.
- Relatively speaking, income is easier to verify than assets or resources and harder to abuse.
- While still complex, MAGI is already used by IRS for certain situations like calculating retirement contributions.
- All things considered, standardization will somewhat increase number of enrollees in states with traditionally more restrictive rules and will likely reduce number of beneficiaries temporarily losing eligibility. Therefore, retention will increase.
- More data matching will be required to help prevent fraud and abuse.

Benchmark Plans

Question: Any special issues in benchmark plans for Medicaid expansion population?

Answer:

- Most of the Medicaid expansion population will receive a benchmark benefit package.
- This will affect plan design and require Medicaid health plans to differentiate enrollees between (a) those entitled to full Medicaid benefits and (b) those entitled to the benchmark package.
- In effect, Medicaid will have minimum of two benefit packages: benchmark package and full Medicaid package.
- The process for a state setting a benchmark or actuarial equivalent is relatively straightforward. It is more common in CHIP than Medicaid.
- In addition, the benchmark must include all services the HHS Secretary determines as essential in a basic Exchange plan.

Impact on Eligibility, Outreach, and Enrollment Processes

Question: What's the impact on state eligibility, outreach, enrollment processes?

Answer:

- The impact will be enormous.
- States will need to make major changes to existing eligibility systems and processes. Both to accommodate new eligibility standards and populations, but also to connect Medicaid eligibility to the web and to the Exchange.
- States must decide whether to run Exchange in-house or contract it out.
- The needs and expectations for outreach are extensive; must be scaled to the large number of prospective enrollees; and carefully coordinated with education and outreach regarding Exchange plans, subsidies, individual mandate, and employer mandate.
- States and local agencies will be hard pressed to process the volume of applications.
- PPACA creates the opportunity for states to create one-stop for eligibility, enrollment, subsidy process, and health plan selection across Medicaid, CHIP, and Exchange plans.

Impact on Enrollment Brokers

Question: How will Medicaid expansion impact third-party enrollment brokers?

Answer:

- States will need to determine the extent they wish to integrate Medicaid enrollment broker functions with the new functions of the Exchanges, which must include health plan selection and consumer education.

- Federal requirements for the Medicaid enrollment broker function continue. However, there's no question that the new Medicaid eligibility process and potential for integration with the Exchange functions create the opportunity for states to rethink their needs.

- It also opens up both a new potential market for current Medicaid enrollment brokers (e.g., offering services to Exchanges) as well as competitors to current Medicaid enrollment brokers (e.g., organizations hired to run Exchanges).

Role of MACPAC

Question: What role will MACPAC play on Medicaid reform implementation?

Answer:

- The Medicaid and CHIP Payment and Access Commission (MACPAC) is an advisory agency of Congress. Commissioners are appointed by the U.S. Comptroller General (head of GAO) and supported by a dedicated staff.
- MACPAC's mission is to advise Congress on virtually everything about Medicaid and CHIP access, quality, payments, delivery systems, etc. Work will include reports, special studies, comments on CMS proposed rules.
- It's sister agency, MedPAC, has been very influential on Medicare issues. We expect MACPAC to have a similar level of influence over time.
- MACPAC will likely increase attention on Medicaid and state-specific health issues inside the Beltway.

NCQA Approval of Medicare Special Needs Plans

Question: For Special Needs Plans, what does NCQA approval mean?

Answer:

- Since 2008, NCQA has been under contract with CMS to develop a process to assess and monitor the quality of care by Medicare Advantage Special Needs Plans (SNPs).

- This includes HEDIS measures (including additional measures for SNPs) and a series of structural and process measures for:

  - ✓ Complex Case Management
  - ✓ Improving Member Satisfaction
  - ✓ Clinical Quality Improvements
  - ✓ Care Transitions
  - ✓ Institutional SNP Relationship With Facility
  - ✓ Coordination of Medicare and Medicaid Benefits

- CMS guidance is expected but we anticipate that the NCQA approval process will lean heavily on this approach.

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Questions and Discussion

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