



**Medicaid Changes Under the  
Patient Protection and  
Affordable Care Act**

And the Health Care and Education Budget  
Reconciliation Act of 2010

# Overview

- Expanded coverage
- Federal Medical Assistance Percentage (FMAP) increases
- Maintenance-of-effort (MOE) requirements
- Additional preventive services
- Payment reform
- Rx Changes
- Delivery system reform
- Long-term care provisions
- Fraud and abuse

# Expanded Coverage

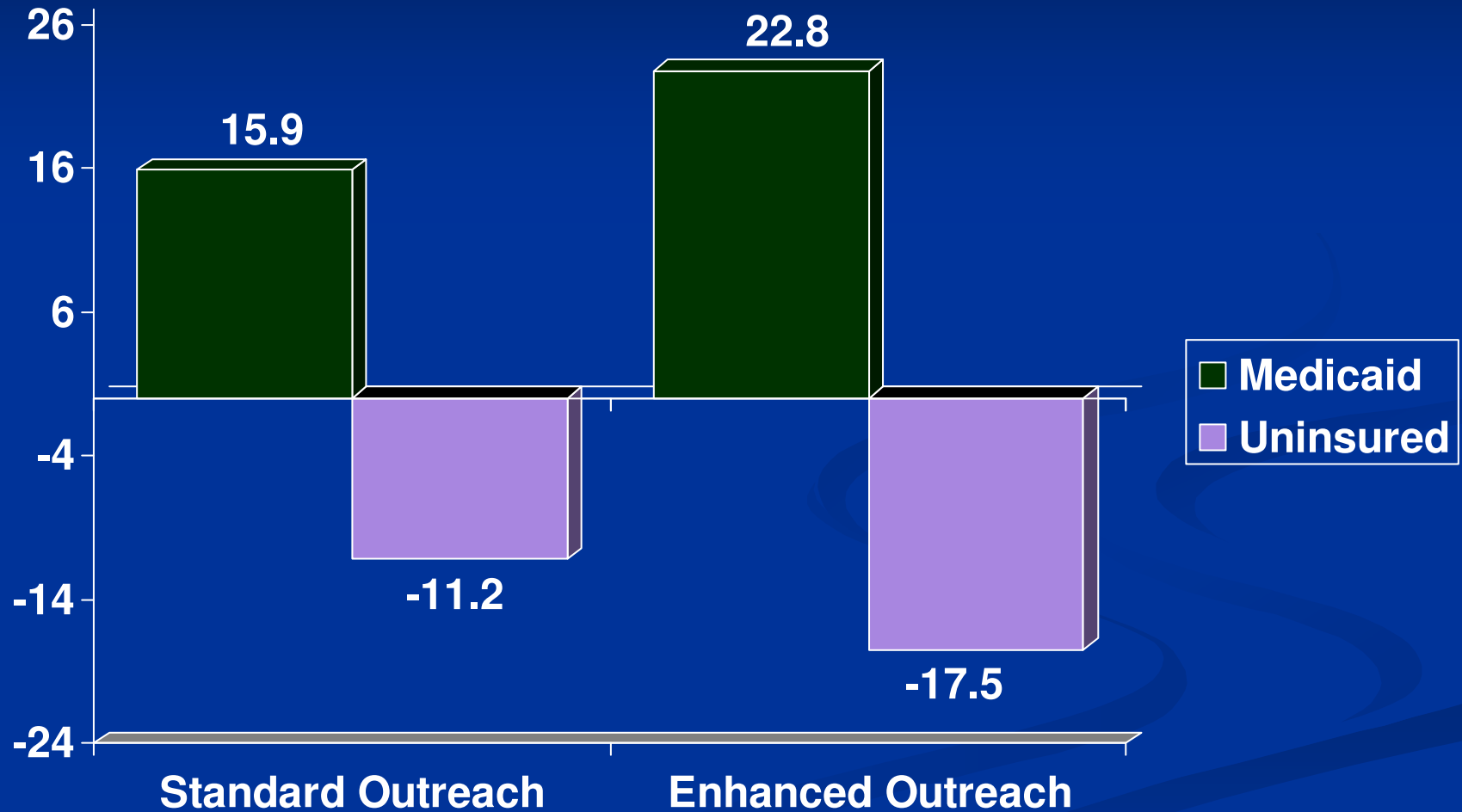
- Beginning January 1, 2014 Medicaid is expanded to 133% of the federal poverty level (FPL). Covers mostly adults, including childless adults. Cannot be Medicare eligible.
- For most enrollees modified adjusted gross income without an assets test is used. Increases effective eligibility to 138% of FPL.

# Expanded Coverage Continued

- 133% is \$14,400 for an individual and \$24,400 for a family of three (2009 data)
- 15.9 million Americans, up from the current 35 million, a 45% increase. With enhanced outreach enrollment could increase by 22.8 million Americans.
- The Medicaid expansion will reduce the number of uninsured Americans by 11 million to 17.5 million depending on outreach.

# Medicaid Enrollment and Reduction in the Uninsured with Standard and Enhanced Outreach

(in Millions of Americans)



Source: Kaiser Commission on Medicaid and the Uninsured, May 2010.

# Expanded Coverage Continued

- Capacity -- both provider and payer -- is a legitimate concern.

# Federal Medical Assistance Percentage (FMAP)

- Normal FMAP varies from 50% to 76%, averaging 57%.
- ARRA increased FMAP by 6.2% points plus additional assistance for states with high unemployment. Cost is \$86.6 billion. Set to expire January 1, 2011.

# FMAP Rates for Medicaid Expansion in 2014

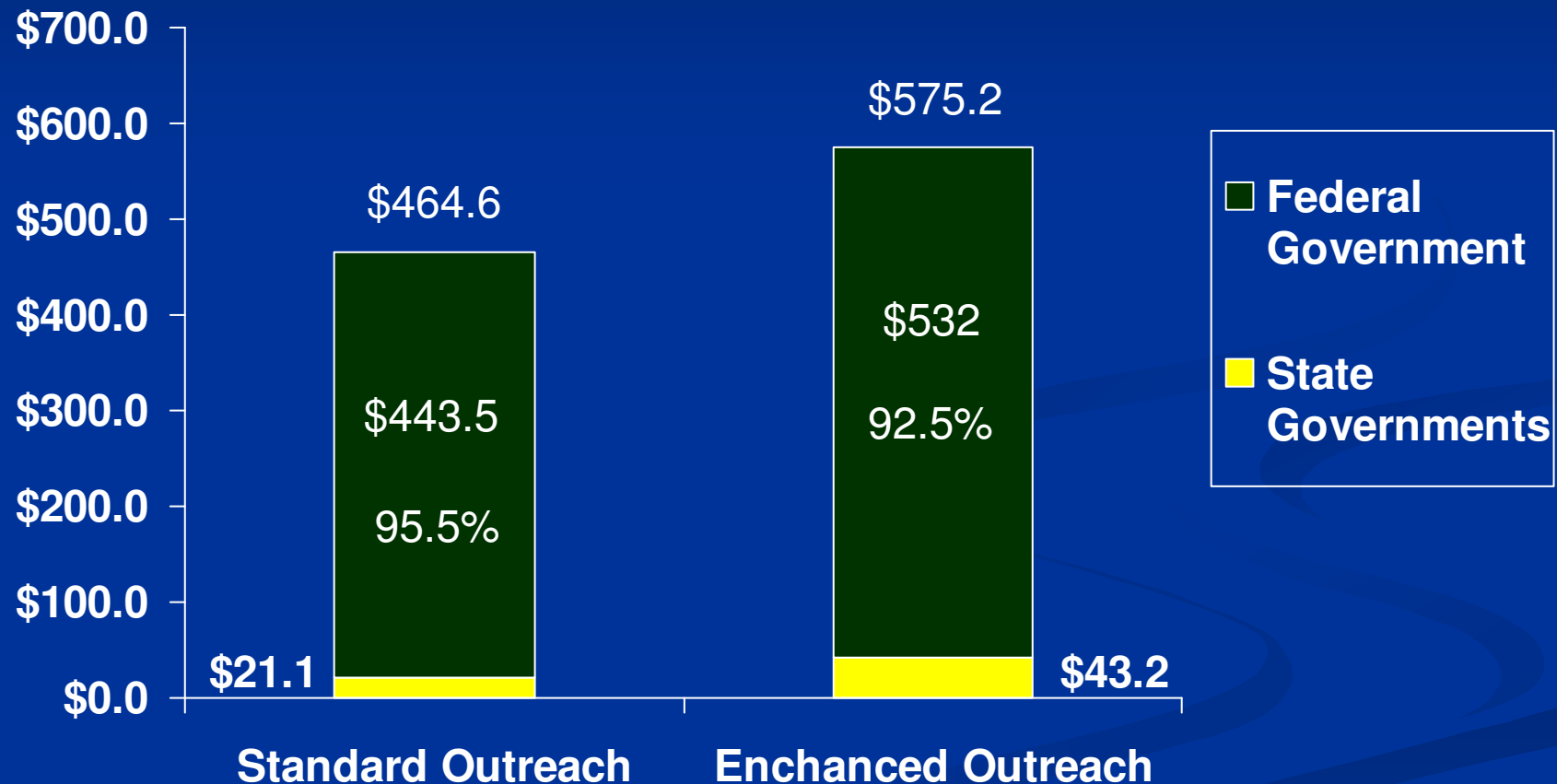
- For expansion population, FMAP increases for most states to:
  - 100% in 2014, 2015 and 2016
  - 95% in 2017
  - 94% in 2018
  - 93% in 2019
  - 90% for 2020 and beyond

# States that Have Expanded Already

- Existing expansion states (AZ, DE, HI, ME, MA, NY, and VT), that have already expanded Medicaid to adults earning at least 100% of FPL are not penalized over time. Their FMAP is equalized by 2019.
- Example, a state with a normal FMAP of 50% will receive a FMAP of 75% for the expansion population in 2014 and grows to 93% in 2019 and 90% and beyond in 2020.

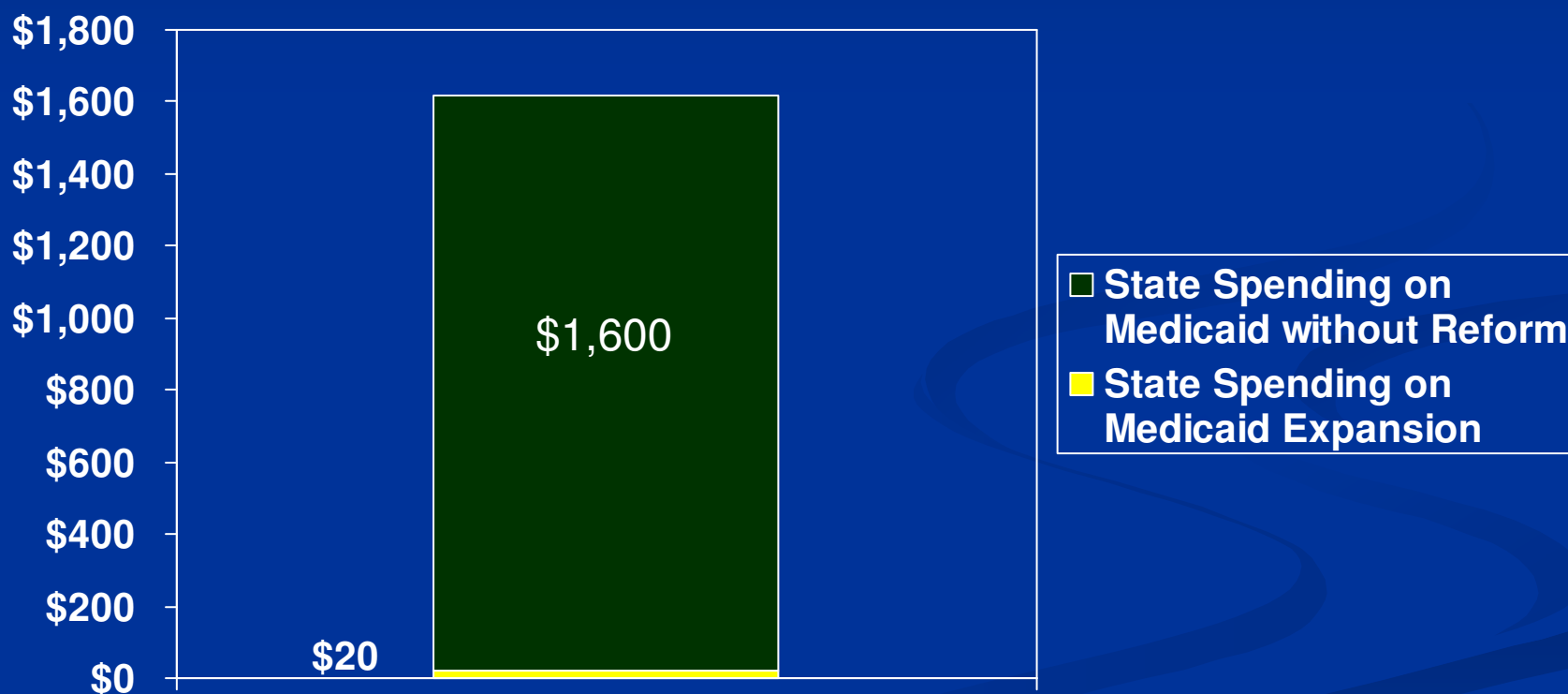
# Federal Government Pays Virtual All of the Medicaid Expansion

(2014 – 2019 in Millions)



Source: Kaiser Commission on Medicaid and the Uninsured, May 2010.

# State Spending on Medicaid with Reform Will Increase Only Slightly: 1 1/4% Increase



Source: Center on Budget and Policy Priorities, April 2010 at [cbpp.org](http://cbpp.org).

# Maintenance-of-Effort (MOE)

- States are required to maintain existing Medicaid eligibility standards for adults until state health exchanges are fully operational (1/1/2014).
- This MOE requirement is in place for children for both Medicaid and CHIP until October 1, 2019.
- Existing expansion states can scale back on populations above 133% of FPL.

# Additional Preventive Services

- State option to provide preventive services rated as either an A or B by the US Preventive Services Task Force, or adult immunizations recommended by the Advisory Committee on Immunization Practices. State that adopt these preventive services receive a 1% FMAP increase.

# Additional Preventive Services Continued

- Requires states to cover diagnostic, therapy, counseling and pharmacotherapy for tobacco cessation in pregnant women. No copayments for these services.
- Secretary of HHS to award state for incentives to Medicaid beneficiaries who successfully participate in health promotion programs (e.g., tobacco cessation, weight maintenance, lowering cholesterol or blood pressure, etc.) \$100 million for 5-years beginning in 2011.

# Payment Reform

- “The current (payment) system, based on volume and intensity, does not disincentivize, but rather **pays more for overuse and fragmentation.**” Mark McClellan, et. al.
- Center for Medicare and Medicaid Innovation (Center) established in CMS. Purpose to research, develop, test and expand innovative payment and delivery systems that improve quality and reduce costs.

# Payment Reform Continued

- Global payment demonstration: from 2010 to 2012, 5 large, safety net hospitals receive capitated, global payment instead of fee-for-service. Center evaluates for changes in outcomes and spending.
- Health care-acquired conditions (HACs): effective July 1, 2011, prohibits the payment of federal Medicaid monies for HACs. Secretary of HHS defines HACs.

# Payment Reform Continued

- Medicaid payment increases to Medicare rates for primary care physicians in 2013 and 2014. This increase is paid with 100% FMAP.

# Prescription Drug Changes

- Effective January 1, 2014, removes smoking cessation, barbiturates and benzodiazepines from Medicaid's excluded drug list.
- Increases rebate for single source and innovator multiple source prescription drugs from 15.1% to 23.1%. Non-innovator and multiple source drug rebates increase from 11% to 13%. Feds keep the additional money.

# Delivery System Reform

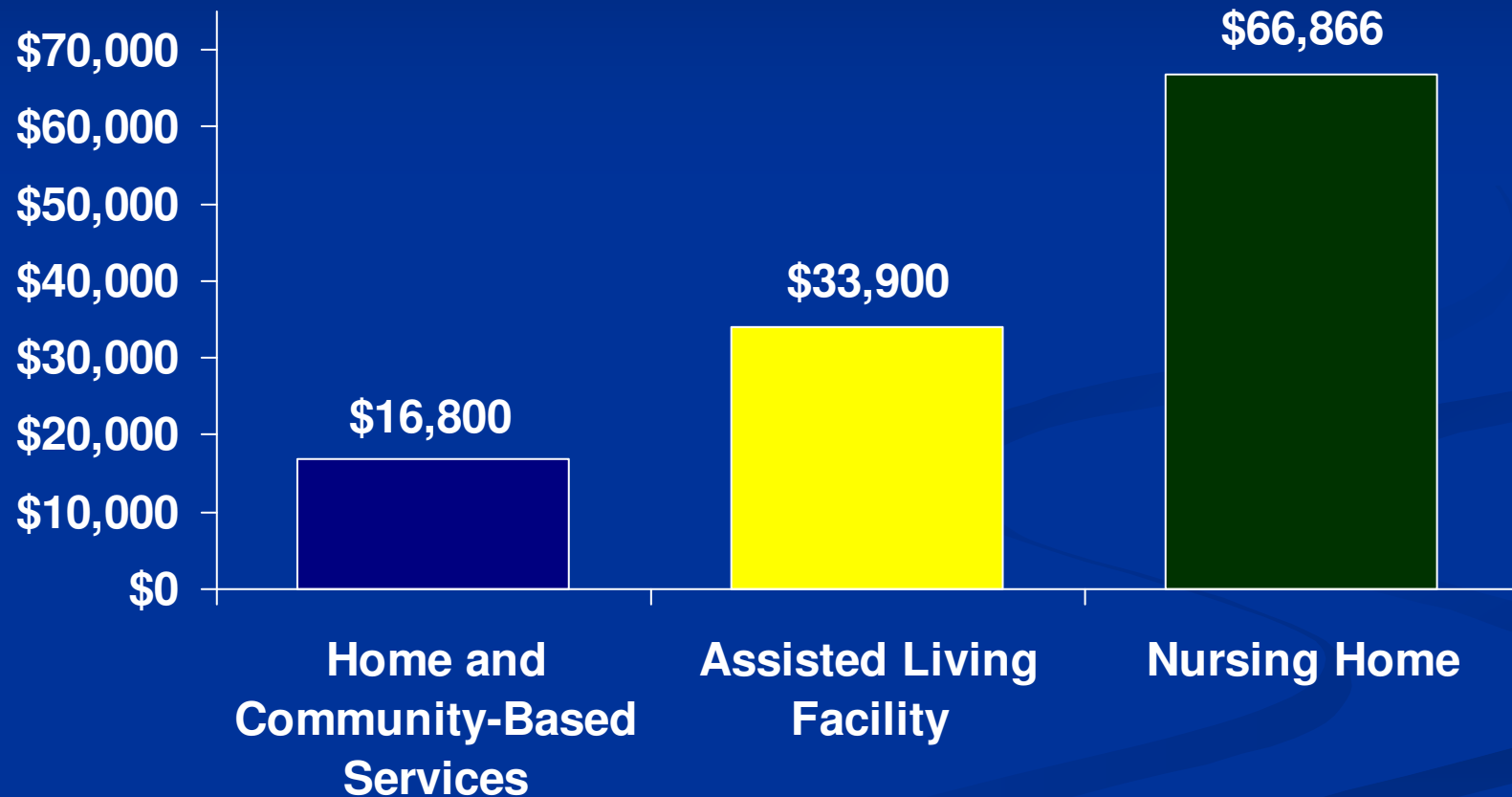
- Medical Home: Medicaid beneficiaries with at least two chronic illnesses, or one illness and risk of developing another, or one illness plus serious mental health condition, can designate a provider or a team of health care professionals as their medical home.
- Medical home must provide care management, care coordination, transitional care, and health promotion.
- Evaluated on reduced hospital and SNF admissions and reduced ER use.

# Delivery System Reform

- Accountable Care Organizations (ACOs): From January 2012 through December 2016 there are pilot projects for pediatric medical providers to become ACOs. They are responsible for the cost and quality of their patients. ACOs that meet quality-of-care targets share savings with Medicaid.

# Cost of Long-Term Care

(2009 Data)



Source: Congressional Research Service, May 2010 at [crs.gov](http://crs.gov).

# Long-Term Care

- Community First Choice Option: Optional Medicaid benefit for community-based attendant services for Medicaid beneficiaries as an alternative to hospital, nursing facilities, or intermediate care facilities for the mentally retarded. Effective October 1, 2011.
- Allows states to use state plan amendment rather than waiver to increase home and community-based services (HCBS).

# Long-Term Care Continued

- Community Living Assistance Services and Support (CLASS) program: a new, voluntary, self-funded, public long-term care insurance plan.
- Funded through payroll deduction (automatic enrollment with an opt-out provision). Individuals are vested after 5 years. Eligible individuals with functional limitations receive at least \$50/day for community living assistance.

# Long-Term Care Continued

- Additional FMAP to encourage states to rebalance spending by reducing nursing homes expenditures and increase funding for HCBS.
- Extends Money Follows the Person Rebalancing Demonstration through September 30, 2016.

# Fraud and Abuse

- Greater screening of providers:
  - Criminal background checks
  - Unscheduled and unannounced site visits, etc.
- Greater penalties for fraud and abuse
- Additional resources (\$250 million over 5 years) to prosecute fraud and abuse

# Conclusion

- Greatly expanded coverage
- Increased federal medical assistance percentage (FMAP)
- Maintenance-of-effort (MOE)
- Improved preventive services
- Payment and delivery system reform
- Long-term care alternatives
- Fraud and abuse

# Resources

- Alston & Bird's "Health Care Public Policy Group Health Care Reform Chart" at [alston.com](http://alston.com)
- Center on Budget and Policy Priorities at [cbpp.org](http://cbpp.org)
- Commonwealth Fund at [commonwealthfund.org](http://commonwealthfund.org)
- Families USA at [familiesusa.org](http://familiesusa.org)
- Kaiser Commission on Medicaid and the Uninsured's "Medicaid Coverage and Spending in Health Reform" at [kff.org](http://kff.org)

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