CHAPTER 1

Medicaid and CHIP in the Context of the ACA

Key Points

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Medicaid and the State Children's Health Insurance Program (CHIP) are undergoing many changes as provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) continue to be implemented. The Medicaid expansion, the creation of health insurance exchanges, premium tax credits for insurance coverage purchased through the exchanges, and both individual and employer mandates for insurance coverage are changing the insurance landscape as well as bringing new opportunities for health coverage. However, these changes are also creating new complexities in existing programs.

- Twenty-five states and the District of Columbia have made the decision to expand Medicaid up to 138 percent of the federal poverty level (FPL) for adults under age 65. States continue to consider their options, and this number could change over time.
- Despite the focus on expanding coverage, some people will remain uninsured, including certain individuals in states that choose not to expand Medicaid and individuals who remain uninsured due to affordability or other reasons. In addition, because citizens below 100 percent FPL are not eligible for premium tax credits, there will be a coverage gap in non-expansion states for those who are between the state's Medicaid eligibility limit for adults and 100 percent FPL.
- There are changes that affect every state, regardless of expansion status, including implementing a standardized income-counting methodology (using modified adjusted gross income (MAGI) for most non-disabled and non-elderly adults and children in place of income-counting and disregard rules that vary by state). Additional changes include moving many formerly paper-based processes online and replacing documentation requirements with applicants' self-attestation verified by third-party data checks.
- MACPAC has identified several issues that merit the attention of the Congress, discussed in subsequent chapters. These issues include stability of insurance coverage for childless adults and parents, equity in benefits between pregnant and non-pregnant enrollees, continuity of care for low-income pregnant women, and program integrity.
- MACPAC will continue to examine emerging issues, including characteristics of the new adult group; provider capacity; market alignment between qualified health plans (QHPs) and Medicaid managed care plan offerings; Medicaid eligibility rollbacks; use of waivers for Medicaid expansions; the ACA's impact on special populations, such as persons with disabilities and medically frail individuals; and program integrity developments.

CHAPTER 1

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The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) represents the most sweeping change to U.S. health care since the creation of Medicare and Medicaid in 1965. With an expansion of Medicaid, the creation of health insurance exchanges offering access to insurance policies for individuals and small businesses in every state, premium tax credits for coverage purchased through the exchanges for those with income between 100 percent and 400 percent of the federal poverty level (FPL), and both individual and employer mandates for insurance coverage, the ACA is changing the insurance landscape and creating new health coverage opportunities for millions of people.[1]

The existence of multiple sources of coverage targeted to people of different incomes, however, adds new complexities to an already complex landscape and creates particular challenges for Medicaid and the State Children's Health Insurance Program (CHIP). For example, while the number of people with insurance coverage will grow, coverage over time will not be seamless for everyone. Medicaid and CHIP enrollees in particular may move among different sources of coverage as their income fluctuates. In addition, the U.S. Supreme Court's ruling that the expansion of Medicaid to adults at or below 138 percent FPL could not be enforced by withholding funds for a state's entire Medicaid program has effectively made the expansion optional.[2] About half of the states are not implementing the expansion, though this number could shift over time as states continue to assess their options.

There are other challenges as well. For Medicaid, these include integrating new enrollees into systems of care, adopting more streamlined eligibility policies for some populations such as non-disabled adults and children, and ensuring accurate transfer of applicant information from the federal and state exchanges to state Medicaid programs. For CHIP, which primarily serves low-income children above Medicaid eligibility levels, the availability of subsidized exchange coverage for families at CHIP income levels and a federal funding stream assured only through 2015 have raised new questions about CHIP's future role.

Further, although state decisions about Medicaid expansion have garnered significant attention in the media, it is important to note that the ACA requires certain changes in eligibility procedures for all state Medicaid and CHIP programs, whether or not the state is expanding coverage. These changes include moving from income-counting and disregard rules that previously varied by state to a standard methodology that uses modified adjusted gross income (MAGI) for most non-disabled and non-elderly adults and children, as well as moving many in-person and paper eligibility processes online and replacing applicant documentation requirements with self-attestation verified by third-party data checks. Such changes are designed to streamline the eligibility and verification process, providing a more user-friendly experience for applicants and making eligibility determinations more accurate and less costly to process.

These issues set the context for MACPAC's examination of the ACA in this report, and they are discussed in greater detail below. Although it is still too early to comment on many of the key questions about the law's impact, such as the extent to which newly eligible individuals will enroll in Medicaid and what stresses this enrollment growth and changes in financing will place on safety net providers, MACPAC has identified several issues that merit the attention of the Congress. These issues, analyzed in Chapters 2, 3, and 4, include stability of insurance coverage for childless adults and parents, equity in benefits between pregnant and non-pregnant enrollees, continuity of care for low-income pregnant women, and concerns about program integrity.

Health Insurance Coverage under the ACA

The ACA provides for a Medicaid expansion up to 138 percent FPL for children and adults under age 65.[3] Those childless adults and parents newly eligible will be financed at a 100 percent federal match rate from 2014 through 2016, phasing down to 90 percent by 2020. Beginning in 2014, children age 6 through 18 between 100 and 138 percent FPL who were enrolled in a separate CHIP program must be covered in Medicaid, with CHIP funding. The benefit package offered to the new adult group, called the alternative benefit plan (ABP), is not required to contain all the benefits that the state offers in traditional Medicaid. For example, a state that has extended optional benefits such as adult dental care to its traditional Medicaid enrollees is not required to extend those benefits to the new adult group. However, the ABP must be benchmarked to one of several insurance plans in the state, and it must provide all 10 of the essential health benefits (EHBs) mandated by the ACA.[4]

The ACA also created, in each state, health insurance exchanges (also referred to as marketplaces) where residents can purchase coverage from a menu of qualified health plans (QHPs) that provide the full range of EHBs. Every exchange offers a variety of plans—catastrophic, bronze, silver, gold, and platinum—with each level defined by actuarial value, a measure of the share of expenses covered by the plan. Lower-tier plans require higher cost sharing but typically have lower monthly premiums, and higher-tier plans require less cost sharing but typically have higher premiums.[5] Platinum plans have the highest actuarial value and highest premiums. Enrollment in exchange plans will be limited to annual open enrollment periods, with exceptions for certain qualifying life events, such as the birth of a baby or loss of minimum essential coverage (45 CFR 155.420). Individuals with incomes between 100 percent and 400 percent FPL who are not eligible for Medicaid, Medicare, CHIP, or affordable employer-sponsored insurance are eligible for premium tax credits to help with the cost of QHPs, and those at or below 250 percent FPL may receive additional cost-sharing reductions.

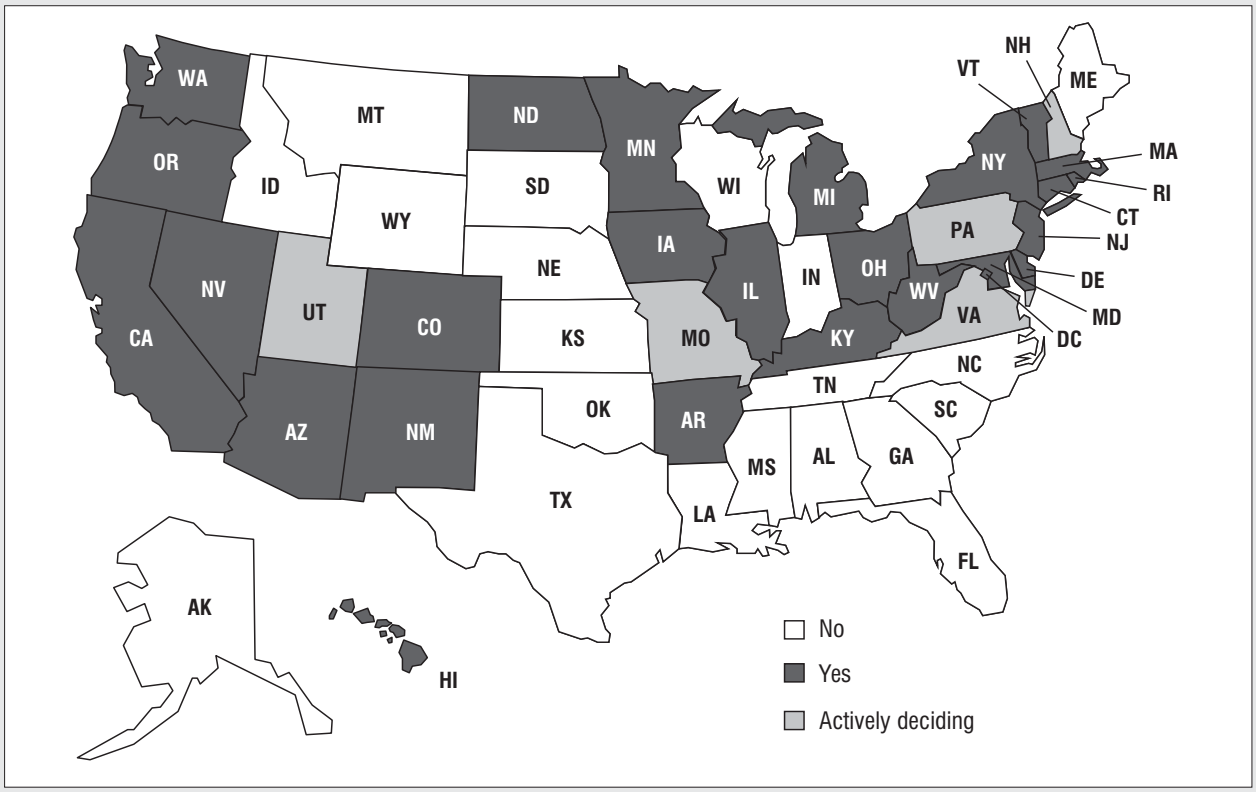
For 2015, employers with at least 100 full-time or full-time equivalent employees will be required to offer health insurance to at least 70 percent of those working full-time and their dependents. Starting in

2016, these employers, as well as employers with 50 to 99 full-time or full-time equivalent employees, will be required to offer health insurance to at least 95 percent of those working full-time and their dependents. Medicare will continue its role as the primary payer for individuals age 65 and older and for certain persons with disabilities. Medicaid will continue to be the primary source of coverage for low-income people.

The ACA's expansion of Medicaid to those up to 138 percent FPL also streamlines aspects of coverage for children. Previously, states could choose whether to cover children 6 through 18 years old between 100 and 138 percent FPL who were not already eligible for Medicaid through a Medicaid expansion or separate CHIP program. Under the ACA, states that had covered these so-called stairstep children in separate CHIP programs are now required to cover these children in Medicaid, albeit with CHIP funding.[6] The ACA also extends CHIP funding through FY 2015.

Medicaid expansion effectively optional. As envisioned, the ACA provided for expansion to the new adult group in all states, making this population one of several groups that state Medicaid programs are required to cover. In June 2012, however, the U.S. Supreme Court ruled that the expansion mandate could not be enforced by withholding funds for a state's entire program, leaving the law otherwise intact but effectively making the expansion optional. Twenty-five states and the District of Columbia have made the decision to expand Medicaid (Figure 1-1). In these states, certain individuals at or below 400 percent FPL without an

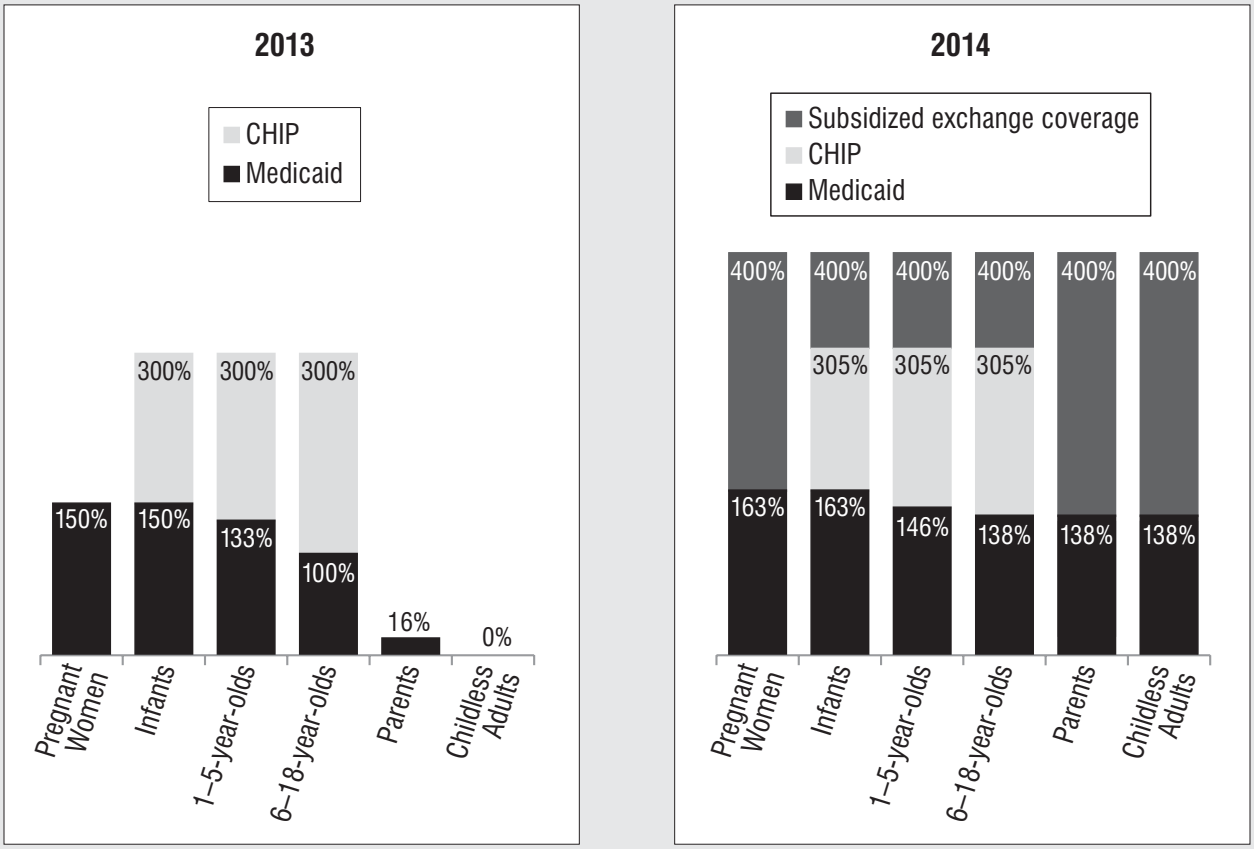
FIGURE 1-1. States Expanding Medicaid in 2014, as of February 18, 2014



Note: Michigan's Medicaid expansion is planned to take effect on April 1, 2014. Several states continue to debate expanding Medicaid in 2014. Missouri's state legislature continues to consider expanding Medicaid but has not yet enacted legislation to do so. New Hampshire is considering a proposal to use federal funds to subsidize the purchase of private insurance for low-income adults, but the proposal has not been approved by the state legislature nor has it been submitted to HHS. Pennsylvania is considering the use of federal funds for the purchase of private coverage. Utah and Virginia continue to actively debate Medicaid expansion.

Source: MACPAC analysis of KFF 2014, The Advisory Board Company 2014, State Refor(u)m 2014, and media accounts.

FIGURE 1-2. West Virginia Income Eligibility Levels in 2013 and 2014 as a Percentage of FPL



Notes: These figures show eligibility levels for citizens. Eligibility for lawfully present non-citizens varies. Non-citizens who are not lawfully present are ineligible for full Medicaid and subsidized exchange coverage. Some citizens in the exchange subsidy income range will be ineligible for exchange subsidies—for example, if they receive an offer of employer-sponsored insurance that is deemed affordable. The 2013 levels do not reflect disregards for certain types of income, such as earnings. In 2014, for populations shown here, Medicaid and CHIP eligibility is determined using modified adjusted gross income (MAGI) rules that require states to disregard an amount of income equal to 5 percent of the federal poverty level (FPL). The income eligibility levels shown here include an increase of 5 percentage points to account for the effect of this disregard. States may receive CHIP funding for some children eligible through Medicaid.

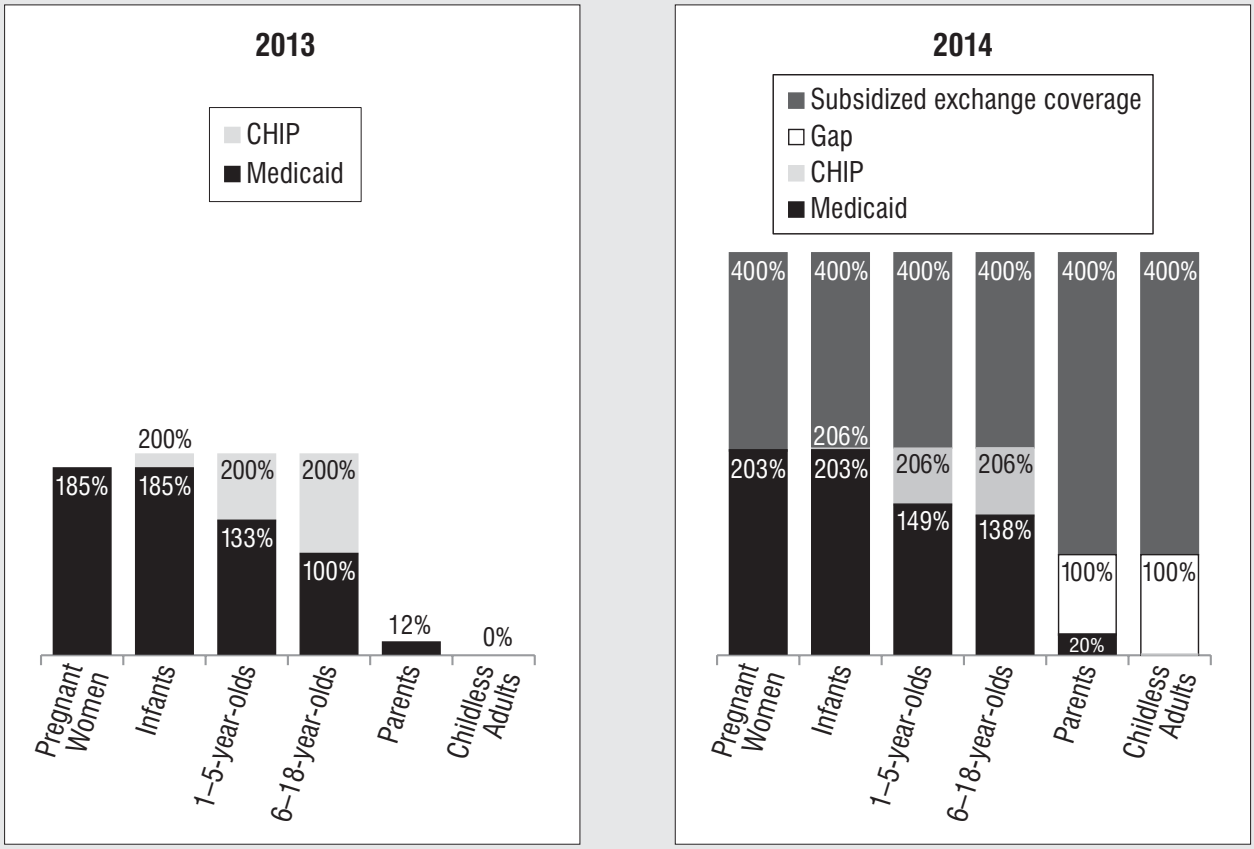
Sources: MACPAC 2013a; CMS 2013a; MACPAC analysis of CMS 2013b.

offer of affordable employer-sponsored insurance have access to either Medicaid, CHIP, or subsidized exchange coverage in 2014. Among the 25 states not yet electing to expand coverage for 2014, several continue to actively debate expansion alternatives (Figure 1-1). State expansion decisions have created different coverage landscapes across the states. Texas and West Virginia are two states that illustrate eligibility changes from 2013 to 2014 as well as the differing picture of coverage in expansion and non-expansion states (Figures 1-2 and 1-3).

Remaining uninsurance. While many people will find themselves newly eligible for insurance affordability programs under the ACA or will realize that they were already eligible for Medicaid or CHIP, not everyone will be covered. Those without coverage include individuals in states that have chosen not to expand Medicaid. In these states, individuals with income below 100 percent FPL who do not qualify for Medicaid or CHIP will fall into a gap in coverage (Figure 1-3).

Though nearly 70 percent of all those without insurance in expansion states will be eligible for Medicaid, CHIP, or subsidized QHP coverage, fewer than 40 percent will be eligible for assistance in states not expanding Medicaid coverage

FIGURE 1-3. Texas Income Eligibility Levels in 2013 and 2014 as a Percentage of FPL



Notes: These figures show eligibility levels for citizens. Eligibility for lawfully present non-citizens varies. Non-citizens who are not lawfully present are ineligible for full Medicaid and subsidized exchange coverage. Some citizens in the exchange subsidy income range will be ineligible for exchange subsidies—for example, if they receive an offer of employer-sponsored insurance that is deemed affordable. The 2013 levels do not reflect disregards for certain types of income, such as earnings. In 2014, for populations shown here, Medicaid and CHIP eligibility is determined using modified adjusted gross income (MAGI) rules that require states to disregard an amount of income equal to 5 percent of the federal poverty level (FPL). The income eligibility levels shown here include an increase of 5 percentage points to account for the effect of this disregard. States may receive CHIP funding for some children eligible through Medicaid.

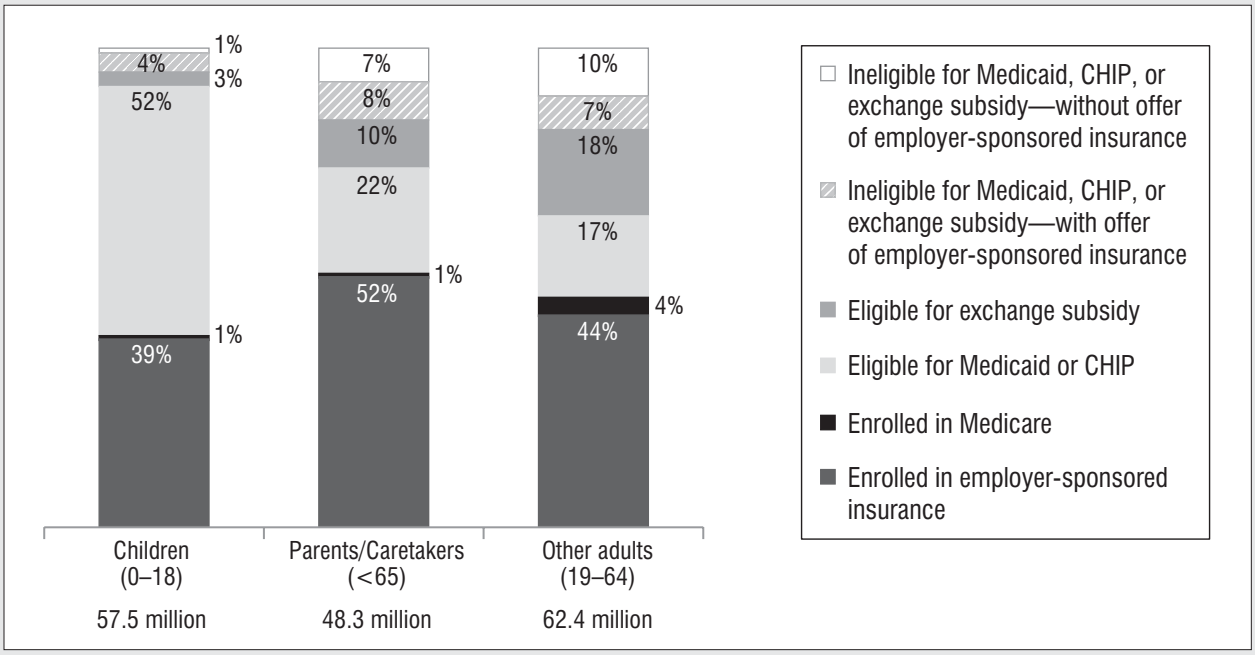
Sources: MACPAC 2013a; CMS 2013a; MACPAC analysis of CMS 2013b.

(Buettgens et al. 2013). In addition, because citizens below 100 percent FPL are not eligible for premium tax credits, the gap between where the state's Medicaid eligibility for adults ends and premium tax credits begin (100 percent FPL) will result in 4.8 million adults who are ineligible for both Medicaid and premium tax credits in non-expanding states (26 CFR 1.36B-2(b)(1), KCMU 2013).

Others remaining uninsured include those who are not lawfully present and thus are both barred from purchasing exchange coverage and ineligible for Medicaid. Non-pregnant adults who are lawfully present but have been in the country for less than five years generally do not qualify for Medicaid and CHIP, but they can qualify for premium tax credits. States have the option to extend Medicaid and CHIP coverage to lawfully present children and pregnant women who have been in the country for less than five years.[7]

Further, an estimated 10.5 million children and adults below 400 percent FPL are not enrolled in coverage offered by their employer (one reason may be that they don't find it affordable), but will not have access to premium tax credits because that offer is considered affordable under the ACA (§36B(c)(2)(C)(i) of the Internal Revenue Code,

FIGURE 1-4. Point-in-Time Eligibility Estimates for Insurance Coverage and Simulated Eligibility for ACA Insurance Affordability Programs for Non-Elderly, Non-Disabled Children, Parents, and Other Adults at or below 400 Percent FPL, 2014



Notes: ACA is the Patient Protection and Affordable Care Act. FPL is the federal poverty level. Coverage and eligibility are assigned hierarchically as follows: employer-sponsored insurance, Medicare, Medicaid/CHIP eligible, exchange subsidy eligible, and ineligible by employer-sponsored insurance offer status. Individuals ineligible for Medicaid, CHIP or exchange subsidy without an offer of employer-sponsored insurance could be ineligible for other reasons, such as being undocumented, subject to the five-year bar, or a citizen under 100 percent FPL. Individuals ineligible for Medicaid, CHIP or exchange subsidy with an offer of employer-sponsored insurance could be ineligible for other reasons, such as being undocumented or subject to the five-year bar.

Source: AHRQ analysis for MACPAC of 2005–2010 Medical Expenditure Panel Survey (MEPS) data.

AHRQ 2014). Employer-sponsored insurance is considered affordable for all members of the family as long as the employee's contribution to a self-only plan is 9.5 percent or less of family income. This measure of employer-sponsored insurance affordability has been called the family glitch or kid glitch because it does not factor in the cost to insure family members and dependents (Figure 1-4). For example, for a family of three with income at 100 percent FPL ($19,530 annually in 2014), the average annual employee contribution for individual coverage ($999 annually) is 5.1 percent of income. However, the average employee contribution for family coverage is $4,565, which is 23.4 percent of this family's annual income.[8] In this example, family members eligible to be covered under the employee's plan would be deemed to have access to affordable insurance, even though the cost of family coverage is well above 9.5 percent of family income (KFF and HRET 2013).

Variation in the operation of exchanges. States have significant flexibility in the design and operation of the exchanges. They can choose to establish and operate their own state-based exchange, participate in a federally facilitated exchange, or establish a federal-state partnership exchange.

As of January 2014:

- Fifteen states plus the District of Columbia are operating a state-based exchange.
- Twenty-six states have opted for a federally facilitated exchange.

- Seven states are operating a federal-state partnership exchange.
- Two states are operating a federally facilitated individual exchange with a state Small Business Health Options Program (SHOP) exchange.

States operating their own exchanges manage enrollment through state websites and certify QHPs according to federal and state requirements. These states have the flexibility to include additional certification requirements beyond federal standards. They can also encourage plan participation through additional requirements or incentives such as requiring certain issuers to participate in the exchange, or accepting any plan that meets exchange requirements (Dash et al. 2013). States defaulting to a federally facilitated exchange cede plan management responsibilities to the federal government, although all QHPs must still be licensed to operate in the state and must comply with its insurance regulations.

Implementation of other key provisions. Several provisions of the ACA came into effect before 2014. For example, children may stay on their parents' employer-based coverage until age 26, health plan issuers are prohibited from imposing lifetime limits, and many preventive services are now available without a copayment. Some of the most significant changes took place in January 2014, including new coverage under the Medicaid expansion and exchange plans, the individual mandate, and the requirement that QHPs offered both on and off the exchanges cover EHBs. The Centers for Medicare & Medicaid Services (CMS) announced in late 2013 that issuers may renew plans that are not fully ACA compliant for another year even when making changes that would have otherwise caused the plan to lose grandfathered status. However, it is unclear how many states will permit issuers to renew these plans and how many issuers will choose to renew them.[9] In addition, individuals whose plans were canceled and who state that they have difficulty paying for an existing exchange plan are eligible for a hardship exemption from the individual mandate. The hardship exemption would allow these individuals to either remain uninsured without penalty or purchase a lower-premium catastrophic plan.

Open enrollment for the exchanges began on October 1, 2013, and coverage for Medicaid's new adult group and under QHPs began on January 1, 2014. Technical troubles have plagued the technology infrastructure powering the eligibility and enrollment functions for exchanges, although some state-based exchanges—including those in Washington, Kentucky, and Connecticut—initially fared better than the federally facilitated exchange. It is not clear whether the problems that dominated headlines at launch are short-term implementation issues or evidence of more systemic problems.[10]

The Intersection of Medicaid, CHIP, and the Exchanges

Historically, Medicaid has played a unique role in U.S. health care, initially providing health insurance coverage to the nation's poorest women, children, individuals age 65 and older, and those with blindness or disabilities who also received other forms of government assistance. As the Congress expanded coverage to other poor children and as states began to use waivers to expand coverage to additional groups and cover optional populations such as the medically needy, Medicaid eligibility moved away from being linked solely to welfare programs.

Gaps in the safety net. In seeking to provide Medicaid coverage for nearly all persons at or below 138 percent FPL including childless adults, the ACA positioned Medicaid in a broader role, as a safety net with primarily income-based eligibility rather than income combined with categorical eligibility.[11] The Supreme Court's decision and

subsequent decisions by states not to expand to the new adult group, however, left gaps in this strategy to ensure coverage for all people with low incomes. Some of these gaps may disappear if additional states choose to expand. However, many people will remain uninsured, including those ineligible due to their immigration status. Safety net providers may face increased pressure in providing care for these uninsured individuals given a scheduled decrease in disproportionate share hospital (DSH) payments.[12]

Continuity of coverage. For Medicaid and CHIP, the existence of exchange coverage will create new market dynamics with potentially wide-ranging effects on individuals, providers, and health plans, as well as states and the federal government. Relatively small changes in income may lead individuals to change coverage between Medicaid, CHIP, the exchange, and uninsurance—a phenomenon known as churning.[13] Churning may disrupt care by requiring individuals to change providers. Likewise, individuals who churn from Medicaid to exchange coverage may need to adjust to paying premiums and copayments. Providers may find it difficult to continue to treat patients who move in and out of their networks. Health plans, states, and the federal government may find churning to be administratively burdensome as they process disenrollments and reenrollments throughout the year.

MACPAC recommended in March 2013 that the Congress create a statutory option for 12-month continuous eligibility for adults in Medicaid and children in CHIP, parallel to the current state option for children in Medicaid. Use of this statutory option would reduce churning and promote continuity of care. The Commission continues to support this recommendation. The ACA also provides an option designed to mitigate churn: allowing states to create a Basic Health Program (BHP) that uses federal tax subsidies to provide lower-cost exchange coverage for people with incomes above 138 but below 200 percent FPL. This option is intended to promote continuity of care by absorbing some of the cost of private plans for people who are just above the Medicaid income eligibility threshold. CMS announced in February 2013 that the BHP will not be operational until 2015 and followed with a proposed rule in September 2013 to establish the BHP (CMS 2013c, HHS 2013).

States can also promote continuity of care for Medicaid and CHIP enrollees by establishing so-called bridge plans offered by Medicaid managed care organizations on the exchanges. Bridge plans would be available to limited groups—such as individuals transitioning from Medicaid or CHIP, parents with children enrolled in Medicaid, or those earning more than the Medicaid threshold but below a certain FPL cap—and would allow those who transitioned to keep the same provider network. The federally facilitated exchange is not implementing bridge plans in 2014, and among the state-based exchanges, only California and Wisconsin appear to be to implementing bridge plans (ACAP 2013a, Covered California 2013, Johnson 2013).

Complex interaction among eligibility policies. Under the ACA, the exchanges will serve as a single entry point to assess all applicants' eligibility for Medicaid, CHIP, or premium tax credits.[14] This no wrong door policy means that the exchanges must use an eligibility system in which Medicaid, CHIP, and QHP eligibility rules interact and can connect eligible individuals to Medicaid. While this process should appear relatively seamless to enrollees, it requires complex system programming on the part of states and the federal government. In addition, the move from paper-based processes to online, real-time adjudication through the exchanges is a monumental change. Intended to streamline enrollment and renewal and create alignment across

insurance affordability programs, it has proved challenging both for state and federal exchanges.

Future Issues

The initial rollout of the ACA was rocky. Some problems will be corrected over time; others may develop as time goes on. MACPAC will be monitoring a number of issues over the next year, with a particular eye on those where the Commission could offer recommendations for improvement.

Enrollment among newly eligible adults. MACPAC, along with federal and state policymakers, will be monitoring enrollment trends. Of particular interest is the extent to which those eligible for the new adult group actually enroll in Medicaid and the health status of enrollees. While some research suggests that members of this group are generally in better health than current Medicaid enrollees, there are also concerns about potential high utilization due to pent-up demand as well as potential significant initial enrollment by those with greater than average health care needs (Chang and Davis 2013, Decker et al. 2013, Holahan et al. 2010, Somers et al. 2010).

Provider capacity. MACPAC will also keep a close eye on how increased Medicaid enrollment may affect the ability of providers to serve current enrollees as well as those newly eligible. The fate of safety net hospitals is of particular interest, as the ACA introduces changes to provider payments via reduced DSH allotments to states. The ACA reduced state DSH allotments in anticipation of a decrease in uncompensated care expected to result from the expansion of insurance coverage. These reductions will proceed despite the Medicaid expansion no longer being universally implemented. However, the budget agreement signed into law on December 26, 2013, delayed the reductions until October 1, 2015 (the Bipartisan Budget Act of 2013, P.L. 113-67). While it remains to be seen how safety net hospitals in expansion states will fare when the reductions are implemented, safety net providers in non-expansion states face an even more challenging future.

Market alignment. The extent to which continuity of care can be facilitated for those who churn is also of concern. Because the ACA provides a continuum of coverage that extends from Medicaid to QHPs, plan participation in both markets has the potential to smooth transitions associated with churning. States have undertaken a variety of efforts to encourage plan participation in both markets (Lucia and Dash 2013). A recent analysis shows that 41 percent of QHP issuers also offer Medicaid managed care plans in the same state and that most new entrants to the individual market on exchanges are Medicaid managed care plans (ACAP 2013b, McKinsey 2013). Plan networks may vary even if a carrier offers products on both markets, so more analysis is needed to determine the extent to which multimarket plans can ease the transition for those who churn. Access to providers who participate in multiple plan networks may also ease transitions and help maintain access to ongoing treatment or preventive care.

Medicaid rollbacks. Another concern is that states that had previously extended coverage to adult Medicaid enrollees may roll back coverage for some adult Medicaid enrollees in 2014, given that the exchanges now present an opportunity for these individuals to obtain health insurance. Maine, Rhode Island, Wisconsin, and Vermont have announced plans to reduce eligibility for some enrollees (Galewitz 2013). Louisiana is rolling back eligibility for pregnant women, and Minnesota is reducing eligibility for parents (Backstrom 2013, Shuler 2013). Additionally, states may roll back or eliminate optional disability pathways (e.g., poverty-related or Medicaid buy-in) for adults. This would result in individuals with disabilities and incomes above Supplemental Security Income (SSI) limits being placed into the new adult group or into

subsidized coverage, where they would be ineligible for certain benefits that they could have received under traditional Medicaid.

Use of waivers for Medicaid expansions. MACPAC will also be watching the experience of states that enroll Medicaid expansion populations in the exchanges through demonstration waivers and how these demonstrations affect costs and churning. Arkansas and Iowa have received approval to pursue the premium assistance option to use Medicaid funds to purchase coverage in the exchange (CMS 2013d, CMS 2013e). As other states continue to debate expansion alternatives, waiver proposals will be an important area to monitor.

Impact on special populations. Still to be seen is how new eligibility policies will affect special populations, including persons with disabilities and medically frail individuals. During the application process, states must identify those who are medically frail and offer them the choice of the ABP or the full Medicaid benefit package. States must also accurately identify individuals with disabilities to ensure that they are determined eligible through disability rules. Individuals with disabilities or those who are medically frail who are not determined eligible under the proper pathway may not receive all the benefits they could have received under Medicaid. For example, if individuals with disabilities were to receive coverage through a QHP, they may not have access to the long-term services and supports (LTSS) that they would have had under Medicaid, if they were income eligible. It will also be important to continue to monitor access and enrollment issues for the traditional Medicaid populations with high needs and high costs, such as individuals age 65 and older and the disabled, whose eligibility is not affected by the ACA.

Program integrity. Finally, policymakers will be monitoring the impact of administrative and implementation issues on program integrity. The ACA mandates many changes to Medicaid and CHIP eligibility processes and policies. These include using MAGI as the methodology for determining Medicaid eligibility for many applicants and replacing paper-based documentation with online, near real-time adjudication. These changes are intended to streamline enrollment and renewal and create alignment across insurance affordability programs. Some of these changes may reduce eligibility errors, while others may increase the risk of error. These changes raise questions about how eligibility quality control processes should be revised in light of ACA policy changes.

Endnotes

[1] Although eligibility for Medicaid and CHIP is determined using the most current FPLs, eligibility for subsidized exchange coverage is based on FPLs for the prior year, consistent with statute. Throughout this report, Medicaid and CHIP FPL dollar amounts reflect calendar year (CY) 2014 levels; dollar amounts for subsidized exchange coverage reflect FPLs in CY 2013.

[2] Before 2014, when determining eligibility, states had the flexibility to disregard whatever sources or amounts of income they chose. Beginning in 2014, a new methodology called MAGI is used to determine subsidized exchange coverage eligibility as well as Medicaid and CHIP for children, their parents, pregnant women, and the new adult group. Only one income disregard exists under MAGI for Medicaid and CHIP. States are required to disregard income equal to 5 percent FPL. For this reason, eligibility for the new adult group is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.

[3] For a family of three in 2014, 138 percent FPL is $27,310.

[4] See Section 1302(b) of the ACA for a list of the 10 EHBs, and Section 1937 of the Social Security Act for a description of benchmark options.

[5] Catastrophic plans are only available to those under 30 years of age and those exempt from the individual mandate due to lack of affordable insurance or a hardship waiver (§1302(e) of the ACA).

[6] Pennsylvania has been granted an extension and will place these children in Medicaid by 2015 (Esack and Darragh 2014).

[7] Twenty-five states have opted to cover five-year barred children, 20 states have opted to cover five-year barred pregnant women, and 15 states cover a pregnant woman's prenatal care, labor, and delivery regardless of immigration status by covering her unborn child through CHIP (Hasstedt 2013).

[8] State Medicaid and CHIP programs will implement FPLs updated as of January 24, 2014 as soon as possible, but no later than April 1, 2014. However, 2013 FPLs will be used to determine eligibility for subsidized exchange coverage for the remainder of calendar year 2014.

[9] Health insurance plans in existence at the time the ACA was signed into law are exempt from risk adjustment as well as many other provisions of the ACA. A plan can retain grandfathered status as long as it does not significantly raise premiums or decrease benefits.

[10] To better understand individuals' experience with the Medicaid eligibility and enrollment process, MACPAC conducted focus groups with individuals newly enrolled in Medicaid, as well as individuals who are eligible but not enrolled, in Maryland, Nevada, and California in December 2013.

[11] Categorical eligibility means that an individual must be a member of a certain group, such as parents, pregnant women, or children, in addition to meeting income and other guidelines, in order to qualify for Medicaid.

[12] The federal government allots DSH funds to states, which in turn make DSH payments as additional compensation to hospitals that serve a high number of Medicaid or low-income patients. DSH payments to a hospital cannot exceed allowable uncompensated care costs (P.L. 108–173, 42 CFR 447.299). For more information on the primary care physician payment increase, see MACPAC's June 2013 report to the Congress.

[13] For more information on stability of coverage, see Chapter 2 of MACPAC's March 2013 report to the Congress.

[14] State-based exchanges that are government entities can make Medicaid eligibility determinations for both MAGI and non-MAGI groups. Federally facilitated exchange states can choose to be a determination or assessment state. Determination states will accept the federally facilitated exchange's eligibility determination for MAGI eligibility groups. A state that chooses the assessment model will receive eligibility information electronically from the federally facilitated exchange and make its own determination.

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Chapter 1 Appendix

Selected Changes under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) Relevant to Medicaid

- Expands Medicaid eligibility to nearly all individuals under age 65 with incomes up to 138 percent FPL regardless of categorical eligibility (effectively made optional by the June 2012 U.S. Supreme Court decision in *National Federation of Independent Business v. Sebelius*)
- Implements modified adjusted gross income (MAGI) method of income calculation for determining eligibility for most non-disabled and non-elderly adults and children
- Implements reduction to state disproportionate share hospital (DSH) allotments in anticipation of a decrease in uncompensated care resulting from an expected increase in those covered by insurance
- Increases payment rate for primary care services provided by certain physicians to 100 percent of the Medicare payment rates for 2013 and 2014
- Extends CHIP funding through 2015
- Prohibits Medicaid payments for health care acquired conditions
- Establishes the Center for Medicare and Medicaid Innovation to support pilot programs for innovative payment and delivery arrangements in Medicare and Medicaid
- Establishes the Federal Coordinated Health Care Office to improve integration between Medicaid and Medicare with regard to dual eligible populations
- Includes funding for bundled payment demonstrations, global payment demonstrations for safety net hospitals, pediatric accountable care organization demonstrations, and a demonstration project to provide Medicaid payment to institutions for mental disease in certain cases
- Requires the development of an adult quality measurement program for Medicaid-eligible adults
- Provides that children who were in foster care and receiving Medicaid on their 18th birthday will continue to be eligible for full Medicaid until age 26
- Allows states to implement health home state plan amendments to provide more integrated care to Medicaid enrollees with chronic conditions
- Extends the Money Follows the Person demonstration program, supporting states as they shift towards providing more long-term services and supports (LTSS) in the home or community, rather than institutional settings
- Requires termination of providers in Medicaid who are terminated in Medicare; suspension of Medicaid payments where there is a credible allegation of fraud; adherence to National Correct Coding Initiative methodologies; establishment of recovery audit contractors in Medicaid; and in-person encounter with a provider prior to the provision of home health services