2010 FEDERAL HEALTH REFORM

MEDICAID & CHILDREN'S HEALTH INSURANCE PROGRAM FACT SHEET

President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act on March 23, and the Health Care and Education Reconciliation Act of 2010, on March 30, 2010. This fact sheet summarizes the provisions related to the Medicaid program and the Children's Health Insurance Program (CHIP).

MEDICAID

Expands Medicaid eligibility to childless adults (non-disabled adults up to age 65) up to 133 percent of the Federal Poverty Level (FPL), effective January 1, 2014.

States will receive federal funding as follows:

- 2014-2016: 100 percent federal funding
- 2017: 95 percent in 2017,
- 2018: 94 percent in 2018,
- 2019: 93 percent in 2019 and
- 2020 and thereafter: 90 percent.

States have the option to expand eligibility as early as April 1, 2010; however, states would not receive the enhanced federal matching rate until January 1, 2014.

Eligibility. A new modified adjusted gross income definition of income, which is based on tax code definitions, will be used to determine eligibility for non-disabled and non-elderly persons for Medicaid. Current income disregards are replaced by a 5 percent income disregard. These changes will make eligibility determinations more complex.

All persons who were in foster care and receiving Medicaid at age 18 will be eligible for Medicaid up to age 26.

Undocumented individuals will continue to be ineligible for non-emergency Medicaid. "New" legal immigrants (residing in the U.S. less than five years – the population California currently serves under a state-only Medi-Cal program) will also continue to be ineligible.

Benefits. All newly eligible adults will be guaranteed a benchmark benefit package that provides at least the essential health benefits. The benefit package will be determined by the Health and Human Services (HHS) Secretary at a later date.

Rates. Increases the Medicaid payments for primary care services provided by primary care doctors to 100 percent of the Medicare payment rates for 2013 and 2014. State will receive 100 percent federal financing for the increased payment rates for these two years.

Enrollment. The asset test will be eliminated for most Medicaid populations (excluding seniors in long term care). Hospitals will also have the option to make presumptive Medicaid eligibility determinations in 2014.

Each state will be required to establish a system with websites that allow for application and enrollment in Medicaid, CHIP or coverage through the Exchange. The HHS Secretary will be creating a single form to apply for Medicaid, CHIP and federal tax credits for coverage through the Exchange. A state's Exchange may enter into a contract with the State Medicaid agency to determine eligibility for tax credits. The new enrollment procedures and website are to be operational by 2013.

New Section 1115 Medicaid Waiver Requirements. Under the measures, the HHS Secretary is required to issues regulations governing applications for or renewals of any Section 1115 demonstration project that would affect eligibility, enrollment, benefits, cost-sharing or financing under Medicaid or CHIP. The regulations are to be issued by October 2010.

New Medicaid Options and Demonstration Projects. The measures also create new state options for the Medicaid program and for demonstration projects, including:

- **Health Homes for Enrollees with Chronic Conditions.** Beginning in 2011, states are provided the option to allow Medicaid recipients with at least two chronic conditions to designate a provider as their health home. States that choose this option would receive a 90 percent FMAP for such services for the first eight quarters that the State Plan Amendment is in effect.
- **Incentives to Prevent Chronic Disease.** Grants will be available to states to provide incentives for Medicaid beneficiaries to participate in programs that promote healthy lifestyles and prevent chronic diseases. The measures appropriate $100 million for a five-year period beginning January 1, 2011.
- **Global Payment Demonstration Project.** Establishes a demonstration project in up to five states that allows participating states to adjust their current payment structure for safety net hospitals from fee-for-service to a global capitated payment model. The project runs from federal Fiscal Year 2010 through 2012; budget neutrality requirements for Section 1115 demonstration waivers will NOT apply.
- **Integrated Care Around a Hospitalization.** Establishes a demonstration project to evaluate the use of bundled payments for the provision of integrated care to Medicaid beneficiaries for episodes of care that includes a hospitalization and for physician services provided during a hospitalization. Up to eight states can participate in the projects that are slated to begin in 2012.
- **Emergency Psychiatric Demonstration Project.** Establishes a three-year Medicaid emergency psychiatric demonstration project under which participating states would be required to reimburse certain institutions for mental disease (IMDs) for care provided to Medicaid beneficiaries between age 21 and 65 who are in need of medical assistance to

stabilize an emergency medical condition. The HHS Secretary will select states on a competitive basis. The measures appropriate $75 million in FFY 2011.

Maintenance of Effort. States are prohibited from reducing eligibility for adults in Medicaid until the Exchanges become operational on January 1, 2014. States are prohibited from reducing Medicaid eligibility for children until 2019.

A state will be exempt for the maintenance of effort requirement for non-disabled adults with incomes above 133 percent FPL for any year from January 2011 through December 31, 2013 if the state certified that it is experiencing a budget deficit or will experience a deficit in the following year.

Local Government Share of Cost. States are prohibited from requiring local governments to incur a percentage share of non-federal Medicaid costs above what was required on December 31, 2009. In addition, the measures clarify that voluntary contributions are not to be considered a required contribution. Please note that the federal government had previously interpreted intergovernmental transfers and certified public expenditures to be required contributions. The language clarified that these are voluntary contributions.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

In California's CHIP program is the Healthy Families Program. CHIP benefit package and cost-sharing rules will continue as under current law.

States are prohibited from reducing CHIP eligibility (unless they have exceeded their federal CHIP allotment) until 2019. States will receive enhanced CHIP matching rates in 2015, at which time the federal matching rate for California's Healthy Families program will go from 66 percent to 89 percent.

PROGRAM INTEGRITY PROVISIONS

The measures impose new program integrity provisions on Medicare, Medicaid and CHIP. The HHS Secretary will establish procedures for screening health providers and suppliers within 180 days to reduce fraud, waste and abuse. Based on the risk of fraud, waste and abuse for each category of provider or supplier, the level of screening shall include, at a minimum, licensure checks and may also include fingerprinting, criminal background checks, database checks and unannounced site visits. States are required to comply with the new provider and supplier screening and oversight requirements under Medicaid and CHIP.