MEDICAID, CHIP, AND THE HEALTH CARE SAFETY NET

Medicaid is considered the “workhorse” of the United States health care system. Medicaid and its sister program, the Children’s Health Insurance Program (CHIP), provide health care coverage to nearly 67 million low-income individuals. In terms of enrollment, Medicaid is the largest public health insurance program in the U.S. Medicaid provides crucial support to the nation’s health care “safety net,” including hospitals and community health centers, and is the largest payer of long-term care services and supports for the elderly and disabled. Under the Patient Protection and Affordable Care Act (PPACA), Medicaid is expected to account for more than half of the reduction in the number of the uninsured and will continue to occupy a major role in the gradual movement towards a universal health care system.1

Under PPACA, Medicaid will change substantially, most significantly by the mandated nationwide coverage of all non-Medicare eligible individuals at or below 133% of the Federal Poverty Level (FPL), effective January 1, 2014. This change alone is expected to result in coverage of at least 16 million uninsured individuals.1,2 Additionally, PPACA adjusts the Medicaid financing states receive from the federal government, payments to providers, provision of long-term care services and supports to the elderly and disabled, and funding and staffing support for community health centers. Collectively, these provisions set the stage for significant transformation of the health care delivery system and will afford providers – both safety net and not – numerous opportunities to participate in the implementation of new models of health care financing and delivery.

PROBLEM STATEMENT

Although many of the most significant Medicaid provisions within the Patient Protection and Affordable Care Act (PPACA) do not go into effect until January 1, 2014, state Medicaid and CHIP agencies and health care safety net providers know they must plan diligently for the anticipated influx of newly insured patients into the safety net. States must make key decisions on how to simplify and fast-track eligibility and enrollment procedures, ensure access to care, and transform how care is delivered while navigating shifting federal financing for Medicaid, all within the midst of a slow economic recovery. Currently, one state (Connecticut) has expanded its Medicaid program, while others have, for the time being, decided not to expand coverage due in large part to ongoing fiscal concerns and uncertainty about a temporary extension of federal funding for Medicaid.3,5
There are a variety of opportunities for health care foundations to support the tremendous changes that will need to take place prior to January 1, 2014 in order to support a high-performing safety net under national health care reform. A recent report by the Commonwealth Fund identified several areas in which the health care safety net’s capacities could be enhanced, including: obtaining off-site specialty care for Medicaid and uninsured patients; building upon community health centers’ capacities to serve as a medical homes to ensure high quality, low cost health care; and improving health information technology infrastructure beyond electronic medical records to support more timely, appropriate, and effective care. These are only a few of a variety of opportunities that foundations have to support the health care safety net during a period of significant transition under national health care reform.

**SUMMARY OF HEALTH CARE LEGISLATION - MEDICAID AND CHIP**

The Patient Protection and Affordable Care Act (PPACA) establishes a mandatory, nationwide floor of 133% of the FPL ($29,326 for a family of four in 2010) for all non-Medicare eligible individuals, effective January 1, 2014. Medicaid coverage varies widely from state to state, characterized by an income floor ranging from 50-133% depending on the eligibility “category” in which individuals fall. PPACA equalizes the income floor across states, eliminates asset and resource tests, effectively eliminates categorical eligibility, and is expected to result in an expansion of Medicaid coverage to at least an additional 16 million individuals. Consistent with current Medicaid regulations, undocumented immigrants are ineligible for Medicaid. States that have previously been more generous with their Medicaid coverage are likely to see minimal increases associated with expansion (1-2% between from 2014-2019) while states that have been less generous are likely to see more substantial increases (3-5%). States may elect to expand Medicaid coverage prior to January 1, 2014.

States may also use designated “Express Lane Agencies” to streamline eligibility and enrollment. The “Express Lane Eligibility” (ELE) option was introduced through the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to encourage states to identify and enroll eligible individuals more efficiently. Under the provision, state Medicaid/CHIP agencies may use existing information available from approved public agencies to identify and enroll eligible individuals into Medicaid and CHIP. States’ participation under the ELE provision is voluntary. Currently, Alabama, Louisiana, and New Jersey have approved ELE proposals.

Under PPACA, Medicaid beneficiaries must be provided with “benchmark” coverage that mirrors one of the following: 1. Coverage provided through the Federal Employee Health Benefits Program, 2. Coverage provided through states’ employee health benefits programs, or 3. Coverage provided through an HMO with the largest commercial, non-Medicaid enrollment in a state. Medicaid benefits may differ from benchmark benefits if approved by the Secretary of the Department of Health and Human Services (DHHS).

Effective January 1, 2014, the federal government will finance 100% of the costs of coverage for all newly eligible Medicaid beneficiaries (i.e., those individuals not eligible for Medicaid prior to the passage of PPACA). This Federal Medical Assistance Percentage (FMAP) decreases
gradually to 93% by 2019. States that have expanded coverage prior to January 1, 2014 will receive federal financing at current levels, but will receive the enhanced FMAP effective January 1, 2014. Overall, the cost of the Medicaid coverage expansion is estimated by the Congressional Budget Office (CBO) to be $434 billion and $20 billion, for the federal and state governments respectively, from 2014-2019. The fiscal liability of the states depends heavily on their previous generosity with Medicaid coverage and the percentage of individuals enrolling in Medicaid deemed newly eligible. Most states can expect a 1-2% increase in Medicaid coverage costs.

PPACA increases Medicaid fee-for-service (FFS) and managed care reimbursement for primary care physicians (PCPs) to Medicare levels for 2013 and 2014, funded 100% by the federal government. In anticipation of a reduction in the cost of uncompensated care, Medicaid disproportionate share hospital (DSH) payments will be reduced by $14 billion from 2014-2019, inversely proportional to the percentage of uninsured in each state.

With respect to CHIP, states must maintain current eligibility levels for the program until 2019. Effective January 1, 2014, all CHIP-eligible individuals with family incomes between 100% and 133% of FPL will be transitioned to Medicaid. CHIP-eligible children not enrolled in the program due to federal allotment caps will be screened for eligibility for Medicaid and, if found ineligible, will be provided with tax credits for coverage under a state Health Benefit Exchange plan that is deemed actuarially equivalent to states’ CHIP plans by the DHHS Secretary. Funding for CHIP is extended through 2015 and, beginning that year, states receive a 23 percentage point enhanced FMAP up to 100%.

COMMUNITY HEALTH CENTERS

The Patient Protection and Affordable Care Act provides $11 billion in funding (from 2011-2015) to federally qualified health centers (FQHCs), $1.5 billion of which may be used for capital improvements. An additional $1.5 billion is allotted to the National Health Service Corps in the form of scholarships and tuition remission to increase the presence of primary care physicians in Health Professional Shortage Areas. Funds are also provided to FQHCs that serve as “Teaching Health Centers” by developing primary care residency programs. Collectively, these provisions support the goal of providing high-quality, low-cost primary care to the uninsured through the health care safety net.

LONG-TERM CARE

Long-term care services and supports account for more than one-third of all Medicaid spending and more than two-thirds of all Medicaid spending for the elderly. Medicaid is the largest payer of long-term care services and supports, more than half of which is institutionally-based.

Under the Patient Protection and Affordable Care Act (PPACA), long-term care for the elderly and the disabled is supported by several provisions: expansion of home and community-based services and supports through state plan amendments; the Community Living Assistance
Services and Supports (CLASS) Act; the “Community First Choice” option; and the extension of the “Money Follows the Person” demonstration.

State plan amendments allow states to provide home and community-based services and supports to individuals at or below a threshold of 300% of social security income without having to submit waivers on a case-by-case basis. The CLASS Act establishes a voluntary (opt-out) national insurance program similar to Social Security in which workers pay into the program (a trust fund) throughout their working lives and then draw a cash benefit (no less than $50/day and dependent on functional limitations) that defrays the costs of long-term services and supports. The Community First Choice option is available to individuals <150% of the FPL with disabilities to encourage them to use home and community-based supports and services as an alternative to institutionally-based care. The Money Follows the Person demonstration is a federal initiative included in the Deficit Reduction Act of 2005 and likewise encourages individuals to consider home and community-based alternatives to institutionally-based care. The demonstration provides an enhanced FMAP to states that successfully move individuals out of institutions and into the community. Collectively, these provisions encourage expanded use of home and community-based services and supports and decreased reliance on institutionally-based care.

In addition, a newly established Federal Coordinated Health Care Office will improve coordination of benefits for dually eligible beneficiaries. Dual eligible beneficiaries rely heavily on Medicaid to cover Medicare costs as well as for services not provided under Medicare, long-term care in particular. Nearly 9 million in number, these individuals are the poorest, sickest, and costliest, accounting for nearly 50% of Medicaid expenditures.

ANTICIPATED ISSUES OF HEALTH CARE REFORM IMPLEMENTATION

Despite the enhanced Federal Medical Assistance Percentage (FMAP) for the newly eligible, the federal government’s share of financing will closely track its current FMAP, which means many states are likely to see an increase in Medicaid expenditures of at least 1-2%. Additionally, the Medicaid expansion paired with the individual mandate is likely to create a "welcome mat effect" and draw out individuals who are currently eligible, but not enrolled. States will be required to cover these individuals at their current FMAP, which may present a further budgetary challenge.

Additionally, the slow economic recovery has depleted states revenues while at the same time increasing demand for Medicaid coverage. Prior work has shown that a 1% increase in the national unemployment rate results in a 3-4% decrease in state revenues and an increase in the uninsured of 1.1 million, 1 million of whom are likely eligible for Medicaid/CHIP. The national unemployment rate has hovered between 9 and 10% for more than a year and prior work has shown that ongoing unemployment at this level is expected to create a shortfall of at least $125 billion in states’ budgets for Medicaid/CHIP funding. The financial liability for states depends heavily on states’ prior generosity with Medicaid coverage and what categories of people (e.g., newly eligible v. currently eligible) enroll in Medicaid. However, for
most states, health care reform means that Medicaid deficits will increase before they decrease.

States that participate in Medicaid must establish websites that allow individuals to apply for and renew Medicaid and CHIP benefits. Whether or not states elect to designate Express Lane Agencies, resources will need to be committed to planning and coordination among public agencies to ensure a simplified application process, accurate enrollment, and secure sharing of data. States’ existing enrollment procedures will not do. Additionally, states that have expanded Medicaid coverage beyond 133% of the FPL will need to establish a system that will successfully transition individuals above 133% of FPL to a Health Benefit Exchange plan. States are prohibited from modifying eligibility for children (adults) between the enactment of the legislation on March 23, 2010 and 2019 (2014). However, states retain discretion over benefits (above the minimum) and exercise some flexibility in provider reimbursement rates (except in the case of primary care, which will be 100% federally financed in 2013 and 2014). Additionally, states are prohibited from capping enrollment into community and home-based services and supports.

The Patient Protection and Affordable Care Act (PPACA) presents both opportunities and challenges to the health care safety net. While Federally Qualified Health Centers (FQHCs) benefit from $11 billion in funding and an influx of Medicaid dollars, safety net hospitals face definite revenue losses from eliminated disproportionate share hospital payments and possible revenue gains from the influx of new Medicaid patients. Whether or not safety net hospitals will realize revenue gains by attracting newly insured non-Medicaid patients depends on the position – in terms of provider mix, payer mix, and capital investment among others – of safety net hospitals relative to their non-profit and private competitors. The overall financial outlook for safety net hospitals at this point remains unclear.

Safety net hospitals are likely to see a spike in demand for specialty care services because of the influx of newly insured patients and the role of safety net hospitals in meeting the “excess demand” for specialty services not normally provided by CHCs. Additionally, an aging Medicaid population requiring increasingly complex care will contribute to the demand for specialty services and points to a need for safety net providers at all levels to work collectively to provide high-quality, coordinated care.

In thinking about staffing the health care safety net, states will need to make decisions to maintain funding for primary care physicians (PCPs) at current levels after 2014, when federal funding expires. Additionally, despite $1.5 billion in funding to increase the presence of PCPs in Health Professional Shortage Areas, there will be a lag of several years between the expected influx of new patients and the supply of PCPs in these areas.

**OPPORTUNITIES TO LEVERAGE HEALTH CARE FOUNDATION INVESTMENTS**

Some illustrative examples of how health care foundations can support the provision of high-quality, low-cost health care to low-income individuals through the health care safety net include:
• Encouraging the development of formal linkages among providers – both inside and outside the health care safety net – for the provision of ambulatory and inpatient care, in particular specialty care for Medicaid and uninsured patients. These linkages might be based on the concept of accountable care organizations (ACOs), which are provider-managed organizations responsible for the entire spectrum of care, including quality and costs, for a defined population. ACOs may take a variety of organizational forms, but the essential element of a successful ACO is a strong foundation in primary care.  

• Enhancing safety net providers’ capacity to operate as medical homes to ensure high-quality, low-cost health care. In support of the preceding recommendation, safety net providers functioning as medical homes may take the helm in providing a strong primary care foundation for their patients. Foundations could provide crucial support in enhancing safety net providers’ existing infrastructure to satisfy National Committee for Quality Assurance standards for provision of care as a medical home. 

• Examining and evaluating models of long-term care services and supports that promote a medical home model of care. Likewise, as PPACA contains a variety of provisions that encourage the provision of long-term care services and supports in the community and the home, foundations could work with long-term care providers to identify measures of success for coordination and quality of care that ensure individuals successfully age in a place of their choosing. 

• Supporting the efforts of the National Academy for State Health Policy, the National Governors Association, the National Association of Insurance Commissioners, and the National Association of State Medicaid Directors to share states’ experiences, issues, and solutions. 

• Providing straightforward information to the public on what coverage and care options are currently available as well as what changes will take place under PPACA. Particular attention should be given to the breadth and quality of services at safety net hospitals and community health centers as well as to long-term care options, especially home and community-based services. 

These funding opportunities are not exhaustive and, by working with safety net providers foundations can identify additional areas where support for the provision of high-quality, low-cost health care to low-income individuals through the health care safety net would be critical.

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The Schneider Institutes for Health Policy at the Heller School was founded in 1978, and conducts domestic and international research in the broad areas of financing, organization, value, high-cost and high-risk populations, and health technologies. The Schneider Institutes are made up of three research and policy groups: The Institute for Behavioral Health; The Institute on Healthcare Systems; The Institute for Global Health and Development.

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References


