

Chapter 3: Federal Health Care Reform

Federal health care reform legislation increases access to health insurance by creating an individual mandate for health insurance coverage, giving states the option to expand Medicaid and subsidizing health insurance for some individuals. There will be significant costs and challenges to the state to implement federal health care reform, which is not fully federally funded.

History and Background

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (HCERA) was enacted on March 30, 2010. Together they are called the Affordable Care Act (ACA) and make significant changes to state health care programs and to the health insurance market. Among a number of other changes, the ACA mandates that all individuals have health insurance coverage and provides individuals up to and including 400 percent of the federal poverty level (FPL) with subsidies to purchase health insurance coverage. It also gives states the option to expand Medicaid eligibility up to and including 133 percent FPL for individuals under age 65.

The ACA also required the establishment of health insurance marketplaces by January 1, 2014, to assist individuals and small employers in accessing affordable health insurance. The marketplace must be operated by a governmental entity or non-profit organization.

States had the option to establish a state-based marketplace, partner with the federal government to establish a marketplace, or have the federal government run the state's marketplace. States that initially opted for a federally-run marketplace may request to move to a state-based marketplace over time. Texas currently has a federally-facilitated marketplace.

As of January 1, 2014, qualified individuals and employees of participating small employers can purchase health insurance coverage from qualified health plans on the marketplace. Individuals above 100 up to and including 400 percent of the FPL may be

eligible for premium subsidies and cost-sharing reductions for coverage purchased through the marketplace.

The new health insurance requirements impacted the number of uninsured in Texas.

Directives Implemented

Many of the major provisions of the ACA impacting HHSC did not become effective until 2014. However, a number of provisions had earlier effective dates. HHSC has implemented changes to Medicaid benefits, pharmacy, federal matching funds, and Medicaid eligibility policies. HHSC also has implemented a number of program integrity provisions.

Eligibility Changes

Effective January 1, 2014, the ACA required states to make significant changes to eligibility for most Medicaid programs and the Children's Health Insurance Program (CHIP).

Financial Eligibility

The ACA makes the following changes to financial eligibility:

- Requires states to determine financial eligibility for most Medicaid programs and CHIP based on the modified adjusted gross income (MAGI) methodology. The MAGI methodology uses federal income tax rules for determining income and household composition.
- Prohibits assets tests and most income disregards for most Medicaid programs and CHIP. The ACA applies a five percentage point income disregard to individuals subject to the MAGI methodology. Prior to the ACA, Texas applied assets tests and income disregards to most Medicaid programs and CHIP.
- The MAGI methodology applies to most Medicaid eligibility groups for children, pregnant women, and parents and caretaker relatives. The ACA provides exceptions to the use of the MAGI methodology and to the elimination of assets tests and income disregards. In Texas, the exceptions primarily apply to emergency Medicaid, foster care children, medically needy, individuals receiving Supplemental Security Income, and Medicaid programs for people age 65 and over and those with disabilities.

Other Eligibility Changes

In addition to financial eligibility changes, the ACA makes changes to other eligibility policies and processes. The ACA requires the following:

- A single, streamlined application form for Medicaid, CHIP, and the marketplace.
- States must redetermine Medicaid eligibility every 12 months and no more frequently than once every 12 months except when a change in circumstance is received by the state that may affect an individual's eligibility.
- An administrative or passive eligibility renewal process for Medicaid and CHIP. To the extent possible, states must use available information to make eligibility redeterminations without requesting information or an application from clients.

Medicaid Benefit Changes

Hospice

The ACA requires states to provide concurrent hospice care and treatment services for children enrolled in Medicaid and CHIP. Under the ACA, a family that elects to receive hospice care for a child can no longer be required to waive treatment for the child's terminal illness. Texas implemented this change in Medicaid and CHIP effective August 1, 2010.

Birthing Centers

At the direction of the Centers for Medicare & Medicaid Services (CMS), Texas stopped providing direct Medicaid payments to birthing centers on September 1, 2009. However, the ACA added birthing centers as a required Medicaid provider. In response, HHSC reinstated birthing centers as a Medicaid provider, which allowed birthing centers to provide covered Medicaid services and receive direct Medicaid reimbursement effective September 1, 2010.

Licensed Midwives

The ACA required states to provide Medicaid reimbursement to all providers recognized by states as a licensed birth attendant providing health care at childbirth. Licensed midwives are a licensed, recognized birth attendant in Texas. Texas Medicaid began recognizing licensed midwives as a provider type effective January 1, 2013.

Comprehensive Tobacco Cessation Services for Pregnant Women

As a result of the ACA, HHSC implemented comprehensive tobacco cessation services for pregnant women on January 1, 2012. Comprehensive tobacco cessation services for pregnant women include prescription and non-prescription tobacco cessation agents approved by the federal Food and Drug Administration and tobacco cessation counseling services. Prior to implementation, Texas covered tobacco cessation drugs but not tobacco cessation counseling.

Pharmacy Changes

The Omnibus Budget Reconciliation Act (OBRA) of 1990 established the federal Medicaid drug rebate program. OBRA requires drug manufacturers as a condition of participation in the Medicaid program to pay rebates that are shared by the federal and state governments for covered outpatient drugs that are dispensed to Medicaid patients. In exchange, state Medicaid programs must cover all of a manufacturer's contracted drug products.

Effective January 1, 2010, the ACA increased the minimum federal rebate percentages that drug manufacturers are required to pay for participation in the Medicaid program and specified that all of the revenues collected due to these changes will be paid to the federal government. The ACA also enables states to collect rebates for drugs dispensed through managed care organizations.

With the March 2012 managed care expansion, pharmacy benefits were carved into the Medicaid managed care delivery system.

Section 1860D-2(e)(2)(A) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was amended to include barbiturates "used in the treatment of epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines. As of January 1, 2013, Texas Medicaid no longer covered barbiturates and benzodiazepines for dual eligible clients.

Changes to Federal Matching Funds

The ACA provided opportunities to receive federal matching funds for services previously reimbursed through general revenue (GR) funds. Texas has pursued the following:

- Allowing for receipt of federal matching funds for CHIP coverage of state employees' children who previously qualified for Teachers Retirement System ActiveCare, which was fully paid for with state GR funding; and
- Allowing for receipt of federal matching funds for CHIP coverage of state employees' children who previously qualified for the State Kids Insurance Program (SKIP), which was fully paid for with state GR.

Temporary Primary Care Provider Rate Increase

The ACA required that reimbursement for certain Medicaid services provided by primary care providers be increased to 100 percent of Medicare rates for calendar years 2013 and 2014. On November 1, 2012, CMS issued regulations defining primary providers, for the purpose of this provision, as specialist and subspecialists within the general category of family practice, general internal medicine, and pediatrics.

This increase applies to physician evaluation and management services and the administration of vaccines. The rate increase is 100 percent federally funded for the difference in the Medicaid rate in place in July 2009 and the Medicare rate in 2013 and 2014. Because Texas implemented rate reductions in 2011, generally of two percent, there will be some cost to the state for a portion of the increase. Medicare co-pays and deductibles, which were reduced in 2012, may also require state matching funds for the affected primary care providers and services.

The state began making payments to qualified providers in February 2014. Qualified providers were eligible for the temporary rate increase for certain primary care services provided in Medicaid through December 31, 2014.

Program Integrity Initiatives

The ACA (Section 6401) established new provider screening and enrollment requirements for providers and suppliers enrolling in Medicare, Medicaid, and CHIP. The new provider screening and enrollment rules became effective March 25, 2011. Newly enrolling providers are subject to the new provider screening requirements. Texas Medicaid began re-screening existing providers in January 2013.

Pursuant to federal law,¹ states must implement the following changes to provider screening and enrollment requirements. The federal regulations allow states to rely on Medicare screening or screening in another state to ensure that a provider has met the federal requirements.

Screening Categories

Providers enrolling in Medicaid or CHIP are subject to federal and state-defined screening requirements. All applications, including applications for new practice locations, re-enrollment, or revalidation, are subject to the highest level of screening by federal- and state-defined risk categories: limited, moderate, or high.² HHSC will establish risk categories for provider types that are not federally defined or adjust federal risk categories for provider(s) who pose increased risk of fraud in Medicaid based on history of waste, fraud, or abuse.

Database Checks

Providers and any persons with five percent ownership or control interest or who are agents or managing employees of the provider shall be subject to routine federal and state database checks at a described frequency on an on-going basis. Database checks shall be used to confirm, identify and determine exclusion status through routine checks of federal databases.

Licensure Verification

Verification of provider licensure in accordance with any state laws and confirmation of licensure status (e.g., active or expired) and current licensure limitation is required.³ Verification must occur at federal- and state-defined intervals.

Site Visits

Moderate and high-risk providers must submit to an on-site pre and post enrollment visit conducted by federal agencies or a state Medicaid agency. A site visit consists of unannounced on-site inspections of any and all provider locations to verify the accuracy of the information submitted on an enrollment application and determine compliance with federal and state laws.⁴

Criminal Background Checks

Providers must consent to criminal background checks, including fingerprinting, when required to do so under state law or if they are designated as high-risk providers under the new enrollment provisions. For providers designated as high risk, each provider or persons with five percent or more direct ownership interest in the provider will be subject to the federally required criminal background check and subject to submitting to fingerprinting within 30 days of a request by federal agencies or HHSC in addition to complying with existing state laws.⁵

Application Fee

Providers enrolling in Medicaid or CHIP, with the exception of physicians and non-physician practitioners (including physician and non-physician practitioners groups), must submit an application fee for enrollment prior to the state executing a provider agreement.

An application fee is required for:

- Newly enrolling providers;
- A new practice location; and/or
- Re-enrollment/revalidation.

An application fee may be waived if the fee has been collected by Medicare, Medicaid (in the case of CHIP), or another state's Medicaid or CHIP program. In cases in which Medicare has granted a provider an exception to the application fee, an application fee will not subsequently be required in Medicaid or CHIP as the state may rely on Medicare for Medicaid or CHIP enrollment.

The application fee is non-refundable with the exception of applications denied prior to initiation of the screening process or if an application is subsequently denied as a result of an imposed temporary moratorium on enrollment.

Enrollment Revalidation

Revalidation and screening of all providers must occur at a minimum every five years. At this time, providers must be rescreened for enrollment. Revalidations will consist of a full enrollment screening, including site visits and criminal background checks as required by designated risk categories. With the exception of physicians and non-physician practitioners, providers revalidating enrollment are subject to an application fee.

National Provider Identifier (NPI)

All providers must submit their NPI for Medicaid enrollment and claims payment.

Enrollment Denial or Termination

Provider enrollment will be denied or terminated when any person with five percent ownership or controlling interest in the provider has:

- Been convicted of a criminal offense related to Medicare, Medicaid, or CHIP in the past 10 years;
- Been terminated from any Medicare, Medicaid, or CHIP program on or after January 1, 2011;

- Failed to submit fingerprints in a manner designated by the Medicaid agency within 30 days of a federal or state Medicaid agency's request;
- Failed to permit access to provider locations for any site visits;
- Failed to cooperate with any of the required screening methods under law;⁶ or
- Failed to submit accurately or timely information as a provider, person with ownership or controlling interest, agent, or managing employee of the provider.

Providers may appeal a termination or enrollment denial adhering to procedures established under state law and regulations.

Ordering or Referring Providers

All providers ordering or referring for services under the state plan or a waiver (e.g., fee-for-service, managed care, long-term care, etc.) must be enrolled as a participating provider.⁷ Verification of ordering and referring provider status is required.

Additionally, the NPI of the provider who referred or ordered an item or service is required for claims payment.⁸

An abbreviated enrollment process is used for providers who enroll for the sole purpose of ordering or referring for services.

Temporary Moratoria

Pursuant to federal law,⁹ with concurrence from the Secretary of U.S. Health and Human Services (HHS), HHSC may impose:

- Temporary moratoria on enrollment of new providers;
- Numerical caps on enrollment; or
- Other enrollment limitations identified by the state and the Secretary of HHS for providers identified as being at high-risk for fraud, waste, and abuse, if the limitations do not adversely affect beneficiaries' access to care.

Moratoria may be imposed for providers determined by the Secretary of HHS as posing an increased risk to Medicaid following a determination by HHSC that the moratorium would not adversely affect beneficiaries' access to medical assistance and has notified the Secretary of HHS in writing. Moratoriums are limited to six months and may be extended in six-month increments with Secretary of HHS approval.

Medicaid & CHIP Caseload Growth

Eligibility Expansions

Effective January 1, 2014, the ACA expanded Medicaid to the following groups:

- Former foster care youth through age 25; and
- Children ages 6 to 18 up to and including 133 percent of the FPL. (These children were CHIP-eligible prior to the ACA.)

Additionally, there are currently increases in Medicaid caseload due to use of modified adjusted gross income (MAGI), rather than income with potential disregards, and 12-month recertification with a periodic income check for children and adults, as well as increases likely due to increased focus and outreach resulting from the ACA. Overall Medicaid caseload rose above 4 million clients in September of 2014, an increase of 9.6 percent over September 2013.

Optional Eligibility Expansion

The ACA also included a mandatory expansion of Medicaid. However, on June 28, 2012, the U.S. Supreme Court issued a decision on the constitutionality of the ACA. The court upheld the Medicaid expansion, but with limitations. It determined that the Medicaid expansion could not be required of states as a condition of receiving federal funding for their existing Medicaid programs, effectively making it optional for states.

Benchmark Benefit Package for Optional Medicaid Expansion

The ACA required states choosing to expand their Medicaid program to the new adult Medicaid expansion groupⁱ to provide a Medicaid benchmark benefit (with some exceptions). Medicaid benchmark coverage is equal to one of three federally-recognized plans, or alternatively Secretary-approved coverage, and must include certain key services.

The Deficit Reduction Act (DRA) of 2005 established an option for states to provide benchmark or benchmark-equivalent coverage in Medicaid. The ACA added prescription drugs and mental health services to the DRA requirements, and directed

ⁱThe optional Medicaid expansion population is non-pregnant adults under age 65 with incomes up to 133 percent of the FPL.

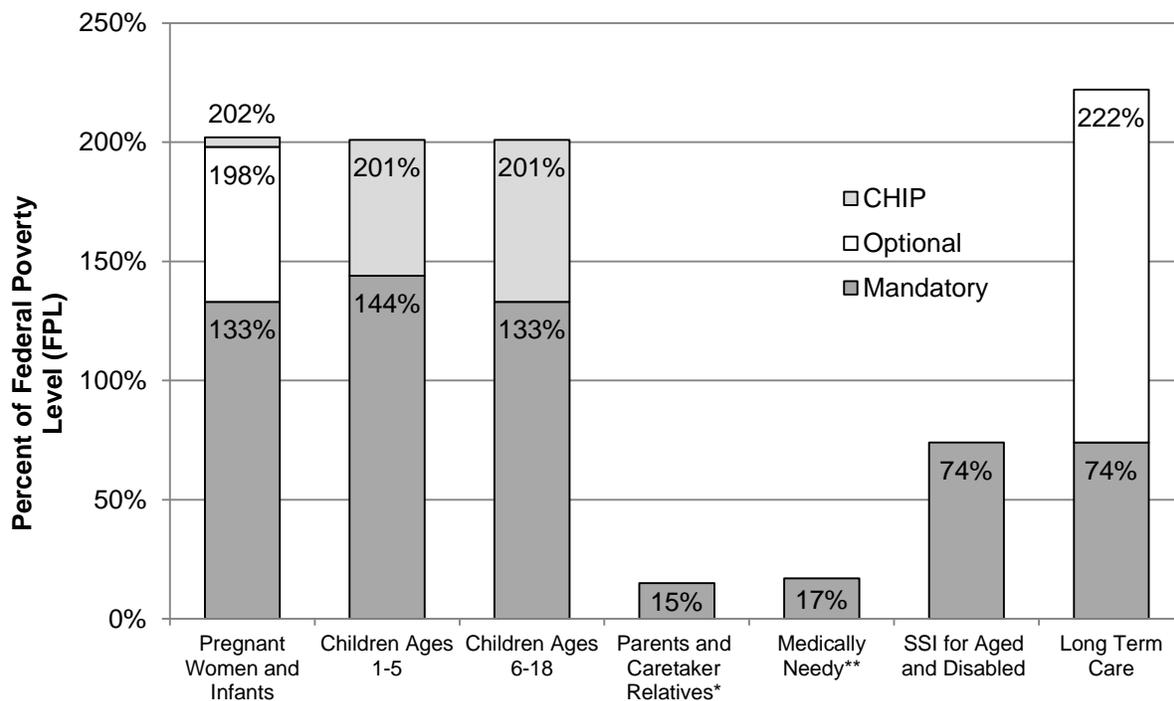
that benchmark coverage include all essential health benefits identified in the ACA. Benchmark-equivalent coverage must include:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative/habilitative services and devices;
- Laboratory services;
- Preventive and wellness services;
- Chronic disease management ; and
- Pediatric services, including oral and vision care.

Current Medicaid and CHIP Eligibility Levels

Texas will experience caseload growth in newly eligible individuals and individuals who are currently eligible, but not enrolled in Medicaid or CHIP.

**Figure 3.1: Current Medicaid/CHIP Eligibility Levels, March 2014
(As a Percent of FPL)**



Effective January 1, 2014, the Affordable Care Act required states to adjust income limits for pregnant women, children, and parents and caretakers to account for Modified Adjusted Gross Income (MAGI) changes (i.e., the elimination of most income disregards).

*In SFY 2014 the monthly income limit for a *one-parent* household is **\$230** and the monthly income limit for a *two-parent* household is **\$251**.

For Medically Needy pregnant women and children, the maximum monthly income limit in SFY 2014 is **\$275 for a family of three, which is the equivalent of approximately 17 percent of FPL.

Maintenance of Effort Requirements

The ACA restricts states' ability to make changes to existing Medicaid and CHIP programs by extending maintenance of effort (MOE) requirements. The American Recovery and Reinvestment Act of 2009 (ARRA) prohibits states from implementing more restrictive eligibility standards, methodologies, or procedures in Medicaid than were in effect on July 1, 2008. Changes to Medicaid benefits, however, can be made. For adults, MOE requirements were in effect until January 1, 2014 (or when an exchange was established), and for children, including children in CHIP, MOE continues through September 30, 2019. Under the ACA, states must comply with MOE requirements to receive Medicaid or CHIP funding, respectively.

Federal guidance has clarified how MOE applies to Medicaid waivers. For instance, Section 1115 and home and community-based waivers can expire and are not required to be renewed under MOE. In addition, states may renew a waiver at the end of the

approved waiver period in effect as of March 23, 2010, with modifications to the waiver program.

Coordination between Medicaid, CHIP, and the Marketplace

Marketplace eligibility determinations must be streamlined and coordinated with eligibility determinations for the Medicaid and CHIP programs. As of January 1, 2014, state Medicaid and CHIP programs were required to establish electronic interfaces with the marketplace to facilitate coordination of eligibility determinations across programs. Applications submitted through the marketplace are electronically transferred to Medicaid and CHIP with no additional required action by the applicant. If an applicant is determined ineligible for state Medicaid and CHIP programs, the application is sent electronically to the marketplace with all information obtained by the state.

In the event that CHIP allotments are insufficient to cover all CHIP-eligible children, the ACA requires states to ensure that CHIP-eligible children (who are also determined Medicaid ineligible) receive coverage through the marketplace after September 30, 2015. In addition, the ACA requires the U.S. Secretary of HHS, no later than April 1, 2015, to certify that the plans in the marketplace that offer services for children have benefit and cost-sharing levels comparable to CHIP.

Health Care Reform Financing

The ACA will result in significant costs over time to Texas due primarily to the increases in enrollment among individuals who are currently eligible but not enrolled. While the ACA increases federal financial participation for Medicaid and CHIP, the increases do not cover the full costs to Texas of implementing ACA requirements. There will be state fiscal impacts due to provider rate increases as well as other ongoing costs.

Federal Financial Participation

The ACA increases the federal match rate for the optional Medicaid expansion and for CHIP. For the first three calendar years of the optional expansion (2014 through 2016), the federal government will cover the full cost of Medicaid for newly eligible adults, for states choosing to implement a Medicaid expansion. From 2017 through 2020, the federal share for Medicaid decreases from 100 to 90 percent.

States will receive the CHIP federal match rate for children (ages 6 to 18 up to 133 percent of the FPL) who move from CHIP to Medicaid eligibility beginning in January 2014.

The ACA also increases the federal match rate for CHIP by 23 percentage points (not to exceed 100 percent) from October 1, 2015, until September 30, 2019. However, the increase does not apply to certain administrative expenditures.

Table 3.1 shows federal match rates by Medicaid and CHIP eligibility groups from 2014–2023.

**Table 3.1: Federal Medical Assistance Percentage (FMAP)
SFYs 2014-2023**

FMAP	Applicable Population	Percent
Regular FMAP All Years	Applies to individuals who are currently eligible but not enrolled or likely to become enrolled because of the individual mandate.	58.69%*
Super FMAP 2014-2016	Applies only to the Medicaid expansion population	100%
Super FMAP 2017	Applies only to the Medicaid expansion population	95%
Super FMAP 2018	Applies only to the Medicaid expansion population	94%
Super FMAP 2019	Applies only to the Medicaid expansion population	93%
Super FMAP 2020 and beyond	Applies only to the Medicaid expansion population	90%
Regular Enhanced FMAP (EFMAP) All Years	Applies to individuals that are currently eligible but not enrolled in CHIP	71.08%*
Super EFMAP 2016 - 2019	Assumed for the same population groups as the Regular EFMAP, but for different years.	94.08%*

* Updated annually. The FMAP rate is derived from each state's average per capita income. As the state's per capita income increases in relation to the national per capita income, the FMAP rate decreases.

Beginning in 2013, the ACA also provides states with a one percent increase in the federal match rate for certain covered services (e.g., preventive screening) when provided without cost-sharing.

The Balancing Incentive Payment (BIP) program opportunity provides an increased federal match of two percent for certain community-based long-term care services for states that agree to make a series of structural changes to their long-term care delivery system. From October 1, 2012 to September 30, 2015, (or until funds are exhausted on a national level prior to this date), Texas will receive an additional two percent federal match on certain community-based long-term services and supports.

The ACA also reduces the aggregate Medicaid disproportionate share hospital (DSH) allotment for all states beginning in 2014. A methodology to allocate the DSH allotment reduction to all states must be developed by HHS and must impose the largest percentage reduction on states that:

- Have the lowest percentage of uninsured individuals during the most recent year; or
- Do not target their DSH payments to hospitals with high volumes of Medicaid inpatients and hospitals that have high levels of uncompensated care.

The aggregate federal DSH allotment to all states will be reduced by \$500 million in federal fiscal year (FFY) 2014; \$600 million in FFY 2015 and FFY 2016; \$1.8 billion in FFY 2017; \$5 billion in FFY 2018; \$5.6 billion in FFY 2019; and \$4 billion in FFY 2020.

Enhanced Funding for Eligibility, Enrollment, and Claims Systems

Enhanced Federal Financial Participation (FFP) at 90 percent is available for design, development, installation, or enhancement of eligibility determination and claims systems that meet required federal standards and conditions. Enhanced FFP at 75 percent is available for maintenance and operation of existing systems if those systems meet required federal standards and conditions.

Initial federal guidance had indicated that enhanced funding only would be made available for projects initiated prior to December 31, 2015. However, more recent federal guidance indicates that enhanced funding is extended indefinitely. To receive enhanced FFP, states must submit a plan for federal approval outlining how the state will comply with federal standards and conditions.

Endnotes

¹ Code of Federal Regulations (CFR) §455.400-§455.414. Application to CHIP §457.990

² CFR §455.450

³ CFR §455.412

⁴ CFR §455.432

⁵ CFR §455.434

⁶ CFR §455 Subpart E – Provider Screening and Enrollment

⁷ CFR §455.410(b)

⁸ CFR §455.440

⁹ CFR §455.470