Medicaid Monitoring
Planning for the Medicaid Expansion

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Background
In 2014, the Patient Protection and Affordable Care Act (PPACA) will require the federal-state Medicaid program to cover individuals under the age of 65 who are at or below 138%[1] of the federal poverty level. This change will allow many people who were previously ineligible for Medicaid — particularly able-bodied, single people — to receive health care services paid for by Medicaid. The Congressional Budget Office estimates an additional 16 million people across the country will qualify for Medicaid when PPACA goes into effect.

The expansion will affect states in a number of ways, including:

- requiring changes to information technology systems to allow Medicaid eligibility to be determined through the newly established health insurance exchanges, which will serve as online "marketplaces" for insurance; and

- paying for some of the costs of covering the new Medicaid enrollees. PPACA calls for the federal government to pay the full costs through 2016. After that, states will gradually assume a portion of the costs, up to a maximum of 10% in 2020 and future years.

This briefing paper provides an overview of some of the key PPACA requirements related to Medicaid expansion and their potential effects on the state Medicaid program.

Information Technology Changes
The federal law requires that states use a streamlined application process for everyone who applies for insurance through the health insurance exchange. The application process will then determine whether applicants qualify for Medicaid, for the Healthy Montana Kids (HMK) program, or for federal subsidies to help them pay for the costs of their insurance policies.

The process must contain the following elements:

- a single, streamlined application for insurance coverage that may be submitted online, in person, or by phone, mail, or fax;

- an information technology system that can, through secure connections, use available federal and state databases to verify application information such as citizenship status and income;

[1] The law establishes eligibility at 133% of the federal poverty level with a 5% income disregard, resulting in an effective eligibility threshold of 138% of poverty.

- the ability to determine whether individuals are eligible for Medicaid, HMK, or tax credits based on their Modified Adjusted Gross Income rather than the current procedure of including some assets and disregarding some sources of income for eligibility purposes;

- the ability to enroll eligible individuals into Medicaid or HMK; and

- the availability of online or telephone assistance to people seeking help with application and enrollment questions.

The federal Medicaid program will pay 90% of the costs for making the changes needed to allow the state's Medicaid eligibility determination system to interact with the insurance exchange in the future. The Department of Public Health and Human Services likely will need to make other changes to its Medicaid and HMK application and eligibility procedures to meet the requirements of PPACA.

Effect on the Medicaid Budget
The Medicaid requirements of PPACA will affect Montana's budget for Medicaid services, perhaps as early as 2014.

The federal government will pay the full costs for the "newly eligible" population of Medicaid enrollees for the first three years of the expansion. However, it's expected that some of the enrollees who obtain coverage in 2014 and beyond would have qualified under existing Medicaid rules if they had applied earlier. Those enrollees will not be considered "newly eligible," and thus states will pay the regular matching rate for the services they receive.

Under PPACA, Montana would not pay costs of medical care for the newly eligible population until 2017, when it would pay 5% of the costs. The state's share is scheduled to increase to 6% in 2018, 7% in 2019, and 10% in 2020 and beyond.

However, the state will pay about 34% of the costs of coverage for people who come into the system beginning in 2014 if they would have been eligible had they applied earlier. The state's share of Medicaid costs under the current program is based on what's known as the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated each year, using a formula that takes into account a state's average per capita income as compared to the national average.

In order to budget for the changes that PPACA will bring to the state budget for Medicaid services, the state will need to project:

- the number of people who will obtain coverage as part of the expansion and the number of years it may take for the full number of eligible people to enroll; and

- the number of people who are currently eligible but not enrolled and who will become Medicaid enrollees in 2014 or future years.

The costs also will be affected by the health benefits package provided to the newly eligible people. That package may differ somewhat from the package of benefits required under current Medicaid law for people who qualify because of their age or because they are blind or disabled.