



– State Medicaid Expansion – Considerations for Health Centers

When the Supreme Court ruled that the federal government could not mandate states to adopt the Affordable Care Act's (ACA) Medicaid Expansion, it effectively created a new optional Medicaid program that will cover individuals up to 138% FPL, but ONLY if a state CHOOSES to participate. The decision has ushered in a whole new set of political and policy considerations for states and far-reaching impacts on community health centers and the patients they serve.

Community health centers are the main source of primary care for medically underserved populations. The Expansion will enable health centers to expand capacity to serve the uninsured as well as those newly covered by Medicaid. Fully implemented by the states, the Medicaid Expansion will allow health centers to reach approximately 19.8 million new patients. Without the Expansion, health centers' new patient care capacity will be reduced by nearly 27%, a 5.3 million drop in new patients.¹

Community health centers, primary care associations and advocates for the medically underserved must make their case to governors, legislators and other decision makers as to why it is essential that their state adopt a Medicaid Expansion. Working in a unified voice, a broader advocacy effort might include building or joining a coalition with other healthcare providers, hospitals, and other groups; conducting a thorough impact analysis of the Medicaid expansion in the state; developing local and statewide public awareness campaigns; and educating elected officials about the impact a Medicaid Expansion will have on your health center and your patients. This is critical for many reasons, including:

- Ensuring your state adopts the Medicaid Expansion fits squarely within the health center mission to ensure every eligible person gets covered and has access to health care services.
- If fully implemented, the Medicaid Expansion will produce over \$2 billion in new revenues for health centers.²
- With or without Medicaid Expansion, health centers anticipate an influx of new patients. It is critical that these new patients be covered in order to preserve health centers' ability to continue providing services.
- Many of the would-be eligible Medicaid patients are already served by health centers, but their care is currently uncompensated. With cuts to state and federal uncompensated care funding, it is critical that states opt to expand Medicaid to ensure the greatest number of individuals can receive coverage.
- Health centers reliance on two main sources of income (Public Health Service Grants and Medicaid payments) means that any significant change in revenues from either of those sources could measurably affect their ability to continue providing care to those most in need in their communities. In addition, direct state funding to health centers, which often provides much needed dollars for uncompensated care, has steadily decreased in recent years.

¹ [How the Supreme Court's Medicaid Decision May Affect Health Centers: An Early Estimate, Policy Research Brief # 30, George Washington University School of Public Health and Health Services Department of Health Policy, July 2012](#)

² NACHC estimate, 2012

Key considerations for Health Centers and Primary Care Associations on State Medicaid Expansion

Medicaid Expansion: Key Issues and Concepts

- **Streamlining Eligibility & Enrollment:** The ACA mandates that states streamline eligibility and enrollment so that there is essentially “no wrong door” for entrance to the health care system. Accordingly, if individuals try to apply for Medicaid but really should receive coverage through the Exchange—or vice versa—the state should route them to the appropriate source of coverage. If a state chooses not to take up the Medicaid expansion it is NOT excused from the requirements to streamline eligibility and enrollment for Medicaid and it will remain eligible for enhanced match (90/10) for these efforts. The Administration has yet to determine what the “penalty” will be if the state does not meet these requirements as set out in the ACA; there should be strict sanctions in order to ensure that states do not try to circumvent this requirement.
- **MOE (Maintenance of Effort):** Some states have suggested that the Supreme Court ruling means that they do not have to comply with the MOE requirements in the ACA, which hold that states must keep their current eligibility levels the same through 2014 and not drop categories of individuals that currently have Medicaid coverage in order to then pick them up again in 2014 with the Medicaid Expansion and garner a higher FMAP for them. Secretary Sebelius has said this is not permitted and the Congressional Research Service (CRS) as well as multiple other sources have issued analyses to the same effect.
- **Provider reimbursement:** In order to ensure that provider capacity is maximized, adequate reimbursement is integral. For Community Health Centers, that will mean making sure that they are reimbursed their full PPS rate for both traditionally-eligible Medicaid populations and newly-eligible Medicaid populations.
- **Provider capacity:** Policymakers at both the federal and state levels must work with providers in order to ensure sufficient capacity to see both the newly-enrolled Medicaid patients and those that remain uninsured. For

example, Community Health Centers will likely be among the few or only providers willing and able to see individuals who gain Medicaid coverage and especially those who remain uninsured because their state did not take up the expansion. Significant investment needs to be made in both infrastructure and operations at health centers to ensure there is sufficient capacity both for Medicaid and uninsured individuals in addition to those who will be newly-covered by plans in the Exchange.

- **Waivers:** It is important that CMS NOT agree to any Medicaid 1115 waivers that would allow a State to use the expansion money in a way that would undermine minimum standards of the program and the fact that it is an entitlement program by nature (i.e. block grants). CMS should use its discretion in finding creative solutions to encourage states to take up the expansion, but not at the expense of the program.
- **Partial expansion:** Some Governors have proposed that taking up just part of the Medicaid expansion, leaving out some categories of individuals who would otherwise be eligible according to the ACA. Citing the intent of the ACA to cover all individuals up to 133% FPL, CMS has stated that it will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. If a state that declines to expand coverage to 133% of FPL would like to propose a demonstration that includes a partial expansion, CMS would consider such a proposal to the extent that it furthers the purposes of the program, subject to the regular federal matching rate.³
- **Duration of expansion:** A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage⁴; for example, states could potentially take up the expansion while the Federal government is paying 100% of the costs, but then drop those individuals as soon as the Federal government's share drops to 90%. This could result in millions of individuals being brought onto Medicaid only to be dropped within just a couple years.

³ Item 26, CMS Frequently Asked Questions on Exchanges, Market Reforms and Medicaid, December 10, 2012

⁴ Item 25, CMS Frequently Asked Questions on Exchanges, Market Reforms and Medicaid, December 10, 2012

- **FMAP & other cost-shifts to states:** The Administration has previously put forward proposals that would shift costs to states, such as the “blended FMAP” or limitations on use of provider taxes, etc. Governors will be very reticent to take up the Medicaid expansion if they think more of the costs will be shifted to states over time. For example if the eventual 90% Federal Match for states to take up the expansion were ultimately to be reduced below 90%, it would put even greater pressure on state budgets. However, CMS has stated that it no longer supports a blended FMAP as previously proposed.⁵
- **Policy on individuals who would otherwise be eligible for Medicaid:** In states that choose not to take up the Medicaid expansion, many individuals may be left without coverage. Sec. Sebelius has discussed the possibility of hardship exemption from the individual mandate for those individuals below 100% FPL.
- **Program Integrity:** The Administration is focused on ensuring that the greatest number of lives are covered by the Medicaid expansion. This is a noble goal, and one that NACHC embraces, if done correctly. If this goal is pursued at the expense of key structural components and principles of the program, however, it could be detrimental to the entire future of Medicaid. There are also a number of related policy concerns that could be impacted by how the Administration chooses to pursue its goal of having as many states as possible take up the Medicaid Expansion.

In building your advocacy strategy:

⁵ Item 27, CMS Frequently Asked Questions on Exchanges, Market Reforms and Medicaid, December 10, 2012

- How does this fit with your current legislative/policy priorities?
- Do you have a plan in place? If not, what assistance/resources will you need to get started?
- How do you make the case and to whom?
- What data/research do you have/need?
- What messages will you have/need?
- What advocacy tools/infrastructure do you have/need?
- Who will be your allies/challengers? Who will be your champions?
- What will the timeframe be?

In thinking through policy options:

- Does your state have any anti-ACA implementation laws on the books that would need to be revised or overturned?
- Who are the decision makers (legislature/governor)? What are the policy options (legislative/regulatory)? What will the process look like?
- Does your state mandate legislative oversight for SPAs or 1115 waivers that may complicate the process where your state has a supportive governor, but a reluctant legislature (or vice versa)?
- Does state law require participation?
- What is your state's current eligibility level for childless adults?
- Are there any other legal issues to consider?