Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Medicaid and CHIP 101:

Medicaid and CHIP's Foundational Role in Covering Kids and Families

Tricia Brooks
Kelly Whitener
09-24-18

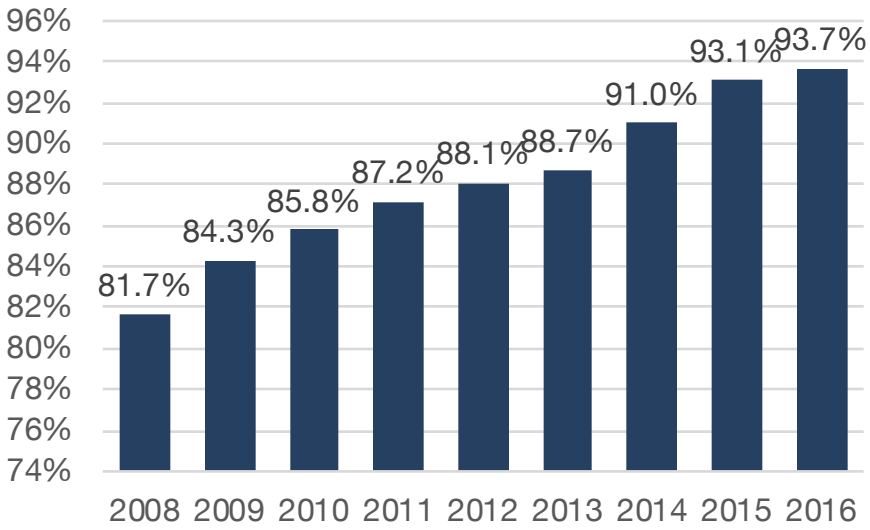
Medicaid ➔ Critical Health Safety Net

Focus of Today's Webinar: Kids and Families

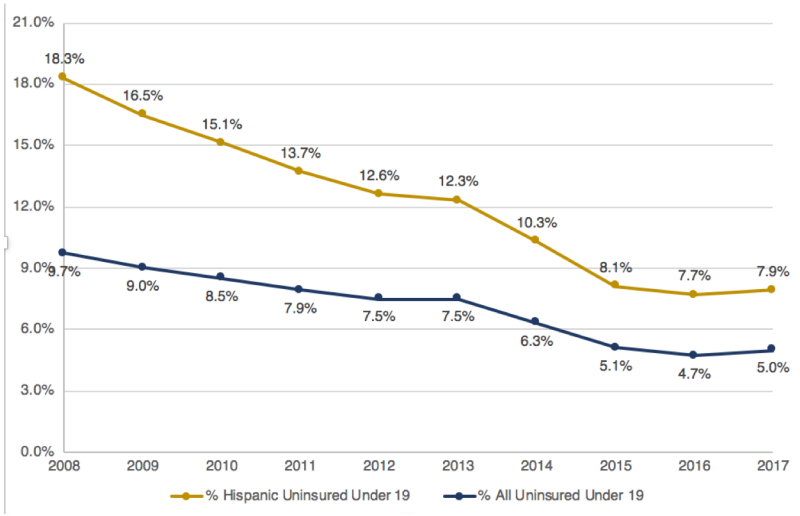
- Groups for which eligibility is based on income (not disability or elderly eligible for Medicaid and Medicare)
  - Children
  - Low income parents
  - Pregnant women
  - Expansion adults
- Also know as the MAGI groups

Increased Participation in Medicaid and CHIP Have Driven Uninsured Rate to Historic Low

Participation Rates in Medicaid/CHIP



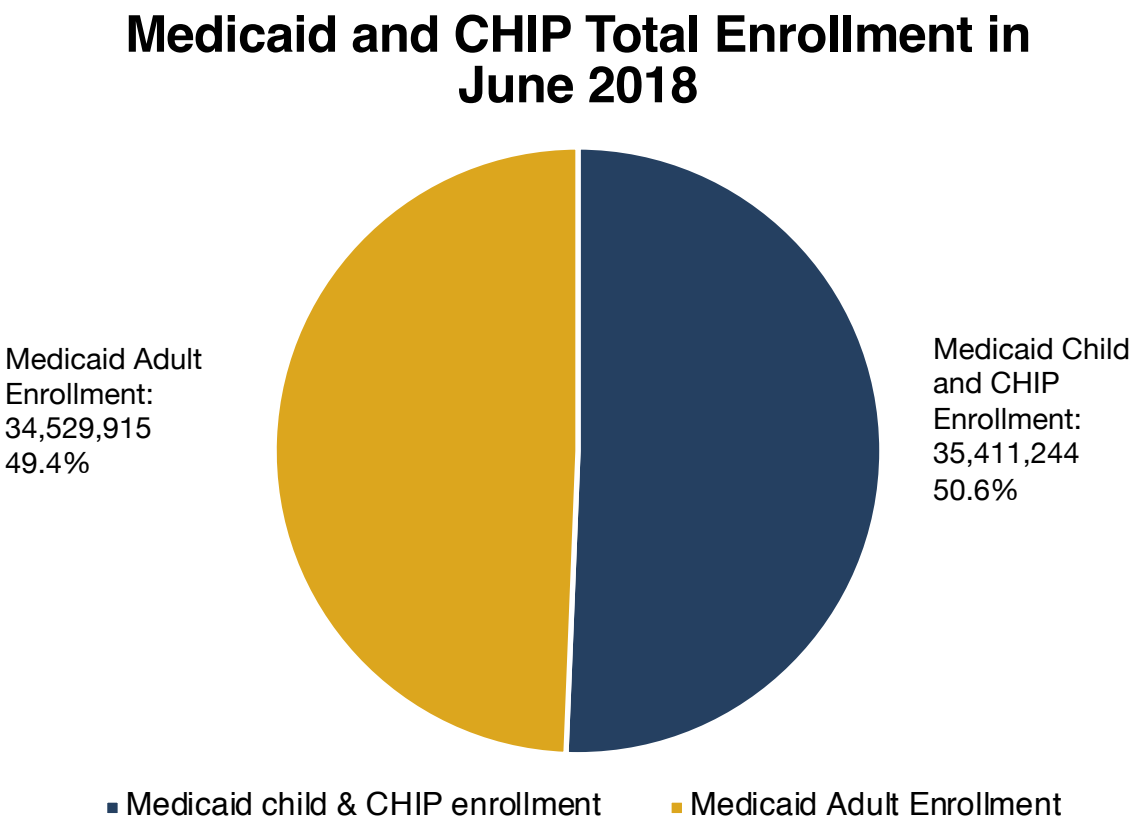
U.S. Child Uninsured Rate



Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

Sources: J.M. Haley et al., "Medicaid/CHIP Participation Rates Rose among Children and Parents in 2016," Urban Institute, August 2018; previous reports in participation rate series. CCF analysis of ACS single-year estimates for child uninsured rate, 2008-2017.

Half of Medicaid Enrollees are Children



Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

Source: Medicaid Child & CHIP Total Enrollment in June 2018, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/child-and-chip-enrollment/index.html.
Note: Arizona, the District of Columbia, and Tennessee are excluded because they did not submit child enrollment data for the current period.

Medicaid Strengthens Families

- Children with Medicaid become healthier adults, have greater academic achievement, and attain greater economic success.
- Parents with Medicaid are healthier and better able to support their children's healthy development
- Families with Medicaid have greater economic security and are less likely to have medical debt or bankruptcy
- Coverage provides peace of mind that reduces family stress

Sources: J. Alker and K. Wagnerman, "Medicaid: A Smart Investment in Children," April 2017, available at https://ccf.georgetown.edu/2017/04/10/medicaid-a-smart-investment-in-children/ and K. Wagnerman, "Medicaid: How Does it Provide Economic Security for Families?," March 2017, available at https://ccf.georgetown.edu/2017/03/09/medicaid-how-does-it-provide-economic-security-for-families/

The view from 30,000 feet

How It Works

FEDERAL

Congress Enacts Laws

- MEDICAID - Title XIX of Social Security Act (SSA)
- CHIP - Title XXI of SSA

CMS Promulgates Rules Subject to Public Comment

- Title 42, Chapter IV of the Code of the Federal Register
- www.ecfr.gov

CMS Issues Sub-Regulatory Guidance

- State Medicaid Director Letters (SMD)
- State Health Official Letter (SHO)

STATE

State Develops State Plan and Submits Plan Amendments (SPA)

- MEDICAID
- CHIP

State Agency Develops Administrative Rules

- Process Varies by State

State Maintains Policies & Procedures

- Operating Manuals may be available online

Medicaid: Background

- Enacted in 1965 as companion legislation to Medicare
- Initially limited to:
  - Children
  - Single parents with dependent children
  - Aged, blind, disabled
- Expansions of eligible groups over time
- Permanently authorized with guaranteed federal funding
- Guaranteed coverage for eligible individuals
- Minimum mandatory requirements with state options

Medicaid: Federal-State Partnership

	Federal Government	States
Administration	Oversight	Direct administration
Financing	• 50% to 83%* of benefit costs, with no cap • 50% of administrative costs • 90% of systems development and 75% systems operations	Pays non-federal share of costs
Program Rules	• Minimum standards on eligibility, benefits, and access • Restrictions on cost sharing • Additional rules regarding managed care	• Delivery system • Optional services • Provider payment rates • Cost-sharing
Coverage Guarantee	Guaranteed enrollment, if eligible	Cannot freeze or cap enrollment

*Match varies by state and sometimes by eligibility group and service

CHIP: Background

- Enacted in 1997 to encourage states to expand coverage to *uninsured* children
- Block grant with capped annual allotments
- Initial authorization was limited to ten years, but funding has been extended several times
- Currently funded through 2027
- No entitlement to coverage
- CHIP legislation has helped create a culture of coverage for kids
  - Outreach requirements
  - Enrollment simplification
  - Emphasis on quality

CHIP: Federal-State Partnership

	Federal Government	States
Administration	Oversight	Direct administration
Financing	• 65% to 85% of costs • 23% point bump in 2016-2019 • 11.5% point bump in 2020	All non-federal share of costs
Program Rules	• Fewer minimum standards than Medicaid • Children must be uninsured	• Delivery system • Provider payment rates • Eligibility rules, benefits, and cost sharing within guidelines
Coverage Guarantee	None required*	Can freeze or cap enrollment* or require waiting periods

* Except under the Maintenance of Effort

State Options for CHIP Program Design

Medicaid

- All Medicaid rules apply except children must be uninsured
- States can use Medicaid funds to cover children with other coverage

Separate CHIP

Benchmark Options:

- State employee plan,
- Federal employee plan,
- Largest HMO in state, or
- Secretary approved

Combination

- Medicaid expansion for certain children based on age or income
- Separate CHIP program for other children

Who's Covered?

Medicaid Eligibility

Minimum Standards

- Children 0-18 with income up to 133% FPL
- Pregnant women up to 133% FPL
  - Infants born to pregnant women covered by Medicaid for first year of life (aka deemed newborns)
- Parents/caretakers at state welfare eligibility level in 1996
  - Known as 1931 parents
  - Median income ~ 50% FPL

Optional Coverage

- Children ages 19 and 20
- Children and pregnant women with income above 133% FPL
- Parents and adults up to 133% FPL
- Medically needy or spend down programs

CHIP Eligibility

- Children above Medicaid income levels at state option
  - 200% FPL upper limit, or
  - 50 percentage points > Medicaid limit in place in 1997
  - Pre-ACA, states used income disregards and deductions to achieve higher income eligibility thresholds; those levels are grandfathered as of enactment of the ACA
- Unborn children at state option
  - Covers pregnant women regardless of immigration status
- Pregnant women
  - State must provide Medicaid at 185% FPL or higher
  - Income eligibility level cannot be higher than for children

Maintenance of Effort

Maintenance of Effort Requirement: What States Can and Cannot Do
States can:
• Adopt or continue enrollment simplification initiatives • Maintain caps or freezes that existed prior to the MOE (March 23, 2010) • Choose not to renew waiver programs once they expire
States cannot:
• Eliminate CHIP or scale back eligibility for children in CHIP or Medicaid below levels in place as of March 23, 2010; • Raise premiums for CHIP or Medicaid children; • Impose or increase waiting periods, or the time that children must remain without group coverage before becoming eligible to enroll in CHIP. Current federal rules do not allow states to impose waiting periods longer than 90 days.[6]

Source: J. Alker and S. Miskell. "Federal 'Maintenance of Effort' Protections Help Kids Maintain Health Coverage Amid Tough State Budget Climates." Georgetown University Center for Children and Families. March 2015.

CHIP Outreach Requirement

- Must describe procedures to inform families of their eligibility for CHIP or other public/private health coverage programs, which may include:
  - Education and awareness campaigns
  - Enrollment simplification
  - Application assistance through community-based organizations and in combination with other benefits and services
- Receives CHIP match up to 10% cap on administration expenses
  - Including outreach expenses

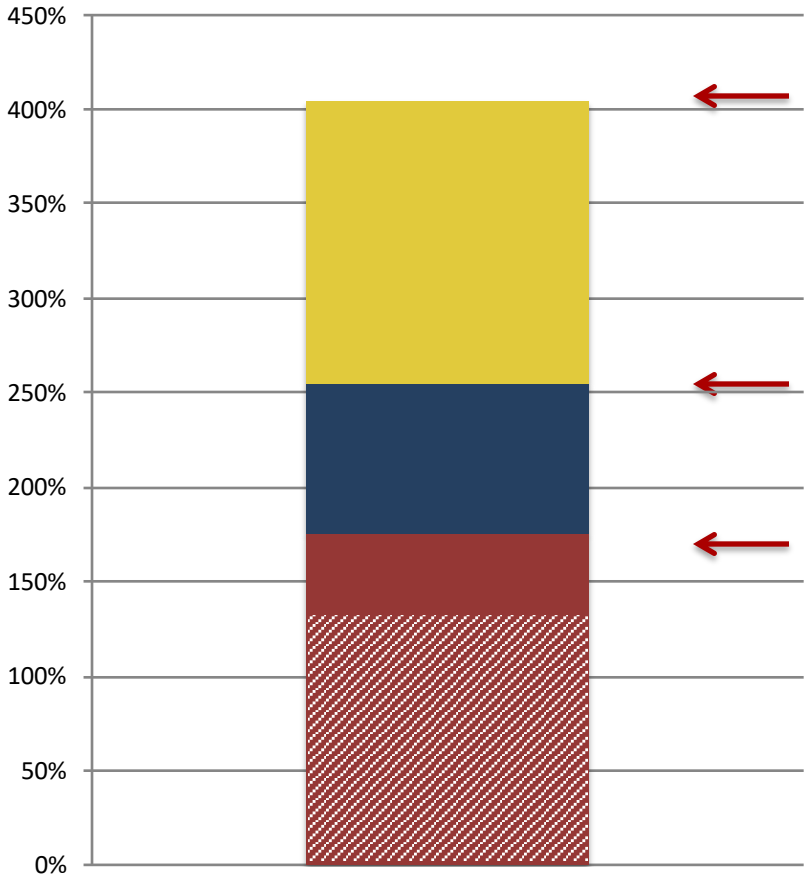
CHIP Health Services Initiatives

- Allow states to use CHIP administrative funds to provide services to low-income children
  - Direct services and public health initiatives
  - Targeted to low-income children less than 19 years of age eligible for Medicaid or CHIP
  - But may also serve children of any income
- Examples
  - Poison control centers
  - MA initiative to prevent youth violence
  - MO promotion of immunizations

https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf

Where eligibility stands today

Children's Income Eligibility: Medicaid & CHIP



Highest State Eligibility 405%

Median State Eligibility 255%

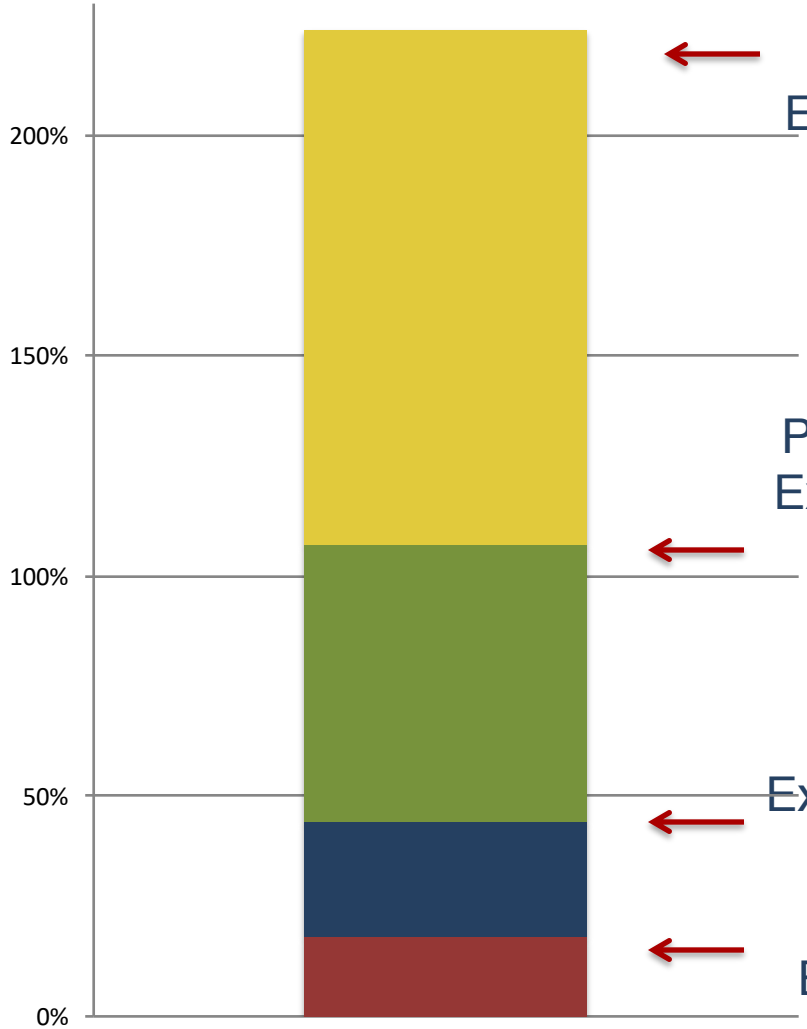
Lowest State Eligibility 175%

Breakdown of State Eligibility	
FPL	# of States
< 200%	2
200% – 250%	21
250% - 300%	9
> 300%	19

Georgetown University Health Policy Institute CENTER FOR CHILDREN AND FAMILIES

Source: T. Brooks et al., "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey" (Washington: Kaiser Family Foundation and Georgetown University Center for Children and Families, March 2018).

Parent's Income Eligibility: Medicaid



Highest State Eligibility - 221%

Pre-ACA Median Expansion States 90%

Median Non-Expansion States- 43%

Lowest State Eligibility - 18%

Breakdown of State Eligibility	
FPL	# of States
< 50%	12
50% – 99%	4
100% - 138%	3
138%	28
> 138%	4

Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

Source: T. Brooks et al., "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey" (Washington: Kaiser Family Foundation and Georgetown University Center for Children and Families, March 2018).

Diving into the details of eligibility, enrollment and renewal policies for the MAGI groups

For MAGI Groups, New Rules with ACA

Dos	Don'ts
• Multiple application and renewal paths (paper, online, phone, in-person) • Coordinate eligibility between programs (account transfers) • Check electronic data before asking for paper documentation • Ex parte (automated) renewals	• No asset or resource tests • Count non-taxable sources of income (child support, SSI, etc) • Renew coverage more frequently than 12 months • No waiting period (period of uninsurance) for CHIP longer than 90 days • No signature at renewal

Verifying Eligibility

Verification Policies

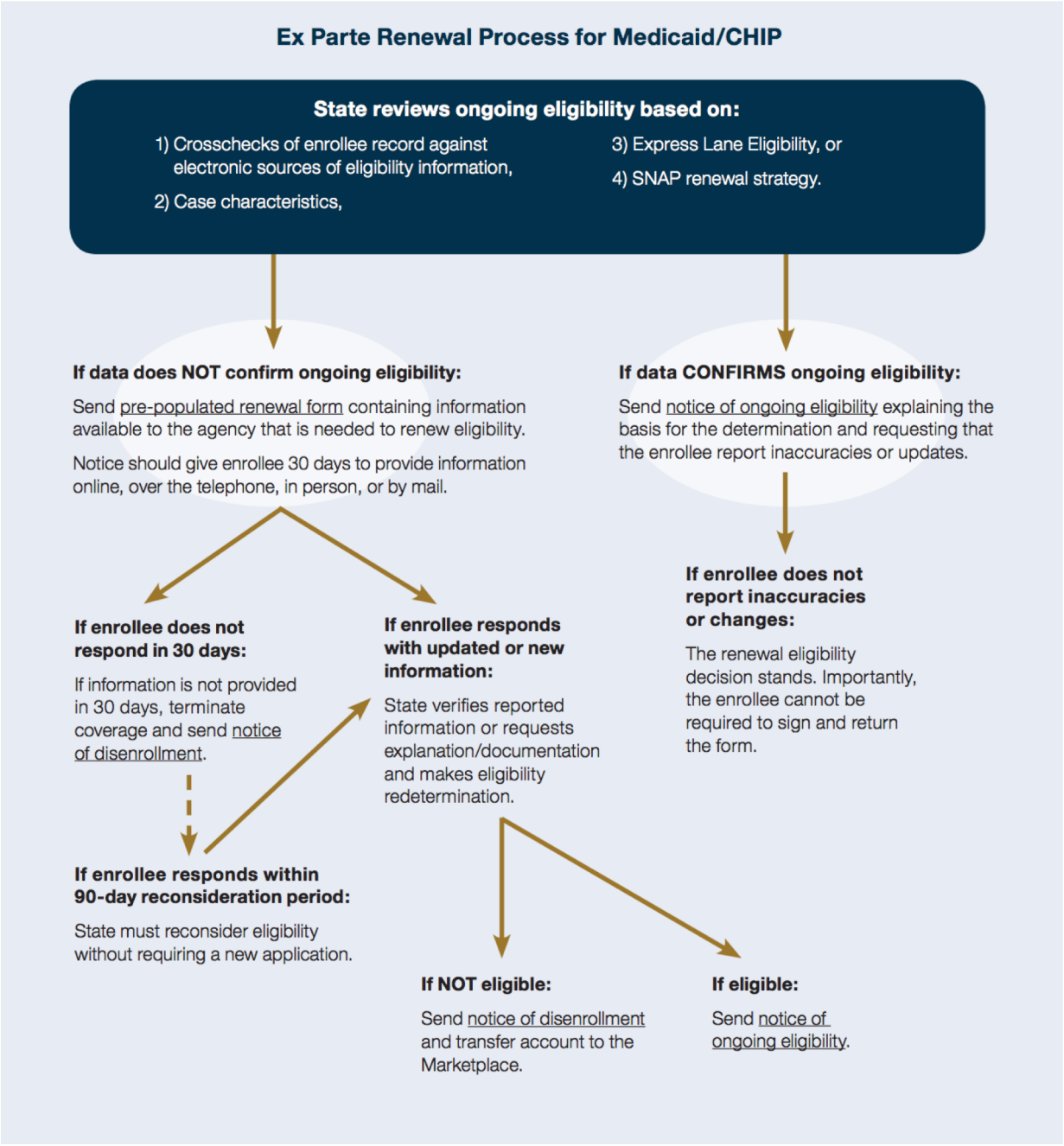
- Must verify citizenship or qualified immigration status
  - Must provide 90 reasonable opportunity period to provide documents if electronic verification
- Must verify income but can do so post-enrollment
  - Reasonable compatibility option
- May accept self-attestation
  - State residency, household size, age/date of birth

Verification Data Sources

- Federal Data Services Hub
  - Social Security Administration*
  - Dept. Homeland Security*
  - Internal Revenue Service
  - Commercial wage data base*
- State wage / unemployment compensation databases
- State tax agency
- State verification plan details must be submitted to CMS**

* - States may connect directly to these sources

** - Source: https://www.medicaid.gov/medicaid/eligibility/verification-plans/index.html

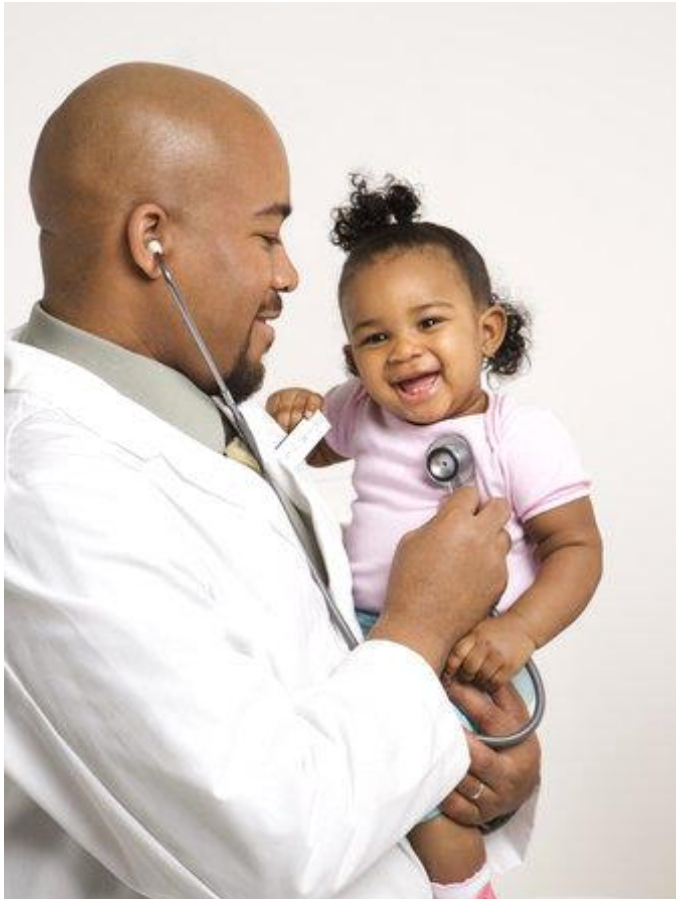


Source: https://ccf.georgetown.edu/wp-content/uploads/2016/04/20160407_Medicaid_Work_Better_Ex_Parte_Renewals.pdf

Children's Policy Options

- Coverage for lawfully residing immigrant kids
- Coverage of former foster youth from other states
- 12 month continuous eligibility
- Presumptive eligibility
- Express Lane Eligibility
- Unborn child coverage

Benefits



Medicaid and CHIP-Funded Medicaid Expansions (M-CHIP)

- Comprehensive services through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit
  - Screenings (developmental, hearing, vision, etc)
  - Diagnostic services
  - Treatment
- All services "medically necessary" to correct and ameliorate physical and mental health conditions
- Cannot impose hard limits; must provide wrap-around services if premium assistance or managed care limit benefits

EPSDT Includes Coverage of All Services… whether listed as mandatory or optional

Mandatory Services

- ✓ Family planning services and supplies
- ✓ Federally Qualified Health Clinics and Rural Health Clinics
- ✓ Home health services
- ✓ Inpatient and outpatient hospital services
- ✓ Laboratory and X-Rays
- ✓ Medical supplies and durable medical equipment
- ✓ Non-emergency medical transportation
- ✓ Nurse-midwife services
- ✓ Pediatric and family nurse practitioner services
- ✓ Physician services
- ✓ Pregnancy-related services
- ✓ Tobacco cessation counseling and pharmacotherapy for pregnant women

Optional Services

- ✓ Community supported living arrangements
- ✓ Chiropractic services
- ✓ Clinic services
- ✓ Critical access hospital services
- ✓ Dental services
- ✓ Dentures
- ✓ Emergency hospital services (in a hospital not meeting certain federal requirements)
- ✓ Eyeglasses
- ✓ State Plan Home and Community Based Services
- ✓ Inpatient psychiatric services for individuals under age 21
- ✓ Intermediate care facility services for individuals with intellectual disabilities
- ✓ Optometry services
- ✓ Other diagnostic, screening, preventive and rehabilitative services
- ✓ Other licensed practitioners' services
- ✓ Physical therapy services
- ✓ Prescribed drugs
- ✓ Primary care case management services
- ✓ Private duty nursing services
- ✓ Program of All-Inclusive Care for the Elderly (PACE) services
- ✓ Prosthetic devices
- ✓ Respiratory care for ventilator dependent individuals
- ✓ Speech, hearing and language disorder services
- ✓ Targeted case management
- ✓ Tuberculosis-related services

Separate CHIP Benefits

Actuarially Equivalent to Benchmark Plan

1. HMO with state's largest enrollment
2. State Employee Plan
3. Federal Employee Plan, or
4. Secretary Approved

Services must include:

- Well child; preventive care
- Immunizations
- Emergency care
- Inpatient and outpatient hospital services
- Physician services
- Lab and x-ray
- Dental services
- Mental health parity

Premiums and Cost-Sharing

Total premiums and cost-sharing limited to aggregate 5% of family income cap for all members enrolled. Applies to all groups in Medicaid and CHIP.

Premiums and Cost-Sharing in Medicaid

Premiums	Cost-Sharing
• Children – None below 150% FPL • Adults – None below 150% FPL (without waiver)	• Children – None below 133% FPL – None for preventive care • Adults – Nominal below 100% FPL – Twice nominal 100% – 150% FPL – None for family planning, emergency, pregnancy-related services

See SSA §§ 1902(a)(14), 1916, and 1916A and 42 CFR 447.52-56.

Maximum Allowable Medicaid Cost-Sharing Varies by Income

	< 100% FPL	> 100% – 150% FPL	>150% FPL
Outpatient Services	$4	10% of what state pays*	20% of what state pays*
Non-Emergency ER	$8	$8	No limit
Prescription Drugs	Preferred: $4 Non-Preferred: $8	Preferred: $4 Non-Preferred: $8	Preferred: $4 Non-Preferred: 20% of what state pays
Inpatient Services	$75 per stay	10% of total cost state pays*	20% of total cost state pays*

Up to 5% aggregate cap.

Source: T. Brooks et al., "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey" (Washington: Kaiser Family Foundation and Georgetown University Center for Children and Families, March 2018).

Premiums and Cost-Sharing in CHIP

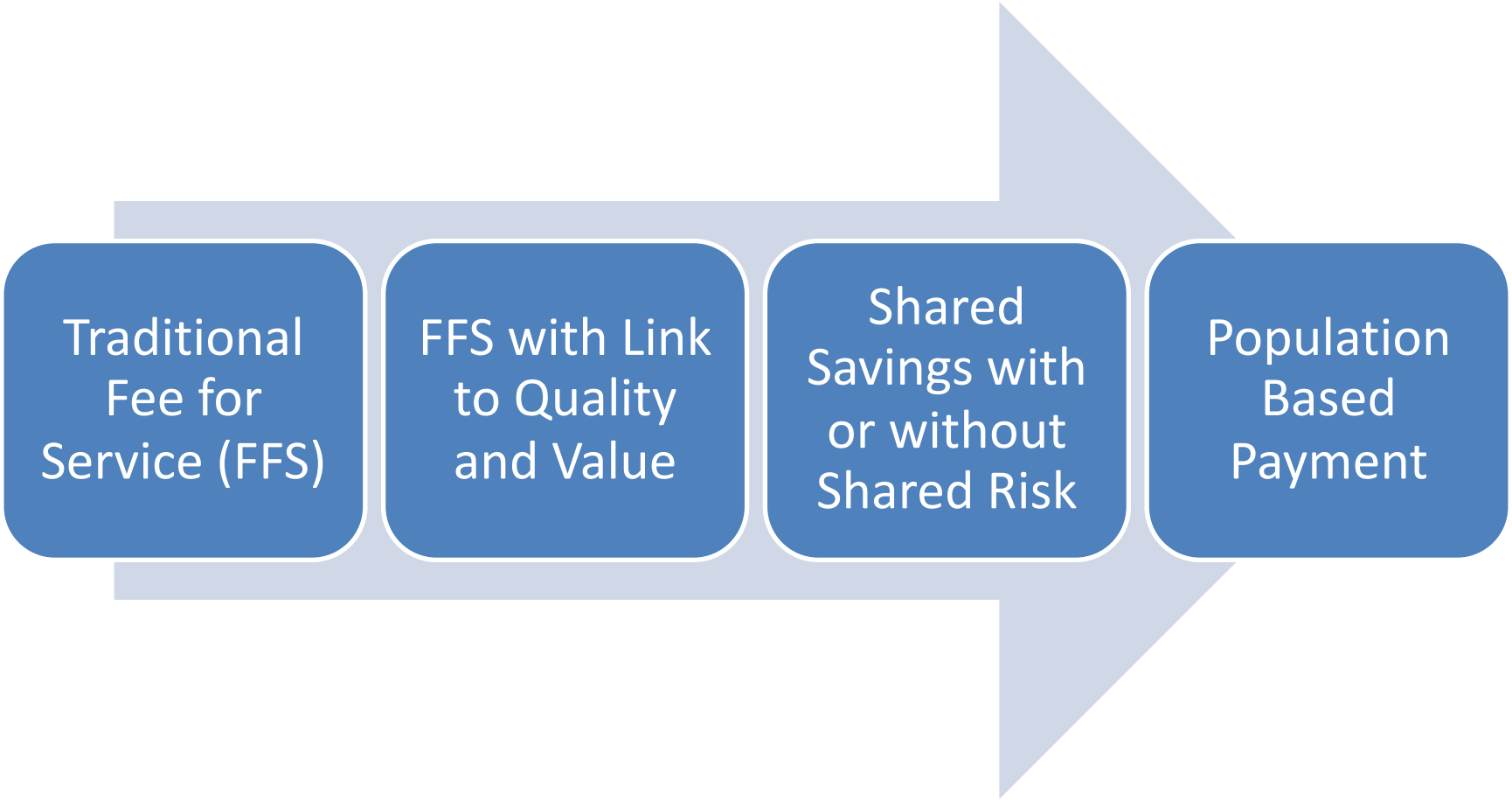
Premiums	Cost-Sharing
• State flexibility subject to 5% aggregate cap • States may impose monthly or quarterly premiums or annual fees • Can impose lockouts up to 90 days for nonpayment	• None for preventive care • Limited cost-sharing for children with income between 133% – 150% FPL* • State flexibility subject to 5% aggregate cap for children with income > 150% FPL • Can impose deductibles and co-insurance (few do)

* Cost-sharing limits in CHIP for children with income equal to or below 150% FPL vary based on type of service and the cost the state pays for the service as described in 42 CFR 457.555.

How do states deliver care?

- **Fee-for-service (FFS)** – state contracts directly with providers and pays them for covered services
- **Managed care** – state contracts with managed care organizations (MCOs) to deliver services
- **Premium assistance** – Medicaid and CHIP funds used to purchase private insurance that is cost-effective and comparable
  - Provide benefit and cost-sharing wraps to achieve comparability
- **Combination of these approaches**

Movement toward Value-Based Purchasing



Source: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

Financing

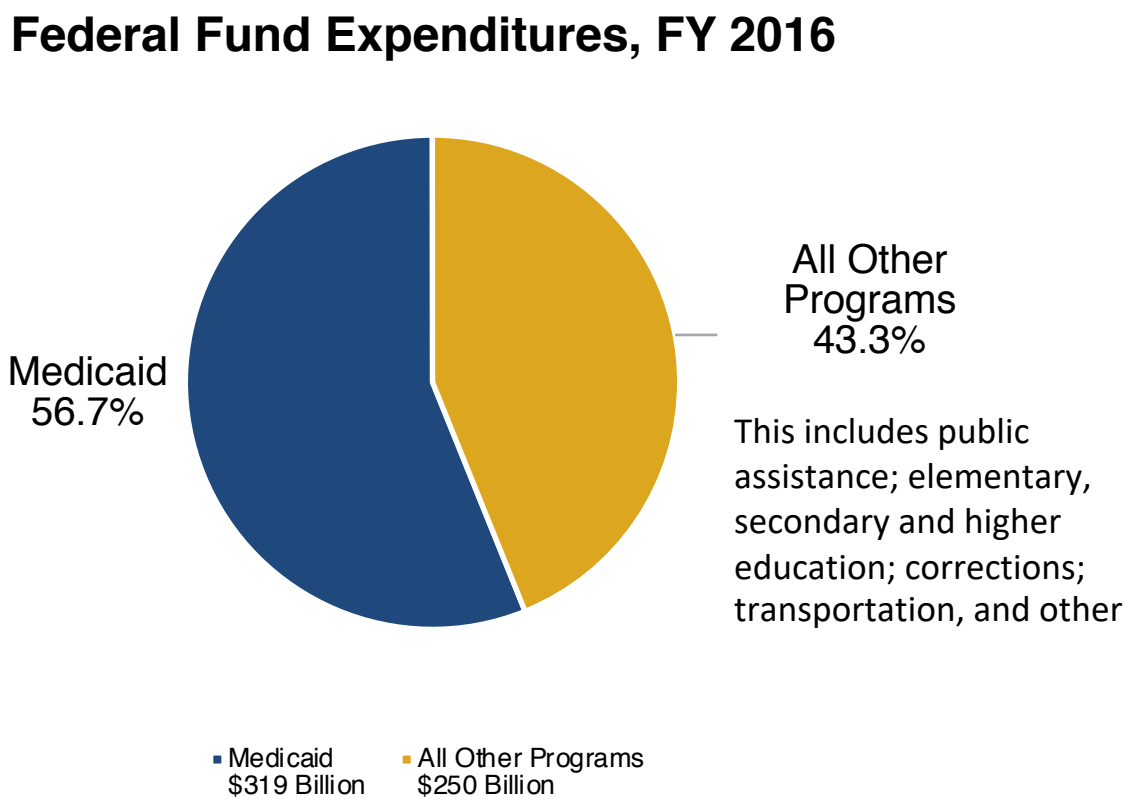
Medicaid Financing

- The federal government matches state spending on an open-ended basis.

Federal Medical Assistance Percentage (FMAP)
Formula based on per capita income, recalculated annually
1 – (0.45 X (state per capita income ÷ U.S. per capita income))

	Statutory Rates	2019 FMAP Rates
Minimum	50%	50%
Maximum	83%	76.4%

Medicaid is the Largest Source of Federal Funds for States



Source: State Expenditure Report: Examining Fiscal 2015-2017 State Spending, National Association of State Budget Officers (NASBO).

CHIP Financing

- Block grant with capped annual allotments
  - Unused allotment available for up to 2 years
  - Redistribution dollars available for federal funding shortfalls
  - Contingency fund covers shortfalls related to increased enrollment
- CHIP bump = 23 percentage points up to 100% in FFY 2016-2019; 11.5 percentage points in FFY 2020

eFMAP Formula

FMAP + (0.3 x (1 – FMAP))

	Statutory Rates	2019 eFMAP Rates	2019 eFMAP with Bump	2020 eFMAP with ½ Bump*
Minimum	65%	65%	88%	76.5%
Maximum	85%	83.5%	100%	96.5%

Source: FY 2018: Federal Register, November 15, 2016 (Vol 81, No. 220), pp 80078-80080.
* Based on statutory minimums and maximums. Actual 2020 matching rates have not been released.

A Closer Look at How Medicaid Could Be Restructured

Restructuring Medicaid – Legislative

Block Grant/Per Capita Cap

- Limit federal funding to a specific amount
- Fundamental change in entitlement and benefit structure
- To achieve federal savings, states would receive less money
- Major implications for beneficiaries, providers, states, and managed care plans

Legislative Process

- Only need simple majority in the House, but typically would require 60 votes in the Senate
- To avoid 60-vote threshold in the Senate, would need to pass a budget resolution with reconciliation instructions
- This has not happened (yet) for the current fiscal year

Restructuring Medicaid – Administrative

Section 1115 Waivers

- Allow HHS to waive federal Medicaid requirements for a state to do an innovative project
- Must be **experimental** and must **promote the objectives** of Medicaid
- Historically used to do coverage expansions, managed care, family planning
- Now being used to limit coverage
- State and federal comment periods allow the public to weigh in

Potential Risks to Children in Restructuring Proposals

- Cuts to Medicaid in exchange for state flexibility could eliminate core protections for children in federal standards:
  - Guarantee of coverage
  - Comprehensive benefits through EPSDT
  - Cost-sharing limitations
- Even without explicitly eliminating these protections, children's coverage would be at risk as federal funding declines

Questions?

For More Information

Tricia Brooks
- pab62@georgetown.edu

Kelly Whitener
- kdw29@georgetown.edu

Center for Children and Families website
- ccf.georgetown.edu

Say Ahhh! Our child health policy blog
- http://ccf.georgetown.edu/blog/