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CHIP TIPS

A new series highlighting opportunities for covering children under Medicaid and CHIP

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MEDICAID PERFORMANCE BONUS

The recently enacted CHIP reauthorization law (known as CHIPRA) includes a number of important program and financing changes that affect both Medicaid and CHIP. One of these is the Performance Bonus, which provides extra financial support to states that succeed in enrolling Medicaid-eligible children above target levels.

WHAT HAPPENED BEFORE CHIPRA?

Since they began implementing CHIP in 1997, states have found that their outreach and enrollment efforts for CHIP also helped to reach and enroll uninsured children in Medicaid. Indeed, about half the gains in child enrollment achieved since CHIP was established have been in Medicaid.[1] Because 7 of every 10 uninsured children are eligible for publicly funded coverage—Medicaid, most often—enrolling Medicaid-eligible children is a top priority for children's coverage efforts.[2,3] Until now, however, the federal government provided no special financial incentive to states to maximize their enrollment of Medicaid-eligible children, and, in fact, the federal matching rate for Medicaid children is lower than the matching rate for CHIP children.

WHAT CHANGES DOES CHIPRA MAKE?

The Performance Bonus provision in CHIPRA recognizes that when states "put out the welcome mat" for children, they bear additional coverage-related costs in Medicaid as well as CHIP. The bonus will offset some of those costs by providing additional federal support to states if their child enrollment in Medicaid exceeds targets specified in the law. The more children a state enrolls above the target, the larger the federal bonus payment to the state. Although the bonus is paid to states in a lump sum, in effect, the bonus increases a state's federal Medicaid matching rate for child enrollment that exceeds the target level. The computations are complicated (they are described later), but Table 1 illustrates the potential extra support a state could receive for marked gains in Medicaid enrollment. Table 1 shows that a state with a regular federal Medicaid match rate of 50% would receive an effective federal match of 57.5% for the number of enrolled children between 100% and 110% of its enrollment target. The effective federal match rate jumps to 81.5% for enrolled children above 110% of the state's target.

Table 1. Examples of Effective Medicaid Match Rate for Achieving Enrollment Targets

Enrollment up to 100% of Target (regular match rate)	Enrollment between 100% and 110% of Target	Enrollment above 110% of Target
50%	57.5%	81.25%
60%	66%	85%
70%	74.5%	88.75%
80%	83%	92.5%

HOW DOES IT WORK?

To qualify for a Performance Bonus, a state must meet two conditions: (1) the state's child enrollment in Medicaid must exceed the target; and (2) the state must have implemented at least five of eight policies that are specified in CHIPRA (see Box 1 on next page). One of the policies (Express Lane) is new, but most of these policies already have been shown to boost enrollment among children. They are described in more detail in a companion CHIP Tip, *Medicaid Performance Bonus "5 of 8" Requirements*.

Box 1. 5 of 8

States must implement at least five of the following eight policies to be eligible for the performance bonus (except for premium assistance, they must be implemented in both Medicaid—for children—and CHIP):

- 12-month continuous coverage
- No asset test (or simplified asset verification)
- No face-to-face interview requirement
- Joint application and the same information verification process for separate Medicaid and CHIP programs
- Administrative or *ex parte* renewals
- Presumptive eligibility
- Express Lane eligibility
- Offer a premium assistance option

- **How are the target levels calculated?**

  A state's enrollment target will be set each year (beginning in fiscal year 2009) by applying the formula set out in CHIPRA to state enrollment data. Specifically, CMS will calculate the target for each state based on the state's child enrollment in Medicaid in 2007, adjusted each year by the state's child population growth and a standard enrollment growth factor that is specified in CHIPRA and that changes over time.[4]

  The standard enrollment growth factor, which is the same for all states, is based on national projected caseload growth. Because of the recession, it is pegged at a fairly high rate—starting at 4 percent but dropping to 3.5, 3 and ultimately 2 percent.

- **Which children count for purposes of determining whether a state has exceeded its enrollment target?**

  The Medicaid bonus is intended to encourage enrollment of *already eligible* low-income children, so for purposes of bonus calculations, only enrolled children who meet the state Medicaid eligibility requirements that were in effect on July 1, 2008 are counted. States that expand Medicaid eligibility for children after that date can begin to count newly eligible children after the third year of implementation.[5]

- **How is the bonus calculated?**

  A state's Medicaid bonus is equal to a percentage of the state's share of the average monthly cost per child, applied to the number of children that exceed the enrollment target.[6] The percentage depends on how much enrollment exceeds the enrollment target.

  A state with enrollment between the target level and 110% of the target level would receive a bonus payment equal to 15% of the state's share of the average cost per child in Medicaid, multiplied by the number of children above the target. The percentage would rise to 62.5% of the state's share of the average cost per child for any enrollment that exceeds 110% of the target. The example in Box 2 shows the different steps in the calculation.

Box 2. Calculating the Performance Bonus

Assume that State has met the "5 of 8" requirements and

- Its Medicaid enrollment target is 2 million children;
- Its Medicaid match rate is 50%; and
- Its average cost per child in Medicaid is $1,500, so the state's share of this cost is $750.

If State X enrolled 2,120,000 children (106% of the target), it would receive a bonus payment of over $13 million (15% x (120,000 x $750)) = $13,500,000).

WHAT ARE THE CHOICES FOR STATES?

Each state should determine whether it meets the "5 of 8" condition for qualifying for the bonus. States that do not will need to adopt additional measures to qualify for bonus payments. Even if a state anticipates that its child enrollment will not exceed the targets in the short term, having these measures in place will allow the state to qualify whenever the targets are met. Given the downturn in the economy, enrollment growth could exceed expectations, and states will want to be in a position to qualify for a bonus if that occurs. (See Box 3 for key dates.)

In addition to the "5 of 8" policy measures, states may find they need to take other steps, including increased outreach and systems simplifications, to effectively boost participation among Medicaid-eligible children. Each state will need to consider its procedures and circumstances to determine what steps would best ensure that eligible children get the coverage they need, enabling the state to reach its performance target.

Box 3. Key Dates for Performance Bonus

- Bonus payments are available **beginning in federal fiscal year (FFY) 2009**. For each year, bonuses will be paid by **December 31** following the end of the fiscal year (e.g., FFY 2009 bonuses will be paid by December 31, 2009, FFY 2010 bonuses by December 31, 2010, etc.).
- **For 2010 and beyond, the 5 of 8 policies must be in place for the full federal fiscal year for a state to qualify** for a bonus. CMS guidance is needed to clarify whether the "full year implementation" requirement applies in FFY 2009.
- Only children who meet a state's eligibility criteria in effect on **July 1, 2008** can be counted in the first years of bonus calculations. Children enrolled under Medicaid expansions that take effect after this date may begin to be counted after the third year of implementation.

WHERE CAN I FIND MORE INFORMATION?

- See the companion piece in this series, *Medicaid Performance Bonus "5 of 8" Requirements*.
- The Performance Bonus provision can be found in section 104 of H.R. 2.
- Further information on strategies to enroll eligible but uninsured children is available on the CCF website at http://ccf.georgetown.edu/index/strategy-center.
- Information on the number of states that have implemented specific "5 of 8" strategies can be found at: D. Cohen Ross and C. Marks, Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009, Kaiser Commission on Medicaid and the Uninsured, January 2009.
- A summary of CHIPRA and related resources are available at the CCF website at http://ccf.georgetown.edu/index/chip-law
- A fact sheet on CHIPRA and other resources on children's coverage can be found at the Kaiser Family Foundation website at http://www.kff.org/medicaid/childrenscoverageresources

ENDNOTES

[1] L. Dubay, *et al.*, "Medicaid at the Ten-Year Anniversary of SCHIP: Looking Back and Moving Forward," *Health Affairs*, 26(2): 370-381 (March/April 2007).

[2] J. Paradise *et al.*, *Next Steps in Covering Uninsured Children: Findings from the Kaiser Survey of Children's Health Coverage*, Kaiser Commission on Medicaid and the Uninsured (January 2009) #7844.

[3] J. Holahan, A. Cook, & L. Dubay, *Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage*? Kaiser Commission on Medicaid and the Uninsured (February 2007) #7613.

[4] For federal fiscal year 2009, 2007 Medicaid enrollment is adjusted first by the rate of growth in the state's child population from 2007 to 2008 plus the standard enrollment growth factor of 4 percentage points, and then by the rate of growth in the state's child population from 2008 to 2009 plus another year's standard enrollment growth factor of 4 percentage points. For fiscal years 2010, 2011, and 2012, the previous year's target is adjusted by the growth in the state's child population during the calendar year underway plus a 3.5 percentage point standard enrollment growth factor; in fiscal years 2013-2015, the previous year's target is adjusted by the growth in the state's child population plus 3 percentage points; in subsequent years, the previous year's target is adjusted by the growth in the state's child population plus 2 percentage points.

[5] The enrollment count is based on the average monthly unduplicated number of children enrolled in Medicaid. States cannot count children covered under the new CHIPRA option for immigrant children who have been lawfully residing in the country for less than five years, and they cannot count children who are presumptively eligible for Medicaid until they have been determined eligible for Medicaid. Although CMS guidance is needed, it appears that states can count children who are covered through CHIP-financed Medicaid expansions.

[6] The per-child cost excludes children receiving Supplemental Security Income (SSI) benefits. Costs are based on the last year for which actual data are available, adjusted to the appropriate year using the growth in National Health Expenditures.

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The Henry J. Kaiser Family Foundation
The Kaiser Commission on Medicaid and the Uninsured
1330 G Street, NW • Washington, DC 20005
phone (202) 347-5270 • fax (202) 347-5274 • www.kff.org

Georgetown University Center for Children and Families
Health Policy Institute
3300 Whitehaven Street, NW, Suite 5000 • Washington, DC 20057
phone (202) 687-0880 • fax (202) 687-3110 • http://ccf.georgetown.edu