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Aligning Eligibility For Children: Moving the Stairstep Kids to Medicaid

Executive Summary

A feature of the Affordable Care Act (ACA) that has not received a lot of attention requires that Medicaid cover children with incomes up to 133 percent of the federal poverty level (FPL) (\$31,322 for a family of four in 2013) as of January 2014. Today, there are “stairstep” eligibility rules for children. States must cover children under the age of six in families with income of at least 133 percent of the FPL in Medicaid while older children and teens with incomes above 100 percent of the FPL may be covered in separate state Children’s Health Insurance Programs (CHIP) or Medicaid at state option. While many states already cover children in Medicaid with income up to 133 percent FPL, due to the change in law, 21 states needed to transition some children from CHIP to Medicaid. New York and Colorado implemented an early transition of children from CHIP to Medicaid. New Hampshire and California moved or are in the process of transitioning *all* CHIP kids to Medicaid. The remaining 17 states will transition an estimated 13 percent to 48 percent of their CHIP kids.

This brief examines how the transition of children from CHIP to Medicaid will affect children and families as well as states. The brief also looks to New York and Colorado for lessons learned from the early transition of coverage. Key findings include:

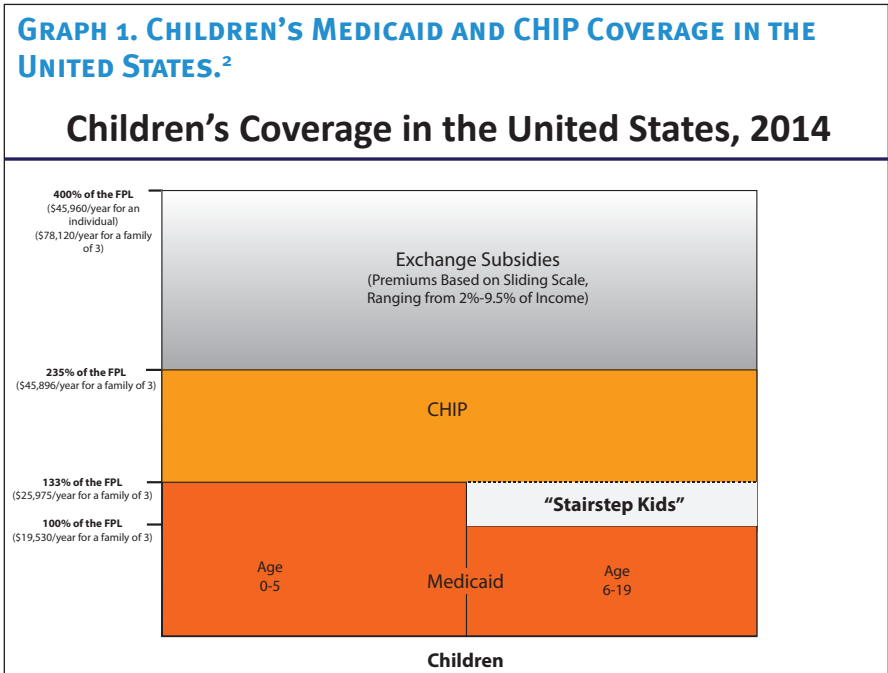
- » The change in the law will align coverage for families in Medicaid and provide access to a better benefits package, greater cost-sharing protections, and the ease and simplicity of having siblings covered in the same program.
- » While all states will need to implement enrollment simplifications required by the ACA, some states still may have more difficult enrollment procedures in Medicaid relative to CHIP, and access to providers may be more limited in Medicaid.
- » States are likely to see some administrative efficiencies and will continue to receive the enhanced CHIP match, but the fiscal impact of the transition varies by state.

- » Early experiences in New York and Colorado indicate that having the administrative capacity to manage the transition as well as strong public awareness and effective communication to the families, providers and stakeholder community affected are important. States where enrollment procedures and provider networks are not aligned between Medicaid and CHIP may face additional challenges in seamlessly transitioning coverage for the stairstep kids.

Introduction

The Affordable Care Act (ACA) (P.L.111-148) is most widely recognized for its expansion of affordable coverage to low-income parents and adults, however, a lesser-known feature of the ACA facilitates alignment of Medicaid coverage across families at 133 percent of the federal poverty level (FPL) (\$31,322 for a family of four in 2013).¹ Today, all states must minimally cover children under the age of six in families with income of up to at least 133 percent of the FPL in Medicaid while older children and teens with incomes above 100 percent of the FPL (\$23,550 for a family of four in 2013) may be covered in separate state Children’s Health Insurance Programs (CHIP). This split source of coverage for children, also referred to as “stairstep” eligibility, results in different aged children in the same family being enrolled in different coverage programs with different benefits, provider networks and cost-sharing, as well as disparate enrollment and renewal procedures. (See Graph 1)

When the ACA was enacted, twenty-one (21) states had stairstep eligibility. In 2011, New York began an early transition, and New Hampshire took a bolder step and moved all of its CHIP kids into Medicaid. Following in the footsteps of New Hampshire, California is currently in the process of phasing in a transition of all children from its separate CHIP program, known as Healthy Families, into the state’s Medicaid program. In January 2013, Colorado also began a phased-in implementation to align Medicaid coverage for children of all ages.



The remaining 17 states that must transition the stairstep kids by January 1, 2014 are: Alabama, Arizona, Delaware, Florida, Georgia, Kansas, Mississippi, Nevada, North Carolina, North Dakota, Oregon, Pennsylvania, Tennessee, Texas, Utah, West Virginia, and Wyoming. This issue brief reviews the implications for children’s coverage associated with the transition, and summarizes lessons learned from states transferring children ahead of the statutory deadline.

While the statutory authority in the ACA for this change emerges from the same section of the law that extends Medicaid eligibility to adults below 133% of FPL, the decision by the Supreme Court effectively allowing states to *choose* whether or not to cover newly eligible adults does not extend to other provisions of the ACA.³ Thus,

the requirement to align children’s coverage stands, as articulated in sub-regulatory guidance released by the Department of Health and Human Services on July 10, 2012.⁴ The Secretary of HHS has further clarified that the stairstep children must be transferred no later than January 1, 2014, and also reassured states, as described below, that they will continue to receive the higher federal CHIP match for this group of children. Some states have expressed an interest in transferring children on their renewal dates, but as of this writing CMS has not opined on this issue.

PART I: OVERVIEW OF THE EFFECTS OF TRANSITIONING STAIRSTEP CHILDREN

How many children will be affected?

Table 1 shows the estimated number of children in each state that will be making the transfer.⁵ On average, 28 percent of CHIP kids will move into Medicaid in 2014 for those states required to eliminate stairstep eligibility. In a handful of states (Mississippi, Oregon, Utah), more than half of their children will transition from CHIP to Medicaid. In the remaining states, 13-48 percent of their CHIP children will move to Medicaid. As discussed below, California and New Hampshire eliminated their separate state CHIP program entirely – moving approximately 860,000 and 9,300 children, respectively, into Medicaid.

TABLE 1. ESTIMATE OF STAIRSTEP CHILDREN MOVING TO MEDICAID

State	Estimated Stairstep Kids Moving to Medicaid in 2014	Estimated Percent of CHIP Children Aligning with Medicaid in 2014
Alabama	25,000	29%
Arizona ^a	6,000	21%
Colorado ^b	19,000	23%
Delaware	2,900	45%
Florida	71,329	28%
Georgia	59,435	27%
Kansas	8,909	19%
Mississippi	40,000	57%
Nevada	11,435	46%
North Carolina	58,000	30%
North Dakota	2,300	48%
Oregon	42,000	59%
Pennsylvania	40,000	21%
Tennessee	10,000	13%
Texas	131,070	23%
Utah	25,725	70%
West Virginia	8,000	32%
Wyoming	1,000	18%
TOTAL	562,103	28%

^a Estimated percent of CHIP children aligning with Medicaid in 2014 calculated using estimates for December 2012 due to large increases in coverage from June to December from open enrollment changes.

^b Colorado began its transition on January 1, 2013.

How will children and families be affected?

We examined four key issues that will affect families with stairstep children transitioning to Medicaid in 2014: Benefits, cost-sharing, enrollment procedures, and access to care. Children and their families gain from more comprehensive benefits, greater cost-sharing protections and coordinated enrollment and renewal procedures for families. While all states will be required to implement the ACA requirements to streamline and coordinate

enrollment across health programs, some states may continue to have more restrictive enrollment procedures in Medicaid than CHIP, however, and some have expressed concern that access to providers may be more limited in Medicaid.

Benefits

Federal law requires that all children in Medicaid receive the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit, a set of comprehensive and preventive health services that includes screenings, hearing, vision, dental, mental health, and developmental services. EPSDT is considered by the American Academy of Pediatrics to be the “gold standard” for children, as Medicaid provides all medically necessary services and treatments for children.

States that use CHIP funds to expand coverage through Medicaid must also cover EPSDT. However, EPSDT is not mandatory in states that have separate CHIP programs. Separate CHIP programs are required to provide a comprehensive and specific set of services including immunizations, well-child visits, dental care, inpatient and hospital care, but states have more flexibility in designing their benefit package. The package may be based on commercial plan benchmarks that are less generous than Medicaid. Thus, benefits vary by state and the type of CHIP program; but all children who transition to Medicaid in 2014 will be entitled to the full Medicaid benefit package, including EPSDT, and thus will be guaranteed a stronger benefit package.

Cost-Sharing

An extensive body of research indicates that when low-income families face higher premiums and cost-sharing, enrollment and the use of needed services decreases.⁶ Medicaid expansion programs funded through CHIP must follow the same rules as Medicaid, which sharply limit cost-sharing for children.⁷ States are not allowed to charge premiums for children in Medicaid in families with income below 150 percent of the poverty level, and allowable co-payments for services are restricted to nominal charges.⁸ Separate CHIP programs have more flexibility to impose premiums, co-payments, deductible and co-insurance on children. Although cost-sharing is not allowed for preventive services including well-child visits, separate CHIP programs can impose cost-sharing up to 5% of a family’s income.⁹

Once moved to Medicaid, stairstep kids will fall under the Medicaid cost-sharing rules, providing these families with stronger cost-sharing and premium protections than they currently have in CHIP.¹⁰ For example, under current rules as noted above, states cannot charge premiums to children in Medicaid, but children in families with income between 100 percent and 150 percent of the poverty level can be charged up to \$19 per child per month in CHIP.¹¹ In Florida, a family of four with income of 120% of the FPL and two children in Florida’s CHIP program (Florida KidCare) is currently charged premiums of \$30 per month (\$15 per child). Once these children transfer, their families will no longer be required to pay premiums. Increasing premiums has been shown to decrease enrollment for lower-income populations. For example, a Florida study found that a \$5 premium increase reduced CHIP enrollment by more than half, with lower-income children more severely impacted than higher-income children.¹² With the transition to Medicaid, stairstep families will no longer be charged premiums and children will be more likely to enroll and stay enrolled.

Enrollment and Renewal Procedures

Many states have simplified administrative procedures to promote enrollment and retention of coverage, and all states are gearing up for new ACA requirements that will further streamline their administrative processes. Beginning in 2014, eligibility and enrollment rules will be aligned for Medicaid and CHIP in many respects. For example, states must review eligibility for children and families no more often than once every 12 months. Currently, Texas requires families to renew children's coverage in Medicaid every six months while CHIP renews coverage once a year. Following the transition, a family in Texas with income of 115% of the FPL, that presently has two children, ages 4 and 8, enrolled in Medicaid and CHIP respectively, will no longer have to renew coverage nor re-enroll their children, more than once a year, through separate processes.

However, the ACA's eligibility and enrollment rules will not require all Medicaid and CHIP policies to be fully aligned. For example, states have the option to adopt continuous eligibility in Medicaid and/or CHIP for children, which allows children to maintain Medicaid or CHIP coverage for up to one full year, even if families experience a change in income or family size.¹³ This is one of the most effective strategies to promote ongoing coverage, which is essential to achieving better health outcomes and enabling states to measure more effectively the quality of care over time. Seven (7) of the states (Delaware, Florida, Nevada, Pennsylvania, Tennessee, Texas and Utah) that will be transitioning "stairstep" kids to Medicaid currently have 12-month "continuous eligibility" for children in CHIP but not in Medicaid.¹⁴ In addition to aligning family coverage, states may want to examine their enrollment and renewal policies more broadly to promote consistency across programs and encourage enrollment and retention of coverage.

Access to Care

Research has proven that Medicaid and CHIP significantly improve access to care for the children they cover, especially with respect to primary and preventive care. Children insured by Medicaid and CHIP report nearly the same levels of access as children covered by private insurance.¹⁵ Most major data sets do not distinguish between the two public programs. However, there is growing concern about the ability of Medicaid to ensure strong access to care with states shifting kids to Medicaid, especially in states that will be expanding Medicaid to newly eligible adults thus creating additional demand for services in 2014.

The ACA partially addresses this issue with a provision that requires states to reimburse Medicaid primary care providers at 100% of the Medicare reimbursement rates in calendar years 2013 and 2014.¹⁶ The federal government will fund 100% of the difference in cost between what a state's Medicaid rate was on July 1, 2009 and the applicable Medicare rate. This aims to ensure access more broadly in Medicaid and to care for children as states eliminate stairstep eligibility, but this is an area that will need to be monitored going forward.

What is the fiscal impact on states?

The Federal Medical Assistance Percentage (FMAP) (also called the federal match rate) determines the share of the cost of Medicaid and CHIP that is paid by the federal government. FMAPs vary by state and are determined annually using a federal formula. The federal government contributes a greater share of CHIP costs than Medicaid costs, hence the CHIP match is often referred to as the "enhanced FMAP." The current national average FMAP is 57% for Medicaid and 71% for CHIP.¹⁷⁻¹⁸ As a result, states are acutely aware of the financial implications of serving children in Medicaid versus CHIP.

Since the ACA was enacted in 2010, states have questioned which FMAP would apply to the stairstep kids – the Medicaid FMAP or the enhanced CHIP FMAP. The Centers for Medicare and Medicaid Services (CMS) has clarified more than once that these children will continue to receive the enhanced CHIP match, most prominently in the final Medicaid and CHIP eligibility rules released on March 23, 2012.¹⁹ On February 6, 2013, HHS also released an Informational Bulletin with the same guidance.²⁰ Although this question persists, it is clear that states will not lose the enhanced CHIP match for this population.²¹

Although aligning coverage will likely free up administrative resources as discussed below, and federal matching dollars will not go down, other state costs associated with the stairstep transition will vary by state depending on the cost of covering a child in CHIP or Medicaid. For example, Utah projects a net increased cost to the state of \$886,403 in 2014. The projections were based on a lower CHIP per child annual cost estimate of \$1,136.55, compared to a Medicaid per child annual cost of \$1,276.95.²² Florida, however, estimates that the state will save an estimated \$17.6 million in 2014 due to the transition.²³

Administrative Efficiency

Aligning coverage will be more cost-effective and efficient for states by eliminating the need to transfer children from Medicaid to CHIP when they turn six. This can involve the Medicaid agency disenrolling a child who is then enrolled by the CHIP agency along with sending new insurance cards and benefit information. Such changes can be confusing to families, particularly when different health care delivery systems and provider networks are used, which in turn generates calls from families potentially to both agencies to understand why the change was made and what the differences are in benefits and cost-sharing. Having all children in the same family covered under one program could also streamline the state's ongoing administrative workload and reduce paperwork by eliminating the duplication of effort by two agencies when processing renewals and other changes.

Not only does aligning coverage free up administrative resources, it promotes continuous coverage that enables states to more easily measure access to care and health outcomes. Few states have systems in place to track access and quality of care across different delivery systems and coverage sources. Thus, efforts to promote better health outcomes are disrupted as children “age out” of Medicaid and move to CHIP, at a time when use of preventive health care begins to decline.

PART II: LESSONS LEARNED FROM STATES THAT HAVE ALREADY TRANSFERRED STAIRSTEP CHILDREN

A Look at New York and Colorado

Both New York and Colorado elected to implement the stairstep transition in advance of the January 1, 2014 deadline. Interviews with state administrators and child advocates in New York and Colorado were conducted to learn more about their experiences and what lessons they might hold for other states.

New York aligned eligibility for children ages 6 to 18 from 100 to 133% of the FPL when the New York State Department of Health issued an administrative directive effective November 1, 2011 to move children from CHIP (known as Child Health Plus) to Medicaid at the time of the child's next renewal. In Colorado, SB 11-008 was signed into law on April 8, 2011, authorizing the transition of stairstep children to Medicaid in the fall of 2011, but the fiscal note assumed that implementation would begin in January 2013. The legislation was never amended, so the transition was delayed until January 2013.

By acting early, both states have avoided a mass transition of children on January 1, 2014 – a time when many other changes will be occurring in states' health care systems.

How have children transitioned from Medicaid to CHIP in states?

In New York, from November 2011 through May 2012 during the renewal process (which is handled by the CHIP health plans), if a child appeared to be eligible for the new Medicaid income group, families were informed that they must apply for Medicaid. To determine final eligibility, families were required to submit a new Access New York Health Care (Medicaid) application to a local Department of Social Services. Children remained in the CHIP program for 60 days to allow time for families to complete the Medicaid application process.

However, this was a labor-intensive process, so the state began to use Express Lane Eligibility (ELE)²⁴ in June 2012 to streamline the transition and reduce the administrative burden on families, health plans, and local Departments of Social Services. Children were enrolled into Medicaid using the Child Health Plus renewal application which is easier for families to complete. Since families in New York can attest to their income at the Child Health Plus renewal, children transitioning through ELE were not required to provide proof of income, which is required for new Medicaid applications.

Instead of undertaking a mass transition of children into Medicaid in Colorado, all *new* applicants with family income between 100-133% of the FPL will be enrolled in Medicaid starting on January 1, 2013. Current enrollees between the ages of 6-18 at 100-133% will be transitioned to Medicaid at their renewal date or when eligibility is otherwise being re-determined (e.g., reported change in family circumstance, at the request of family). The decision to not do a mass transition was made so that children would be ensured continuity of care and to avoid disrupting children's 12-month continuous coverage in CHP+.²⁵

How have families been notified about the changes?

Families in New York identified with stairstep children at renewal were mailed notices informing them that their children would be transitioned to Medicaid at the end of their Child Health Plus enrollment period. Once the children were enrolled in Medicaid, their managed care health plan sent the family a Medicaid welcome package and member handbook outlining the benefits, including EPSDT. The state does not impose premiums or cost-sharing on children with family incomes below 133% of the FPL in Medicaid and Child Health Plus, thus no changes occurred on that front.

When stairstep children are identified during the renewal process in Colorado, a Medicaid eligibility notice is automatically generated from the state's eligibility system. After the new eligibility information goes through the Medicaid Management Information System, families receive enrollment materials relating to the transition. This includes a letter explaining the purpose of the materials, a summary comparison of the Medicaid plans available, a quality report card containing ratings for the plans, changes in cost-sharing and information about Medicaid's EPSDT benefit. New enrollees also decide if they want to accept their assigned provider or request the Medicaid provider of their choice.

How do delivery systems affect the alignment?

With almost identical delivery systems of managed care for Medicaid and Child Health Plus, there was significant overlap in provider networks in New York, which facilitated the transition considerably. Most families continued with the same PCP as they were transitioned to Medicaid. Since all but one of the managed care plans in the state cover both Medicaid and Child Health Plus, most families received this information from their current plan. If the Child Health Plus plan did not participate in Medicaid managed care in a certain county, children were enrolled in a default plan. The default plan was selected by comparing provider networks of PCPs and pediatricians to find the closest network of providers. If a family was not pleased with the default assignment, the family had 90 days to change plans. The State Department of Health continuously evaluates the provider networks to ensure that capacity is adequate and requires managed care health plans to submit their provider networks to the Department quarterly.

Colorado has different health care delivery systems for Medicaid and CHP+, as most Medicaid enrollees are in fee-for-service while CHP+ has a managed care delivery system. Past analysis has indicated that there is a 70% overlap in provider networks but Colorado was unable to identify families prospectively that would be affected by the transition. Thus, assuring provider continuity for these children was not guaranteed.

How were providers engaged in the process?

Due to the overlap of provider networks, New York did not specifically educate providers about the change. Only the health plans were informed of the transition through the administrative directive.

Colorado chose to inform providers through Medicaid and CHIP bulletins, newsletters, and other publications about the transition. The State also presented a series of four webinars outlining the changes to county workers, eligibility workers, certified application assistance site workers, Family Health Coordinators, and the State's enrollment broker. All webinars were followed by Question and Answer (Q&A) sessions, and all Q&As were posted to a State website. The stakeholder community also was involved in communications as they assisted the Department in drafting "talking points."

As previously mentioned, CHIP+ children in Colorado have 12-month continuous eligibility, but children in Medicaid do not. Many providers did not like the idea of moving children from a program with 12-month continuous eligibility to a program where there may be an increase in churning. Passage of House Bill 09-1293, a reform bill funded by a hospital provider fee, which authorized the Department of Health Care Policy and Financing in Colorado to implement 12-month continuous eligibility for children in Medicaid. However, the policy has not yet been implemented.

Other Models to Coordinate Medicaid and CHIP

By transferring their entire CHIP programs into Medicaid, New Hampshire and California also accomplished an early transition of their stairstep children albeit through a more far-reaching method.

In 2012, New Hampshire aimed to achieve savings of \$6.6 Million in the 2012-13 biennium by transitioning approximately 8,200 children enrolled in the state's CHIP program (New Hampshire Healthy Kids or NHHK) to Medicaid. California followed suit with a similar proposal in 2012 through Assembly Bill (AB) 1494, which authorized the transition of 860,000 children enrolled in the state's CHIP Program (Healthy Families Program or HFP) to the state's Medicaid program (Medi-Cal) beginning in January 2013.²⁶

Both states pushed for this concept as a way to save the state money through administrative efficiency and as a way to benefit families, as children would be under the same health plan as their siblings, receive EPSDT, and no longer have waiting periods, premiums, or cost-sharing. However, many child advocates and providers in both states were concerned that the provider capacity would not be sufficient to serve the children moving to Medicaid, especially considering the lower reimbursement rates of Medicaid providers. In California, many stakeholders advocated for moving only the stairstep children initially and delaying the transition for the remaining HFP children until later, so that this would allow the state to evaluate and monitor the transition closely, while also addressing any access issues that may occur. Despite pushback from stakeholders, the state has moved forward with the entire transition of Healthy Families Program into Medi-Cal.

To educate families affected by the transition, families with children in New Hampshire's Healthy Kids program were sent a letter two months before the NHHK program ended and a new Medicaid card. Before the transition, NHHK had administered enrollment and eligibility for children in Medicaid (Healthy Kids Gold), children in CHIP (known as Healthy Kids Silver), and a Healthy Kids Buy-in program (children in families with incomes above New Hampshire's CHIP income limit of 300% of the FPL were allowed to purchase a subsidized HMO product and pay a premium for their coverage). Both Silver and Buy-in Families paid premiums, with buy-in families' premiums being higher than the Healthy Kids Silver. Approximately 500 children were in the buy-in program, which was eliminated, leaving them without assistance for health care until new federal options become available on January 1, 2014. A study to examine the impact of how buy-in kids have adjusted in the absence of subsidized coverage is currently underway. Medicaid enrollment has increased by an estimated 9,300 children in New Hampshire since the transition.

California's much larger transition began on January 1, 2013 and will continue throughout 2013 over four phases.²⁷ Because this change is going forward under Section 1115 waiver authority, CMS monitors and evaluates the transition, and the state must have written approval from CMS before starting each implementation phase. To inform families affected by the transition, the State must provide a written notice to the families at least 90 days prior to the start of each phase. Additionally, stakeholders and CMS have had the opportunity to comment on all draft notices before they are sent to families. In all phases, the state must send transitioning children subsequent notices throughout the 90 days leading up to each phase of the transition so that families are sufficiently informed about the transition and can get their questions answered.

CONCLUSION

Experiences in New York and Colorado indicate that having the administrative capacity to manage the transition is essential, as some states may be overburdened and have limited resources. Both states felt that it would be important to have strong public awareness and effective communication to the families, providers and stakeholder community affected. States should also consider alignment of enrollment procedures and provider networks as important issues to address early in the process, especially in states that may not have much overlap in provider networks between Medicaid and CHIP.

Aligning coverage for families in Medicaid will bring benefits for families and children such as a better benefits package, greater cost-sharing protections, and the administrative ease of covering siblings in the same program. Downsides may include more difficult enrollment procedures if Medicaid is not as streamlined as CHIP and fewer providers, although this remains to be seen. The fiscal impact varies by state. Nevertheless, states face a significant administrative task in aligning family eligibility for children in 2014 – particularly those that have been slow to move forward with ACA implementation. Thus, states and stakeholders may want to consider phasing in the transition as soon as possible and proactively communicate this alignment to providers, families, and eligibility workers.

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Endnotes

- ¹ As discussed below, these children will continue to receive the higher CHIP matching rate after they are transferred to Medicaid.
- ² Currently, all children from birth to age 6 with family incomes up to 133% of the FPL are eligible for Medicaid. For CHIP, 46 states and D.C. cover children up to or above 200% of the FPL. The minimum upper income limit in CHIP is 160% of the FPL in North Dakota, and the maximum upper limit in CHIP is 400% of the FPL in New York.
- ³ *National Federation of Independent Business v. Sebelius*, Slip Opinion, Syllabus, at 5.
- ⁴ Letter from Secretary of Health and Human Services Kathleen Sebelius to the Governors (July 10, 2012) <http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf>.
- ⁵ Estimates calculated based on the number of estimated stairstep children moving to CHIP in 2014 was collected from state officials and state advocates and using June 2012 CHIP monthly enrollment data provided to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured.
- ⁶ Snyder, Laura and Robin Rudowitz. "Premiums and Cost-Sharing in Medicaid: A Review of Research Findings." Kaiser Commission on Medicaid and the Uninsured, February 2013. <http://www.kff.org/medicaid/upload/8417.pdf>.
- ⁷ It is important to note that the Centers for Medicare and Medicaid Services (CMS) issued proposed rules on January 22, 2013, that would streamline and simplify Medicaid premium and cost-sharing rules and provide states more flexibility. For a comparison of the current Medicaid cost-sharing rules and the CMS proposed rules, see Snyder, Laura and Robin Rudowitz. "Premiums and Cost-Sharing in Medicaid." Kaiser Commission on Medicaid and the Uninsured, February 2013.
- ⁸ Georgetown University Center for Children and Families. "Cost Sharing for Children and Families in Medicaid and CHIP," 2009.
- ⁹ Ibid.
- ¹⁰ States cannot impose any cost sharing on children in Medicaid below 150 percent of the federal poverty level except in a narrow range of circumstances (e.g., a non-emergency use of the emergency room, only if a Medicaid enrollee has been provided with an appropriate referral to an alternative provider and for certain prescription drugs). At more moderate-income levels, federal rules also exempt some services, such as preventive services for children, from cost sharing.
- ¹¹ States can charge premiums through Section 1115 waiver authority.
- ¹² J. Boylston Herndon, et al., "The Effect of Premium Changes on SCHIP Enrollment Duration," *Health Services Research*, 43: 458-477 (September 2007).
- ¹³ Recently, HHS released guidance to states confirming that through Section 1115 waiver authority, states may implement 12-month continuous eligibility for parents, which will further align family coverage.
- ¹⁴ States have the option to implement continuous eligibility, allowing children to maintain Medicaid or CHIP coverage for up to one full year, even if families experience a change in income or family status.
- ¹⁵ Georgetown University Health Policy Institute Center for Children and Families. "Medicaid Provides Needed Access to Care," February 2013.
- ¹⁶ Public Law 111-152. Health Care and Education Reconciliation Act of 2010 (HCERA), enacted on March 30, 2010.
- ¹⁷ "Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)." Kaiser Commission on Medicaid and the Uninsured, September 2012.
- ¹⁸ Section 2101(a) of the Patient and Protection and Affordable Care, P.L. 111-148 includes a provision that will increase each state's CHIP FMAP by 23 percentage points on October 1, 2015. However CHIP funding expires in 2015 and must be renewed by Congress; so it is unclear if this increase will go into effect.
- ¹⁹ Federal Register / Vol. 77, No. 57 / Friday, March 23, 2012 / Rules and Regulations / Page 17149. Available at <https://www.federalregister.gov/articles/2012/03/23/2012-6560/medicaid-programeligibility-changes-under-the-affordable-care-act-of-2010>.
- ²⁰ Center for Medicaid and CHIP Services Informational Bulletin, *Questions and Answers: Medicaid and the Affordable Care Act*, Feb. 6, 2013, available at <http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/ACA-FAQ-BHP.pdf>.
- ²¹ States will likely see savings through this continuation of enhanced FMAP in 2014.
- ²² Public Consulting Group. "State of Utah Medicaid Expansion Assessment. Impact Analysis 2014-2023." <http://health.utah.gov/documents/PCGUtahMedicaidExpansionAnalysis.pdf>.
- ²³ Social Services Estimating Conference. Estimates Related to the Affordable Care Act: Title XIX (Medicaid). http://www.fdhc.state.fl.us/medicaid/pdffiles/Estimates_as_requested_by_House_Staff.pdf. December 20, 2012
- ²⁴ The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allowed states to use tools to implement ELE. States can use eligibility determinations from other public need-based programs, such as Supplemental Nutrition Assistance Program, or Head Start to streamline enrollment.
- ²⁵ States have the option to keep children covered in Medicaid and CHIP for 12 months, regardless of whether their family income changes in that time frame.
- ²⁶ The Centers for Medicare and Medicaid Services (CMS) granted federal approval for the Department of Health Care Services (DHCS) to begin the transition via the Bridge to Reform 1115 Demonstration Waiver.
- ²⁷ The HFP transition will occur in four phases in 2013:
Phase 1A: Children enrolled in a HFP plan that is also a Medi-Cal managed care plan.
Phase 1B: Additional children enrolled in a HFP plan that is also a Medi-Cal managed care plan, in their county of residence.
Phase 1C: Remaining children enrolled in a HFP health plan that is also a Medi-Cal managed care plan, in their county of residence.
Phase 2: Children enrolled in a HFP plan that is a subcontractor of a Medi-Cal managed care plan, in their county of residence.
Phase 3: Children enrolled in a HFP plan that is not a Medi-Cal managed care plan and does not contract with a Medi-Cal managed care plan.
Phase 4: Children enrolled in the HFP residing in a county that is not currently a Medi-Cal managed care county.



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