Medicaid and CHIP 101:
Medicaid and CHIP’s Foundational Role in Covering Kids and Families

Tricia Brooks
Kelly Whitener
12-18-17
Medicaid ➔ Critical Health Safety Net

Children and Families

People with Disabilities

Seniors
Focus of Today’s Webinar:
Kids and Families
Increased Participation in Medicaid and CHIP Have Driven Uninsured Rate to Historic Low

Participation Rates in Medicaid/CHIP

U.S. Child Uninsured Rate

Half of Medicaid enrollees are children

Medicaid and CHIP Total Enrollment in September 2017

Medicaid child & CHIP enrollment: 35,576,509;

Medicaid adult enrollment: 35,055,569; 49.6%

Includes data from 48 states that report both adult and child enrollment. Excludes enrollment data from AZ, CT, and TN.

Source: CMS Medicaid and CHIP Enrollment Report, September 2017
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.

The view from 30,000 feet
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

<table>
<thead>
<tr>
<th></th>
<th>Federal Government</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administration</strong></td>
<td>Oversight</td>
<td>Direct administration</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Pays 50% to 83%* of benefit costs, with no cap 50% of administrative costs</td>
<td>Pays non-federal share of cost</td>
</tr>
<tr>
<td><strong>Program Rules</strong></td>
<td>Minimum standards:</td>
<td></td>
</tr>
<tr>
<td>Children:</td>
<td>• Strong benefits (EPSDT)</td>
<td>• Delivery system</td>
</tr>
<tr>
<td></td>
<td>• No cost-sharing &lt;150% FPL</td>
<td>• Optional services</td>
</tr>
<tr>
<td>Adults:</td>
<td>• Mandatory and optional services</td>
<td>• Provider payment rates</td>
</tr>
<tr>
<td></td>
<td>• No premiums under 100% FPL</td>
<td>• Cost-sharing</td>
</tr>
<tr>
<td><strong>Coverage Guarantee</strong></td>
<td>Guaranteed enrollment, if eligible</td>
<td>Cannot freeze or cap enrollment</td>
</tr>
</tbody>
</table>

*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
  - Reauthorized in 2009 - 2013 (CHIPRA) with additional state options
  - Funding extension through 2015 (ACA) with additional federal match (23 percentage point bump) and requirement to maintain eligibility (MOE)
  - Funding extended through 2017 (MACRA) but reduced state ability to carry over more than 2/3’s of 2017 unspent allotment
  - Still waiting for Congressional action to fund 2018 and beyond

- Block grant with capped annual allotments
- No entitlement to coverage
CHIPRA

- Extended funding through 2013
- Dropped State in SCHIP
- Updated formula for state allotments
- Revised rules regarding carry-over funds
- Built in contingency funds for states that run out of allotment
- Enacted new tools and incentives to enroll Medicaid children
- Gave states options to expand eligibility
- Boosted benefit requirements
- Launched significant new emphasis on quality and access
### CHIP: Federal-State Partnership

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<td><strong>Administration</strong></td>
<td>Oversight</td>
<td>Direct administration</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Pays 65% to 85% of costs; with a 23% point bump in 2016, 2017</td>
<td>Pays non-federal share of cost</td>
</tr>
</tbody>
</table>
| **Program Rules**             | Fewer minimum standards than Medicaid | • 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 Expansion**
- All Medicaid rules apply except children must be uninsured
- States can use Medicaid funds to cover children with other coverage

**Separate CHIP Program**
Choice of Benchmark Plan:
- State employee plan
- Federal employee plan
- Largest HMO in state
- Secretary approved

**Combination Program**
- 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
- Infants born to women covered by Medicaid under pregnant women’s coverage
  - Deemed newborns
- Parents/Caretakers at state eligibility level welfare reform in 1996
  - Known as 1931 parents
  - Median income ~ 41% FPL

### Optional Coverage
- Children ages 19 and 20
- Children with income above 133% FPL
- Parents and adults up to 133% FPL
- Medical 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
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 Medicaid outreach/assistance
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**

<table>
<thead>
<tr>
<th>FPL</th>
<th># of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 200%</td>
<td>2</td>
</tr>
<tr>
<td>200% – 250%</td>
<td>21</td>
</tr>
<tr>
<td>250% - 300%</td>
<td>9</td>
</tr>
<tr>
<td>&gt; 300%</td>
<td>19</td>
</tr>
</tbody>
</table>
Parent’s Income Eligibility: Medicaid

Highest State Eligibility - 221%

Pre-ACA Median Expansion States 107%

Median Non-Expansion States - 44%

 Lowest State Eligibility - 18%

<table>
<thead>
<tr>
<th>FPL</th>
<th># of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 50%</td>
<td>12</td>
</tr>
<tr>
<td>50% – 99%</td>
<td>4</td>
</tr>
<tr>
<td>100% - 138%</td>
<td>3</td>
</tr>
<tr>
<td>138%</td>
<td>28</td>
</tr>
<tr>
<td>&gt; 138%</td>
<td>4</td>
</tr>
</tbody>
</table>
Benefits
Medicaid and CHIP-Funded Medicaid Expansions (M-CHIP)

- Comprehensive services through Early Periodic Screening Diagnostic and Treatment (EPSDT)
  - Screenings (developmental, hearing, vision, etc)
  - Diagnostic services
  - Treatment

- All services “medically necessary” to correct and ameliorate physical and mental health conditions

- Cannot impose limits; must provide wrap-around services if premium assistance or managed care limits benefits
Separate CHIP Benefits

<table>
<thead>
<tr>
<th>Actuarially Equivalent to Benchmark Plan</th>
<th>Services must include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HMO with state’s largest enrollment</td>
<td>• Well child; preventive care</td>
</tr>
<tr>
<td>2. State Employee Plan</td>
<td>• Immunizations</td>
</tr>
<tr>
<td>3. Federal Employee Plan, or</td>
<td>• Emergency care</td>
</tr>
<tr>
<td>4. Secretary Approved</td>
<td>• Inpatient and outpatient hospital services</td>
</tr>
<tr>
<td></td>
<td>• Physician services</td>
</tr>
<tr>
<td></td>
<td>• Lab and x-ray</td>
</tr>
<tr>
<td></td>
<td>• Dental services</td>
</tr>
<tr>
<td></td>
<td>• Mental health parity</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Premiums</th>
<th>Cost-Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td>• Children</td>
</tr>
<tr>
<td></td>
<td>– None below 150% FPL</td>
</tr>
<tr>
<td></td>
<td>– None below 133% FPL for preventive care</td>
</tr>
<tr>
<td><strong>Adults</strong></td>
<td>• Adults</td>
</tr>
<tr>
<td></td>
<td>– None below 150% FPL (without waiver)</td>
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</tbody>
</table>
## Maximum Allowable Medicaid Cost-Sharing Varies by Income

<table>
<thead>
<tr>
<th>Service</th>
<th>&lt; 100% FPL</th>
<th>&gt; 100% – 150% FPL</th>
<th>&gt;150% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services</td>
<td>$4</td>
<td>10% of what state pays*</td>
<td>20% of what state pays*</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$8</td>
<td>$8</td>
<td>No limit</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Preferred: $4</td>
<td>Preferred: $4</td>
<td>Preferred: $4</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred: $8</td>
<td>Non-Preferred: $8</td>
<td>Non-Preferred: $8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>20% of what state pays</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>$75 per stay</td>
<td>10% of total cost state pays*</td>
<td>20% of total cost state pays*</td>
</tr>
</tbody>
</table>

*Up to 5% aggregate cap.*
# Premiums and Cost-Sharing in CHIP

<table>
<thead>
<tr>
<th>Premiums</th>
<th>Cost-Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• State flexibility subject to 5% aggregate cap</td>
<td>• None for preventive care</td>
</tr>
<tr>
<td></td>
<td>• Limited cost-sharing for children with income between 133% – 150% FPL*</td>
</tr>
<tr>
<td></td>
<td>• State flexibility on all other services subject to 5% aggregate cap for children with income &gt; 150% FPL.</td>
</tr>
</tbody>
</table>

* 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 § 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**
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

\[ 1 - (0.45 \times \frac{\text{state per capita income}}{\text{U.S. per capita income}}) \]

<table>
<thead>
<tr>
<th>Statutory Rates</th>
<th>2018 FMAP Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>50%</td>
</tr>
<tr>
<td>Maximum</td>
<td>83%</td>
</tr>
</tbody>
</table>
Medicaid is the Largest Source of Federal Funds for States

Federal Fund Expenditures, FY 2016

- **Medicaid**: 56.7%
  - $319 Billion

- **All Other Programs**: 43.3%
  - $250 Billion

This includes public assistance; elementary, secondary and higher education; corrections; transportation, and other

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

• ACA bump = 23 percentage points up to 100% starting in FFY 2016

**eFMAP Formula**

\[ \text{FMAP} + (0.3 \times (1 - \text{FMAP})) \]

<table>
<thead>
<tr>
<th>Statutory Rates</th>
<th>2018 eFMAP Rates</th>
<th>2018 eFMAP with Bump*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>65%</td>
<td>65%</td>
</tr>
<tr>
<td>Maximum</td>
<td>85%</td>
<td>82.9%</td>
</tr>
</tbody>
</table>

*This assumes CHIP funding is renewed with the bump, as both House and Senate bills propose

A Closer Look at How Medicaid Could Be Restructured
## Restructuring Medicaid

### Waivers
- State Innovation Waivers (Section 1332) allow states to pursue new models of integrated coverage
- Section 1115 Waivers allow states to change benefits, cost-sharing and other program rules

### Block Grants
- Sets a specific amount for each state
- Fundamental change in entitlement and financing structure
- Would have major implications for beneficiaries, providers, managed care plans, states and localities
- To achieve federal savings, states would receive less funding

### Per Capita Caps
- Would set amount states are reimbursed per enrollee
- Protects states if enrollment grows but does not protect against other risks (e.g. formula doesn’t account for new treatments or epidemics)
- If costs exceed cap, states, providers and/or enrollees will make up the difference
What do we know about past restructuring proposals and ACA repeal efforts?
State Choices to Offset Loss of Federal Funding

Boost State Spending

- Close or cap enrollment
- Impose more red tape to suppress enrollment and retention
- Reduce Eligibility
- Cut Benefits
- Increase Enrollee Costs
- Lower Reimbursement for Providers

Georgetown University Health Policy Institute
Center for Children and Families
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
Uninsured Rate Rose with CHIP Freezes

Full Repeal of the ACA: 
Direct Impact on Children and Families 

- Maintenance of Effort provision (MOE) requiring states to hold children’s eligibility levels steady 
- Coverage for former foster youth up to age 26 
- Roll-back of stair-step kids (6-18, 100% - 133% FPL) 
- Loss of parent expanded coverage and impact on: 
  - Parent health 
  - Family economic security 
  - Welcome mat effect on child enrollment 
- Loss of Marketplace coverage for 1 million kids
Diving into the weedy details of roll-back of ACA streamlining provisions
### Also Known as MAGI Provisions

<table>
<thead>
<tr>
<th>ACA Eliminated</th>
<th>ACA Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Asset/resource tests</td>
<td>• Multiple application paths</td>
</tr>
<tr>
<td>• Longer than 90-day waiting periods in CHIP</td>
<td>• No wrong door access; coordination with other programs</td>
</tr>
<tr>
<td>• Paper-driven eligibility verification</td>
<td>• Must use electronic data before asking for paperwork</td>
</tr>
<tr>
<td>• Signatures at renewal</td>
<td>• Option to apply reasonable compatible standard</td>
</tr>
<tr>
<td>• Renewals more frequently than every 12 months</td>
<td>• 90% funding to upgrade eligibility systems</td>
</tr>
<tr>
<td>• Counting non-taxable sources of income</td>
<td></td>
</tr>
</tbody>
</table>
Questions?
For More Information

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

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