Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

The Families First Coronavirus Response Act: Medicaid and CHIP Provisions Explained

by Tricia Brooks and Andy Schneider

Introduction

On March 18, 2020, the Families First Coronavirus Response Act was signed into law (P.L. 116-127).[1] Subsequently, Congress passed a much larger economic stimulus package – the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136) – that amended certain provisions in the Families First law and became law on March 27, 2020.[2] The Families First legislation covers a broad range of programs affecting children and families, including the Supplemental Nutrition Assistance Program (SNAP), the Women, Infants and Children's Program (WIC), School Lunch, family and medical leave, unemployment insurance, emergency paid sick leave, and Medicare. This explainer focuses on the provisions impacting Medicaid and the Children's Health Insurance Program (CHIP).[3]

Medicaid Provisions in Families First

Families First, as amended by CARES, includes three policy changes that:

1. Temporarily increase the federal Medicaid matching rate (FMAP) by 6.2 percentage points for all states and the territories, and increase the allotments to Puerto Rico and the territories to cover the increased FMAP (this does not apply to Medicaid expansion populations);
2. Require states to cover COVID-19 testing in Medicaid and CHIP without cost-sharing;
3. Allow states to extend Medicaid coverage for testing to the uninsured.

These changes have two broad purposes: 1) to increase the ability of Medicaid and CHIP to provide COVID-19 testing for their 71 million beneficiaries[4] and an estimated 6 million uninsured individuals at risk for serious COVID-19 illness;[5] and 2) to provide immediate fiscal relief to the states and territories to help them navigate the economic downturn that the pandemic has triggered.

The fiscal relief to states and territories is effective retroactively to January 1, 2020, while the new provisions to cover COVID-19 testing are effective as of March 18, 2020—the date of enactment. All of these changes will continue at least to the end of the public health emergency declared by the Secretary of HHS on January 27, 2020.[6] The details of each policy follow.

1. Temporary Increase in Federal Medicaid Matching Rate

Under current law, the federal government matches state spending on services furnished to Medicaid beneficiaries on an open-ended basis. For most eligibility groups, the regular matching rate, or FMAP, ranges from 50 percent to 77 percent, depending on a state's per capita income; current state FMAP rates can be found here. On average, the federal government's share of Medicaid spending is 65 percent.[7] In the case of the Medicaid expansion adults, the FMAP is 90 percent.

CMS has issued guidance explaining that the 6.2 percentage point FMAP increase applies to CHIP indirectly, so that a state's CHIP matching rate will also increase.[8] The amount of the increase, however, will not be 6.2 percentage points; instead, it will be 4.34 percentage points for all states and is in addition to the 11.5 percentage point increase that is currently in effect through September 30, 2020. The total federal CHIP match cannot exceed 100 percent through September 30, 2020, and 85 percent thereafter. This means that a few states may receive less than a 4.34 percent point increase starting in October 2020.[9]

Section 6008 of the new law increases the regular FMAP by 6.2 percentage points for all states, the District of Columbia and the territories. For example, California's FMAP would increase from 50 to 56.2 percent, and its state share would decline from 50 to 43.8 percent. Kentucky's FMAP would increase from 71.8 to 78 percent; its state share would decline from 28.2 percent to 22 percent.

The increase is effective for the calendar quarter beginning January 1, 2020 and will end on the last day of the calendar quarter in which the coronavirus public health emergency ends. However, it does not affect Medicaid expenditures for which the regular FMAP does not apply, including the 50 percent matching rate for administrative costs, the 90 percent matching rate for the Medicaid expansion adults, and the already-enhanced federal matching rates for CHIP.

In a related provision of the new law, section 6009 increases the federal Medicaid allotment amounts for Puerto Rico and the other territories (American Samoa, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands) in fiscal years 2020 and 2021 to accommodate the increase in FMAP. This is necessary because unlike Medicaid funding for the states, federal funding for Puerto Rico and the territories is capped. Without an allotment increase, the territories would not fully benefit from the FMAP increase.

State Requirements in Order to Qualify for the Medicaid FMAP Bump

In order to receive the FMAP increase during a calendar quarter, state Medicaid programs must meet four Maintenance of Effort (MOE) requirements. The state may not:

- Implement any eligibility standards, methodologies, or procedures that are more restrictive than those in effect in the state on January 1, 2020. This MOE requirement already applies to children through the end of fiscal year 2027.
- Impose new or increased premiums on any beneficiary that exceed the amount of the premium in effect as of January 1, 2020.[10]
- Disenroll any individual who is enrolled as of March 18, 2020 (the date of enactment) or who newly enrolls during the public health emergency period for any reason unless the individual is no longer a resident of the state or requests voluntary termination.
- Fail to cover, without cost-sharing, testing services and treatment for COVID-19 in Medicaid, including vaccines, specialized equipment, and therapies.

2. Coverage for COVID-19 Testing Under Medicaid and CHIP with No Cost-Sharing

Under current law, the basic state Medicaid benefit package must include coverage for laboratory services provided in a physician office, clinic, or referral laboratory, as well as those provided in a hospital. States are allowed to impose cost-sharing requirements on some beneficiary populations within federal parameters for these services. Families First specifically addresses cost-sharing in regard to COVID-19 services. Each of these requirements became effective on March 18, 2020, and will continue until the end of the coronavirus public health emergency period.

Section 6004 of the law:

- Specifies that mandatory laboratory services include any tests for the detection of the coronavirus (SARS-CoV-2) or the diagnosis of the virus that causes COVID-19 disease.[11] This mandatory coverage includes not just the test itself, but also the cost of administering the test by a nurse or other practitioner.
- Prohibits any cost-sharing on any Medicaid beneficiary with respect to COVID-19 testing or administration of the test. The prohibition on cost-sharing also applies to "COVID-19 testing-related services for which payment may be made under the State's Medicaid program," which appears to include the physician, clinic, and outpatient hospital visit during which the test was administered. Separately, in section 6008 under the requirements for the FMAP increase, no-cost-sharing may be imposed for COVID-19 treatments in Medicaid as well.
- Requires mandatory coverage of testing and the administration of testing for children and pregnant women covered in CHIP. Similar to Medicaid, separate state CHIP programs are required to cover COVID-19 tests, as well as the administration of those tests and a related visit.

3. State Option to Provide Coverage for Uninsured Individuals

The Kaiser Family Foundation estimates that almost 6 million uninsured Americans are at high risk for serious COVID-19-related illness. The law gives states an option to use Medicaid to pay for COVID-19 testing for these individuals with 100 percent federal reimbursement. Unfortunately, it does not provide coverage for COVID-19-related treatment of individuals covered under this new optional group.

Specifically, section 6004 creates a new Medicaid optional eligibility group: "uninsured individuals." These are individuals who do not fall into a mandatory Medicaid eligibility group category (e.g., low-income children, pregnant women, section 1931 parents, etc.) and are uninsured—that is, not enrolled in a federal health care program,[12] qualified health plan offered through a federal or state-run Marketplace, an employer group health plan, or the plan for federal employees (FEHBP). There is no income or resource limit. The benefits to which they would be entitled are limited to COVID-19 testing and its administration.

If a state opts to cover these individuals, they, like other Medicaid applicants, would be able to enroll in Medicaid through hospitals making presumptive eligibility determinations. In addition, the law provides that these individuals can be enrolled in Medicaid by eligibility workers who may be outstationed at locations like a safety net hospital or community health center.

The costs of testing for these individuals, as well as the state administrative costs of enrolling these individuals in Medicaid, will be matched at 100 percent by the federal government. This option is effective March 18, 2020 and will end at the conclusion of the coronavirus public health emergency period.

The law gives states the option to use Medicaid to pay for COVID-19 testing for uninsured individuals.

Implications for Children and Families

No New Eligibility and Enrollment Requirements or Restrictive Procedures

Maintenance of effort provisions have been previously used during temporary FMAP rate hikes. Under the MOE requirements in Families First, states may not add new eligibility requirements or make it more difficult to enroll during the public health emergency. This is similar to the longstanding MOE in Medicaid and CHIP for children, which is in effect through fiscal year 2027.

In addition, due to the seriousness of the pandemic, states should consider what more they can do to further streamline the application process. For example, states may want to adopt or expand the use of presumptive eligibility to get uninsured individuals into coverage quickly. Additionally, states should consider suspending or eliminating extraneous requirements such as work reporting and premiums that were in place as of January 2020 since those pre-existing barriers are not addressed by the new law.

No Increases in Premiums

As part of the MOE in Families First, states may not introduce new premiums or increase premiums in Medicaid above levels in place as of January 1, 2020 or disenroll people for failure to pay. Only four states (CA, MD, MI, VT) charge premiums in Medicaid for children while five states (AR, IN, IA, MI, MT) charge premiums or monthly contributions on expansion adults. Indiana is the only state that imposes monthly contributions on parents.[13]

Research has shown that premiums are a barrier to enrollment for low-income families. While states may not disenroll individuals for nonpayment of premiums during the emergency declaration, this would be a good time for states to revisit these policies and suspend or eliminate premiums entirely in both Medicaid and CHIP. Doing so will not only help families whose income has been impacted by the economic repercussions of the pandemic but it will likely save administrative costs associated with premium collection.[14]

No Cost-Sharing for Testing or Treatment of COVID-19 in Medicaid

States may not charge any copayments for testing for COVID-19 in either Medicaid or CHIP. However, cost-sharing is widespread with nearly half of states charging copayments to children in Medicaid and CHIP and two-thirds of states charging copayments to parents and expansion adults in Medicaid. States should also consider suspending or eliminating all cost-sharing at a time when many low-income Americans are out of work. This will ease the financial impact on families and remove the administrative burden on providers of collecting premiums at a time when the health sector is also under tremendous stress in dealing with this public health crisis.

No Disenrollment during Emergency Declaration

The fact that states may not disenroll anyone enrolled in Medicaid while the emergency declaration is in effect is one of the strongest consumer protections in the law. But based on the legislative language, the law does not necessarily require states to suspend renewals or periodic reviews of eligibility immediately. They simply cannot disenroll anyone for any reason during the emergency declaration unless the individual moves out of state or requests voluntary termination. It would be prudent for states to suspend both renewals and any periodic reviews in order to direct limited state resources to handle the influx of new applicants, compensate for eligibility workforce shortages, and take other actions to address the pandemic.

Due to the seriousness of the pandemic, states should consider what more they can do to streamline the enrollment process.

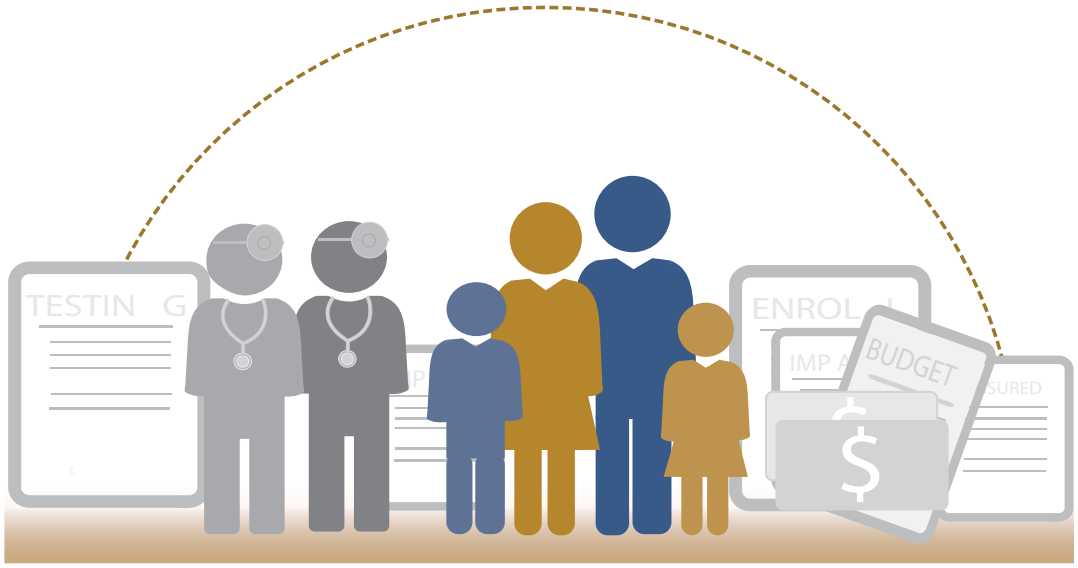
Testing for Uninsured Parents and Other Adults

Many parents and other low-income adults remain uninsured and ineligible for coverage, particularly in states that have not implemented the ACA's Medicaid expansion. State and local public health agencies will receive federal funding for testing and surveillance activities under both COVID-19 response laws enacted so far.[15] Using open-ended federal Medicaid funds to cover testing for the uninsured will free up fixed state appropriations for other public health needs.

States should not procrastinate in submitting a state plan amendment to take up the new option to provide testing to all uninsured individuals, regardless of circumstances. Any delays in identifying, isolating, and treating those who have contracted the virus, with or without symptoms, is a missed opportunity to slow the progression of the pandemic. Moreover, this public health crisis reminds us of the importance of closing the coverage gap for low-income adults.[16] In the 15 states that have not implemented the Medicaid expansion, the median eligibility level for parents is less than half of the poverty level and with the exception of Wisconsin, low-income adults without dependent children are not eligible.

Impact on State Budgets

FMAP increases during public health crises, natural disasters, or economic downturns are intended to help states address higher Medicaid costs resulting from higher enrollment as people lose their jobs or see their hours or wages reduced and become eligible for Medicaid. It also allows for greater financial support to the health care safety net that disproportionately serves Medicaid beneficiaries (and the uninsured) and is likely to face growing, severe stress in coming weeks and months. Moreover, the increased FMAP provides overall fiscal relief to states that may face budget deficits as demand for public services increase and state revenues decline due to the economic downturn. But advocates will need to be on guard for cuts to benefits or provider payments as a way to mitigate budget shortfalls at a time when the nation faces the most significant public health threat in a century.



Unfinished Business

As with any new Medicaid statutory language, additional issues and questions will surface during implementation by CMS and the states. There is scarce time to go through the rule-making process so it will be important for CMS to provide additional information and sub-regulatory guidance to clarify its interpretation of the new law and promptly respond to questions from states and stakeholders.

It is also important to note that the Medicaid and CHIP provisions in Families First are all "temporary"—that is, they are tied to the coronavirus public health emergency declared by the HHS Secretary over a month before the World Health Organization declared a pandemic. The Centers for Disease Control and Prevention (CDC) identifies a number of phases of a respiratory pandemic from initiation and acceleration to peak and deceleration. It notes that different parts of the country can be in different phases at the same time. Notably, the CDC does not say where the United States as a whole, or any individual states, are at this point, or when the pandemic will end. But it does state unequivocally that, "In the coming months, most of the U.S. population will be exposed to this virus."

Even though we do not know how long the pandemic will last in the U.S., or how long the Secretary will keep the public health emergency declaration in place, it is not only reasonable but prudent to assume these provisions will need to be in effect for many months. As a consequence, CMS and the states should implement these provisions as quickly as possible. Rapid implementation will serve both the public health objective of identifying those who become infected so they can be isolated and get treatment, and the fiscal policy objective of blunting the impact of the coming economic downturn on state budgets. Expediting implementation of Families First is absolutely necessary but demonstrably insufficient. The 6.2 percentage point FMAP increase is likely too small to overcome the effects of the coming economic downturn on state budgets; private economists are recommending a ten-percentage point increase that extends beyond the end of the public health emergency to the end of a likely recession.[17] And limiting coverage for "uninsured individuals" to testing without providing treatment for COVID-19 disease is not only illogical, it also promotes and deepens health inequities among the uninsured.

This is not an exhaustive list of actions that the administration should take to ensure that states can leverage the potential impact of Medicaid and CHIP in addressing the pandemic. For example, the administration should withdraw—or Congress should block—a proposed rule related to state Medicaid financing and supplemental payments that would significantly undercut the health and economic benefits of the Families First FMAP increase[18] (and any additional fiscal relief provided by Congress). With the health of the nation at stake, the country's public coverage programs must be leveraged to the maximum extent possible, and all barriers to coverage and access to testing and treatment for COVID-19 should be removed in these challenging times.

This brief was written by Tricia Brooks and Andy Schneider. The authors would like to thank Joan Alker, Cathy Hope, Edwin Park, and Kelly Whitener for their thoughtful input. Design and layout provided by Nancy Magill.

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for America's children and families. CCF is based in the McCourt School of Public Policy's Health Policy Institute.

Endnotes

1 The Families First Coronavirus Response Act can be found at https://www.congress.gov/bill/116th-congress/house-bill/6201/text.
2 After the posting of this brief, the Coronavirus Aid, Relief, and Economic Security Act (CARES) was enacted in response to the coronavirus pandemic. The CARES Act modified some of the provisions in the Families First Act. This explainer has been revised to reflect those modifications. The CARES Act can be found at https://www.congress.gov/bill/116th-congress/house-bill/748/text?q=%7B%22search%22%3A%5B%22h.r.+748%22%5D%7D&r=1&s=1.
3 For additional information on other provisions in the Families First law, see https://www.cbpp.org/blog/families-first-will-strengthen-statesability-to-address-rising-food-needs.
4 Medicaid and CHIP enrollment as of December 2019 reported by the states to CMS can be found at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/reporthighlights/index.html.
5 W. Koma, et al., "How Many Adults Are at Risk of Serious Illness If Infected with Coronavirus," Kaiser Family Foundation, March, 2020, available at https://www.kff.org/global-health-policy/issue-brief/howmany-adults-are-at-risk-of-serious-illness-if-infected-with-coronavirus/.
6 Secretary of the Department of Health and Human Services declared a public health emergency retroactive to January 27, 2020. For more information see https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx.
7 The average 65 percent share of Medicaid program spending was published by the Congressional Budget Office (CBO) on March 6, 2020, available at https://www.cbo.gov/system/files/2020-03/51301-2020-03-medicaid.pdf.
8 Federal guidance on the FMAP bump in the Families First Coronavirus Response Act can be found at: https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf
9 Estimates of the revised CHIP e-FMAP levels for 2020 and 2021 can be found at: https://ccf.georgetown.edu/2020/03/25/cms-guidance-clarifies-that-families-first-covid-19-response-bills-fmap-increase-will-benefit-chip-too.
10 Section 3270 of the CARES Act provides a 30-day grace period for compliance in the case of a state that had a premium increase in effect on the date of enactment of the CARES Act.
11 Section 3717 of the CARES Act struck the requirement that the tests be "approved, cleared, or authorized by the FDA."
12 Section 3716 of the CARES Act clarifies that individuals in some optional Medicaid eligibility groups are still "uninsured individuals" because their Medicaid benefits are limited: TB-infected individuals, women with breast or cervical cancer, women receiving family planning services only, medically needy children receiving ambulatory services only, and pregnant women receiving pregnancy-related services only.
13 T. Brooks, et al., "Medicaid and CHIP Eligibility, Enrollment and Cost-Sharing Policies as of January 2020: Findings from a 50-State Survey," Kaiser Family Foundation, March 2020, avalilable at https://ccf.georgetown.edu/2020/03/26/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/.
14 For more information on how premiums are administered in Medicaid and CHIP, see https://ccf.georgetown.edu/2013/12/04/handle-withcare-how-premiums-are-administered-in-medicaid-chip-and-themarketplace-matters/.
15 "TFAH Applauds Passage of Supplemental Funding for COVID-19 Response: Now Funding Must Move Quickly to States and Other Entities," Trust for America's Health, March 2020.
16 M. Leachman and J. Sullivan, "Some States Much Better Prepared Than Others for Recession," Center on Budget and Policy Priorities, March 2020, available at https://www.cbpp.org/sites/default/files/atoms/files/3-20-20sfp.pdf.
17 M. Zandi, "COVID-19: Darkening Global Outlook," Moody's Analytics, March 2020, available at https://www.economy.com/economicview/analysis/378643/COVID19-Darkening-Global-Outlook.
18 For more information on the impact of the Medicaid Fiscal Accountability Rule, see https://ccf.georgetown.edu/2020/03/18/cmss-hould-withdraw-medicaid-state-financing-and-supplemental-paymentrule-that-undercuts-covid-19-relief-bills-enhanced-federal-medicaidmatch/.

Georgetown University
Center for Children and Families
McCourt School of Public Policy
Box 571444
3300 Whitehaven Street, NW, Suite 5000
Washington, DC 20057-1485
Phone: (202) 687-0880
Email: childhealth@georgetown.edu


ccf.georgetown.edu/blog/


facebook.com/georgetownccf


twitter.com/georgetownccf