Fundamentals of Medicaid and CHIP

Chris L. Peterson
Feb. 11, 2011
Session Agenda: Medicaid & CHIP

- Legal framework: Joint federal/state programs
- Context: Medicaid and State Children’s Health Insurance Program (CHIP) in the U.S. health care system
- How Medicaid works
  - How much do states get? Federal financing
  - Who is covered? Eligibility
  - What is covered? Covered benefits and cost-sharing
  - How much do providers get? State payment policies
  - Pass? Waivers
- How CHIP differs
- What’s next? PPACA et seq.
Medicaid and CHIP Payment and Access Commission (MACPAC)

• History
  – Established February 2009 (Children’s Health Insurance Program Reauthorization Act, CHIPRA)
  – Expanded and funded in March 2010 (PPACA)
  – 1st nonpartisan congressional agency devoted to Medicaid and CHIP

• Statutory charge
  – Review and make recommendations on specific topics
  – Submit reports to Congress on March 15 and June 15 of each year
  – Review and submit reports and/or comments on:
    • Secretarial reports and regulations related to Medicaid and CHIP
    • National and state-specific Medicaid and CHIP data
  – Create early-warning system to identify provider shortage areas and other factors that adversely affect access to care or health status of beneficiaries
  – Report on alternatives to current tort litigation and determine the impact on Medicaid and CHIP programs by 2016
Legal Framework: Joint Federal/State Programs
Joint federal/state programs

- States run day-to-day Medicaid and CHIP program operations and make policy decisions within federal parameters.
- Programs administered at federal level by Centers for Medicare and Medicaid Services (CMS).
- States submit and federal government approves (disapproves):
  - Medicaid and CHIP state plans
  - State plan amendments (SPAs)
  - Waiver applications, renewals
  - Claims for federal reimbursement
Legal framework

- **Medicaid**: Title XIX of the Social Security Act
  - §1900. Medicaid & CHIP Payment & Access Commission (MACPAC)
  - §1902. Federal requirements on Medicaid state plans

- **State Children’s Health Insurance Program (CHIP)**: Title XXI of the Social Security Act
  - §2104. Federal CHIP allotments
  - §2110. Definitions, like “targeted low-income child”

- Federal regulations (42 CFR 430 et seq.)

- “Subregulatory guidance,” such as
  - Letters to State Medicaid Directors (SMDs)
  - Letters to State Health Officials (SHOs)
Context: Medicaid and CHIP in the U.S. Health Care System
Context: Medicaid and CHIP serve millions of people

• Medicaid covers 65+ million people
• CHIP covers 8 million people
• Medicaid and CHIP cover many low-income populations and benefits, such as
  – People for whom other insurance may not be available or affordable
  – Benefits other insurance may not cover (e.g., long-term care, transportation)
  – More than one-third of U.S. children
  – More than 15 million aged, blind and disabled individuals
    • 8+ million dual eligibles (enrolled in Medicare and Medicaid)
  – Another 15 million or more low-income adults
Medicaid & CHIP finance a substantial portion of U.S. health spending

• Medicaid and CHIP pay for:
  – 15% of U.S. health care spending [2009]
    • FY09 Medicaid spending: $381 billion total ($251 billion federal, $130 billion state)
    • FY09 CHIP spending: $11 billion total ($7.5 billion federal, $3.1 billion state)
  – 62% of all long-term care spending [2008]
  – ¼ to ⅔ of U.S. births, depending on state [2007]
  – ¼ of mental health and substance abuse spending [2003]
Medicaid enrollment vs. spending, FY09

- Children: 49% enrollment, 20% spending
- Disabled: 18% enrollment, 44% spending
- Adults: 23% enrollment, 14% spending
- Aged: 10% enrollment, 22% spending

Estimated ENROLLMENT as a share of total
Estimated benefit SPENDING as a share of total
Medicaid and CHIP support provision of care to high-need populations

- Medicaid pays for about 40% of nursing home care and most home and community-based long-term care [2009]
- More than 7 million Medicaid and CHIP enrollees served by health centers in high-need areas [2009]
- Hospitals serving large numbers of low-income and uninsured people receive supplemental payments
Source of funding and economic activity, but also responsibility for states

• Major source of federal funding that might otherwise be borne by state and local governments

• Affects local economies

• Medicaid is largest or 2nd largest item in state budgets, although much smaller when excluding federal government money
  – 21% of TOTAL state budgets
  – 12% of STATE-FUNDED portion of state budgets
How Medicaid Works
How Much Do States Get?

Medicaid Regular FMAPs

[Federal Medical Assistance Percentage]
How Much Do States Get? (example)

Health care provider or plan → State Medicaid office → $1,000

$1,000 claim → FMAP 60% → $600

State share: 40% → $400
Other FMAPs

Medicaid: Not regular FMAP

For example:

- Indian Health Services – 100%
- Family Planning – 90%
- Administrative – Generally 50%

CHIP: Enhanced FMAP (E-FMAP)

- State share
  - 30% reduction in state share

E-FMAP
Who Is Covered?

Pre-PPACA Medicaid Misconception

Federal Poverty Level (FPL)

0%  50%  100%  150%  200%  250%  300%  350%

100% FPL
$10,890
+$3,820
+$3,820
+$3,820

Eligible for Medicaid?

Everybody

MACPAC Medicaid and CHIP Payment and Access Commission
Pre-PPACA Medicaid Income Eligibility

Federal Poverty Level (FPL)

CHIP: Most states at 200% FPL

Mandatory

Category

- Pregnant women
- Infants
- 1-5-year-olds
- 6-18-year-olds
- Elderly
- Disabled
- Parents
- Childless Adults

CHIP: Most states at 200% FPL
General Medicaid Eligibility Requirements

• Only citizens and qualified aliens can receive full Medicaid benefits
  – Previously, aliens had to reside in U.S. for at least 5 years to be eligible for full benefits
  – Since 2009, states can opt to cover children and pregnant women during this “5-year bar”

• Some groups eligible for only limited benefits
  – Nonqualified aliens who meet all other eligibility criteria can only receive limited emergency Medicaid benefits
  – Other limited-benefit eligibility pathways include family planning, Medicare cost-sharing

• Coverage of long-term care services may require meeting functional criteria (e.g., problems getting out of bed)

• Eligible individuals are entitled to coverage
What Is Covered?

**Mandatory Medicaid Benefits**

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic (RHC) services
- Federally qualified health center (FQHC) services
- Laboratory and x-ray services
- Nursing facility services (for ages 21 and over)
- Early and periodic screening, diagnosis and treatment (EPSDT) for individuals under age 21
- Family planning services and supplies
- Tobacco cessation for pregnant women
- Medical/surgical dental services (not regular dental services)
- Physician services
- Home health services
- Nurse midwife services (as authorized under state law or regulation)
- Nurse practitioner services (as authorized under state law or regulation)
- Freestanding birth center services
What Is Covered?

Optional Medicaid Benefits

- Medical/remedial care provided by licensed practitioners per state law
- Private duty nursing services
- Clinic services
- Dental services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, & language disorders
- Prescribed drugs
- Dentures, prosthetic devices, and eyeglasses
- Diagnostic, screening, preventive and rehabilitative services
- Inpatient hospital services, nursing facility services, and intermediate care services for individuals age 65 or older in institutions for mental diseases
- Intermediate care facility services for individuals with developmental disabilities
- Nursing facility services, other than institutions for mental disease
- Inpatient psychiatric services for individuals under age 21
- Hospice
- Personal care services
- Primary care case management services
- Case management services
- Home or community based-services
- Home and community-based services for individuals age 65 and over
- Respiratory care for ventilator-dependent individuals
- Services furnished in a religious nonmedical health care institution
- Skilled nursing facility services for individuals under age 21
Mandatory vs. Optional Mandatory Spending (2001)

Source: Figure 4, Anna Sommers et al., Medicaid Enrollment and Spending by “Mandatory” and “Optional” Eligibility and Benefit Categories, Kaiser Commission on Medicaid and the Uninsured Report 7332, June 2005.
What Is Covered? Benefit Standards

• Amount, duration and scope
  – “Sufficient … to reasonably achieve its purpose”
  – States have flexibility even for mandatory benefits, except EPSDT for children

• Comparability—same benefits for all enrollees

• Statewideness—same benefits regardless of place of residence within state

• Freedom of choice—providers choose whether to participate; enrollees can choose among participating providers
What Is Covered? Enrollee Cost-Sharing

• No cost-sharing for these exempt groups:
  – Children under age 18
  – Pregnant women’s pregnancy-related services
  – Beneficiaries receiving hospice care
  – Beneficiaries in nursing facilities and intermediate care facilities for the mentally retarded, and certain enrollees in hospitals and other medical institutions

• No cost-sharing for these exempt services:
  – Emergency services
  – Family planning services and supplies
  – Items and services provided to an Indian by an Indian health care provider
## Non-Exempt Enrollee Cost-Sharing

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<thead>
<tr>
<th></th>
<th>Up to 100% FPL</th>
<th>101%-150% FPL</th>
<th>Over 150% FPL</th>
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<tr>
<td><strong>Cap</strong></td>
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<td></td>
<td>Cost-sharing may not exceed 5% of family’s monthly/quarterly income</td>
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<tr>
<td><strong>Premium</strong></td>
<td>No</td>
<td>No</td>
<td>Up to $19 a month</td>
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<td><strong>Non-Institutional Services</strong></td>
<td>Deductible: Up to $2.30</td>
<td>Deductible: Up to $2.30</td>
<td>Deductible: Up to $2.30</td>
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<tr>
<td></td>
<td>Coinsurance: Up to 5%</td>
<td>Coinsurance: Up to 10%</td>
<td>Coinsurance: Up to 20%</td>
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<td></td>
<td>Copayment: Up to $3.40</td>
<td>Copayment: Up to $3.40</td>
<td>Copayment: Up to $3.40</td>
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<td><strong>Institutional Services</strong></td>
<td>Up to 50% of payment for the first day of care per admission</td>
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<tr>
<td><strong>Non-Emergency Care in ER</strong></td>
<td>Copayment: Up to $3.40</td>
<td>Copayment: Up to $6.80</td>
<td>No limit (subject to 5% cap)</td>
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<td>($6.80 with a waiver)</td>
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<td><strong>Prescribed Drugs</strong></td>
<td>Up to $3.40 copayment or up to 5% coinsurance</td>
<td>Up to $3.40 copayment or up to 5% coinsurance</td>
<td>Preferred: Up to $3.40 copayment or 5%</td>
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<td>Non-preferred: Up to 20% of drug cost</td>
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How Much Do Providers Get?
State Payment Policies: FFS vs. MCO

• Fee for service—State sets amounts it will pay providers; state is billed, pays for services

• Managed care—State pays premiums to plans; plans/managed care organizations (MCOs) pay providers

• Almost half (47%) of Medicaid enrollees are in managed care plans with comprehensive benefits, which exist in all but 14 states (AK, AL, ID, IA, LA, MS, MT, NH, NC, ND, OK, SD, UT, WY)
How Much Do Providers Get?
Provider Payment Rates

- §1902(a)(30)(A)
  - Safeguard against overutilization
  - Payments consistent with efficiency, economy, quality
  - Sufficient to enlist enough providers …

- On average, Medicaid pays hospitals 98% of what Medicare pays [AHA]

- On average in 2008, FFS Medicaid pays drs 72% of Medicare—ranging from 41% (NJ) to 143% (WY) [Zuckerman, *Health Affairs*]

- Medicaid managed care plans negotiate provider payment rates
Pass? Waivers

- Used to waive certain provisions in federal law
- HHS Secretary must approve
- Cannot increase federal spending
- 1115 research and demonstration waivers—approved in almost all states, to waive eligibility, benefits, many other federal provisions
- 1915(b) “freedom of choice” waivers—approved in more than half of states to permit managed care enrollment that waives freedom of choice, statewideness, comparability
- 1915(c) home & community based services (HCBS)—approved in every state to waive comparability, statewideness
How CHIP Differs from Medicaid
Comparing CHIP and Medicaid

For Enrollment, Medicaid is 8 Times Larger Than CHIP

For Spending, Medicaid is 35 Times Larger Than CHIP
Impact of CHIP

Percentage Point Change in Health Insurance, 1997-2010
Among Those With Income 100%-199% FPL

Source: National Health Interview Survey
How CHIP Differs from Medicaid: Coverage

- CHIP pays for children above each state’s 1997 Medicaid income-eligibility levels
  - States choose CHIP upper-income eligibility
  - Highest are New York (400% FPL) and New Jersey (350% FPL)
  - 17 states and DC are at 300% FPL
  - 28 states are between 200%-275% FPL
  - Lowest are Idaho (185%), Alaska (175%), S. Dakota (160%)

- Two options for creating CHIP programs
  - Medicaid-expansion CHIP [Medicaid rules, CHIP financed]
  - Separate CHIP [CHIP rules, CHIP financed]
    - No individual entitlement to coverage; states can cap enrollment, institute waiting periods
    - States have more benefit and cost-sharing options
  - Can have both types—“combination”
CHIP Enrollment Facts

• Title XXI calls CHIP-enrolled children “targeted low-income children” [7.7 million]

• Adult coverage in CHIP [#s from FY09]
  – Waiver coverage of parents and childless adults
    • Childless adult coverage ended 12/31/09 [260,000]
    • Parent coverage phasing out by FY2014 [236,000]
  – Coverage of pregnant women and unborn children
    • Waiver coverage [8,000]
    • Unborn children [390,000]
    • Targeted low-income pregnant women
How CHIP Differs from Medicaid: Financing

• States’ CHIP spending reimbursed from capped federal CHIP allotments at E-FMAP
  – Possible for states to experience “shortfalls”
  – Less than $1 billion appropriated in FY06-07 for shortfalls [10-year BBA97 period, FY98-07]

• Since CHIPRA, allotment formula better targeted to actual state spending
  – For FY2010, federal CHIP allotments of $10.1 billion
    • Plus prior-year unspent balances of $5.2 billion
    • States spent $7.9 billion in federal CHIP funds
  – For FY2011, federal CHIP allotments of $8.5 billion

• Federal CHIP appropriations only through FY15
What’s Next?

PPACA (P.L. 111-148)
March 23, 2010

As amended by reconciliation (P.L. 111-152)
and others
1. Maintenance of effort (MOE): “a State shall not have in effect eligibility standards, methodologies, or procedures” more restrictive than those in effect at PPACA’s enactment
   - For adults: Until exchanges operational (2014)
   - For children: Until 10/1/2019 (includes CHIP)

2. Option to 133%+ FPL at regular FMAP
   - Under age 65,
   - Not pregnant, and
   - Ineligible for Medicare
PPACA Medicaid: Who, Immediately

1. Maintenance of effort
2. Nonelderly option to 133% + FPL at regular FMAP

Note: Eligibility in new pathway not on the basis of being a parent, disabled, etc.
PPACA Medicaid: Who, 2014

1. Mandatory expansion to nonelderly adults (& 6-18-year olds) up to 133% FPL
2. Adult MOE expires

Note: Eligibility in new pathway not on the basis of being a parent, disabled, etc.
Enrollment in millions. Source: CBO
### PPACA Medicaid: How Much, 2014

#### FMAPs

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<td>All states</td>
<td>Newly eligible</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>94%</td>
<td>93%</td>
<td>90%</td>
</tr>
<tr>
<td>Expansion states</td>
<td>Already eligible childless adults</td>
<td>75%-90%</td>
<td>80%-92%</td>
<td>85%-94%</td>
<td>86%-92%</td>
<td>90%-93%</td>
<td>93%</td>
<td>90%</td>
</tr>
<tr>
<td>All states</td>
<td>All others</td>
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‘Newly eligible’ = generally not eligible on 12/1/09

‘Expansion state’ = covered parents and childless adults in Medicaid/state-only at 100% + FPL on 3/23/10:
Perhaps AZ, DC, DE, HI, ME, MA, MN, NY, PA, VT, WA, WI
Other PPACA Provisions, p. 1

- Newly eligible adults get benchmark package, not (necessarily) “full Medicaid”
  - Benefit package may look more like private health insurance for adults
  - Cost-sharing may apply at state option

- Primary care services provided by certain doctors must be paid at Medicare rates in 2013-2014; difference above state’s 7/1/09 level fully paid for by federal government
Other Provisions, p. 2

- CHIP $ extended by 2 years, thru FY2015
- Screen and enroll: Beginning 2014, if people applying for exchange credits are found eligible for Medicaid or CHIP, they will be enrolled in Medicaid or CHIP
- Beginning 2014, standardized income definition (Modified Adjusted Gross Income—MAGI), with exceptions. Also 5% FPL disregard
- Proposed regulation: 90% FMAP for eligibility systems upgrades
Questions