

CHANGES TO MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM UNDER THE AFFORDABLE CARE ACT



ELIGIBILITY FOR MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM

Medicaid eligibility changes in the Affordable Care Act (ACA) are best understood in the context of the goal for health care reform: that, after 2014, nearly everyone would have either public or private health coverage. At that time, a single system for screening individuals and families for eligibility, enrolling them in individual private plans or public coverage, and ensuring smooth transitions across coverage types became available in the form of the health insurance marketplaces or exchanges.

Several important provisions of the ACA went into effect in 2014.

- Medicaid programs could cover people with income below 138% of the federal poverty level (FPL).¹
- Children and youth who had been enrolled in the Children's Health Insurance Program (CHIP) and whose family income was below 138% of the FPL were shifted to Medicaid, which expanded their access to certain services because of Medicaid's unique Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit (see Section 5).
- Young people who were in foster care when they turned 18 became eligible to maintain their Medicaid benefits until age 26. The aim of this extended eligibility is to help ease the transition from foster care to adulthood, including access to higher education and employment, by guaranteeing continued health care coverage.²

Finally, states were given a new option to offer CHIP coverage to eligible children of state employees. Previously, it was assumed that all state employees had access to affordable coverage, and thus this group of children and youth was barred from enrolling in CHIP. Under the ACA, if a state can demonstrate that it has maintained

1. The ACA language sets the eligibility limit at 133% of the federal poverty level (FPL) in 2014, but then instructs states to disregard an amount of income that brings the household to 138% of the FPL. ACA, §2001(a); Health Care and Education Reconciliation Act, Pub. L. No. 111-152 §1004(e). <https://www.govinfo.gov/content/pkg/PLAW-111publ152/html/PLAW-111publ152.htm>

2. Wilson-Simmons, R., Dworsky, A., Tongue, D., & Hulbutta, M. (2016). *Fostering Health: The Affordable Care Act, Medicaid, and Youth Transitioning from Foster Care*. New York: National Center for Children in Poverty, Columbia University Mailman School of Public Health. Retrieved May 12, 2021, from https://www.nccp.org/wp-content/uploads/2016/10/text_1165.pdf

its own contribution toward family coverage but that annual premiums and cost sharing for a family exceed 5% of their income, children of low-income state employees can enroll in CHIP.

The ACA also includes a “maintenance of effort” (MOE) provision that prohibits states from reducing Medicaid or CHIP eligibility limits below those that were in effect when the ACA was enacted on March 23, 2010. MOE was required for adults until 2014 and for children and youth under age 19 through September 30, 2019.³

Under the ACA, people whose incomes exceed the limit for Medicaid or CHIP eligibility and who do not have access to employer-sponsored insurance can purchase private coverage through a health insurance marketplace (also known as an exchange). Marketplace enrollees are eligible for federal help with the cost of coverage if their income is below 400% of the FPL. Anyone who applies through the marketplace and is found to be eligible for Medicaid or CHIP will be referred to or enrolled in the appropriate program.

The manner in which states calculate Medicaid and CHIP eligibility for most people was another important change under the ACA.⁴ In 2014, states began determining Medicaid or CHIP eligibility by counting a family’s income using a formula called Modified Adjusted Gross Income (MAGI). MAGI changes two key factors in the eligibility calculation: the definition of “household” (which affects whose income counts in the eligibility calculation) and the deductions from income that applicants can take when calculating eligibility.

The shift to MAGI in calculating eligibility for Medicaid and CHIP aligns with the calculation used to determine eligibility for premium subsidies in the ACA-created health insurance marketplaces. This makes any transition between Medicaid, CHIP, and the marketplaces—all of which are income-sensitive—easier for both consumers and coverage administrators.

With a consistent definition of income used to calculate eligibility for Medicaid, CHIP, and marketplace insurance plans, a single application can be used to determine eligibility for any of these programs.

The change in calculating eligibility for Medicaid did not affect many people who have special health care needs, including:

- Children, youth, or adults who qualify for Medicaid due to disability or because they receive SSI or are low-income and over the age of 65;
- People receiving long-term care services, Home and Community-Based waiver services, home-health or personal-care services, or other home- and community-based services; and
- Children and youth who qualify for Medicaid under the TEFRA/Katie Beckett option (see Section 11) or because they are in foster care.⁵

Finally, the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the ACA also include provisions to simplify and improve enrollment in Medicaid and CHIP, including provisions that require or allow states to:

- Establish a system of enrollment and enrollment renewals via a website as well as by phone or in person.
- Coordinate the determination of Medicaid or CHIP eligibility along with the determination of eligibility for tax credits to purchase private insurance in the marketplaces.
- Conduct outreach to vulnerable populations, including families with CSHCN, to encourage enrollment in Medicaid and CHIP.
- Permit hospitals to make “presumptive eligibility” determinations for Medicaid, to be verified later by the state Medicaid program.

3. Center for Medicaid, CHIP and Survey & Certification. (2011). Maintenance of Effort. Retrieved May 12, 2021, from <https://www.medicaid.gov/federal-policy-guidance/downloads/smd11001.pdf>

4. The ACA language sets the eligibility limit at 133% of the FPL in 2014, but then instructs states to disregard an amount of income that brings the household to 138% of the FPL. Affordable Care Act, §2001(a); Health Care and Education Reconciliation Act, Pub. L. No. 111-152 §1004(e). <https://www.govinfo.gov/content/pkg/PLAW-111publ152/html/PLAW-111publ152.htm>

5. National Health Law Program (NHeLP). (n.d.). *NHeLP Analysis of the Health Care Reform Law: PPACA and the Reconciliation Act, Part II: Role of Public Programs*, p. 9. Retrieved May 12, 2021, from <https://healthlaw.org/resource/nhelp-analysis-of-the-affordable-care-act-and-the-reconciliation-act/>

- Permit Medicaid and CHIP eligibility for children and youth to be decided by public “express lane” agencies—i.e., agencies that use household income to determine eligibility for other federal programs such as the Women, Infants, and Children nutrition program; subsidized housing; and school lunch programs.⁶

COVERED SERVICES FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Under the ACA, states are encouraged or required to adjust benefits in numerous ways. Significantly, EPSDT became available to more children and youth in 20 states in 2014⁷ because Medicaid eligibility for children and adolescents ages 6 to 19 increased in those states to 138% of the FPL, shifting many children and youth from CHIP to Medicaid.⁸ The remaining states already covered these children and youth under Medicaid.

Depending on the benefits covered by their state’s CHIP program, children and adolescents ages 6 to 19 also became newly eligible for assistance with nonemergency transportation for medical appointments. Another important service change under the ACA is that families of terminally ill children and youth who are enrolled in Medicaid or CHIP may elect to receive hospice care without having to forgo potentially curative care. (For more information about concurrent care, see the Catalyst Center’s ACA fact sheet, available at <https://ciswh.org/resources/affordable-care-act-fact-sheets-families/>).

FINANCING CHANGES

As described above, many more people became eligible for Medicaid in 2014. The federal government financed health coverage for newly eligible people at 100% through 2016, after which the federal matching rate began to phase down annually from 100% to 90% in 2020.

Unlike Medicaid, federal funds for the CHIP program are capped, with the capped amount based on a state’s recent CHIP spending and growth. States have two years to spend their allotted funds. Regardless of program design, the federal government reimburses states’ CHIP spending at a matching rate higher than that for Medicaid.^{9,10}

In 2018, the HEALTHY KIDS Act extended federal CHIP funding through fiscal year (FY) 2023; later that year, the Bipartisan Budget Act of 2018 funded CHIP through 2027.¹¹

The ACA offers state Medicaid programs significant financial incentives to improve the quality of health care while controlling costs. These opportunities include:

- Expanded access to preventive care;
- Care for people with disabilities in the community instead of in institutions;
- Restructuring provider payment arrangements to include incentives to improve health outcomes; and
- Creating “health homes” for people with certain chronic health conditions. As explained below, health homes are similar to medical homes.

6. Children’s Health Insurance Program Reauthorization Act of 2009, P.L. 111-3, §203, codified in 42 U.S.C. §1396a(e)(13) and §1397gg(e)(1)(B) <https://www.govinfo.gov/app/details/PLAW-111publ3>

7. The 20 states were Alabama, Arizona, California, Colorado, Delaware, Florida, Georgia, Kansas, Mississippi, Nevada, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Tennessee, Texas, Utah, West Virginia, and Wyoming. Farrell, K., Hess, C., & Justice, D. (2011). *The Affordable Care Act and Children with Special Health Care Needs: An Analysis and Steps for State Policymakers*, p. 25. Retrieved May 12, 2021, from <https://ciswh.org/resources/the-affordable-care-act-and-children-with-special-health-care-needs-an-analysis-and-steps-for-state-policymakers/>

8. The ACA language sets the eligibility limit at 133% of the poverty level in 2014, but then instructs states to disregard an amount of income that brings the household to 138% of the poverty level. Affordable Care Act §2001(a); Health Care and Education Reconciliation Act, Pub. L. No. 111-152 §1004(e). <https://www.govinfo.gov/content/pkg/PLAW-111publ152/html/PLAW-111publ152.htm>

9. For the enhanced CHIP federal match rate in FY 2021 by state, see <https://www.macpac.gov/publication/federal-medical-assistance-percentages-fmaps-and-enhanced-fmaps-e-fmaps-by-state-selected-periods/>

10. For the Medicaid federal match rate in FY 2021 by state, see <https://www.macpac.gov/publication/federal-medical-assistance-percentages-fmaps-and-enhanced-fmaps-e-fmaps-by-state-selected-periods/>

11. Medicaid and CHIP Payment and Access Commission (MACPAC). (n.d.) CHIP financing. Retrieved May 129, 2021, from <https://www.macpac.gov/subtopic/financing/>

SERVICE DELIVERY

Health reform offers state Title V programs opportunities to realign health care delivery for children and youth with special health care needs (CYSHCN), promoting high-quality care rather than simply a high volume of services. For example:

- Beginning in January 2011, states had a new option to implement health homes for Medicaid-eligible children, youth, and adults with chronic conditions to better integrate physical and mental health, coordinate care, and promote efficiencies.¹²
- Health homes, as established in section 2703 of ACA, receive a 90% federal match for the first two years of operation. After that, the state receives its regular Federal Medical Assistance Percentage (FMAP) for the health-home-enrolled population. To be considered a health home, a practice or clinic must offer comprehensive care management, patient and family support, comprehensive transitional care from a hospital or institution to home, referrals to community and social support services, use of health information technology to link services, care coordination, and health promotion.
- Health homes can be implemented through a contract either with a managed care organization or directly between the Medicaid program and a practice or clinic. States have broad flexibility in designing health homes and may claim the 90% match for health-home-related services provided to people who have serious and persistent mental health conditions or two or more of the following: a mental health condition, substance use disorder, asthma, diabetes, or heart disease, or who are overweight. With approval from CMS, states may specify additional conditions, such as autism and pediatric asthma.¹³
- The ACA also contains language to implement state-level demonstration projects for pediatric accountable care organizations (ACOs). ACOs are provider organizations that aim to align financial incentives with better health outcomes for patients. For example, a hospital might partner with physician practices to contract with Medicaid or an insurer to share any savings that result from better management of chronic diseases or a reduction in emergency department visits.¹⁴
- Many state Medicaid programs have applied for newly available grants designed to create incentives for healthy behaviors and prevent chronic diseases.¹⁵ From 2011 to 2015, 10 states received grants as part of the Medicaid Incentives for the Prevention of Chronic Diseases Model. A list of participating states and the final evaluation report are available at <https://innovation.cms.gov/innovation-models/mipcd>.

12. Affordable Care Act, §2703, *State option to provide health homes for enrollees with chronic conditions*. See also Center for Medicaid, CHIP and Survey & Certification. (2010, Nov. 16). *Health Homes for Enrollees with Chronic Conditions*. [Letter to State Medicaid Directors and State Health Officials from Cindy Mann: SMDL# 10-024 ACA # 12]. Retrieved May 12, 2021, from <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10024.pdf>

13. See Center for Medicaid, CHIP and Survey & Certification. (2010, Nov. 16). *Health Homes for Enrollees with Chronic Conditions* [Letter to State Medicaid Directors and State Health Officials from Cindy Mann: SMDL# 10-024 ACA # 12]. Retrieved May 12, 2021, from <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10024.pdf>

14. NC-PFCMH, NASHP, and the Catalyst Center. 2017. Supporting Title V and Medicaid Collaboration in Pediatric Medical Home Implementation. https://youtu.be/R_k_XHSq1IE

15. See Centers for Medicare & Medicaid Services, *Medicaid Incentives for Prevention of Chronic Diseases Program*, at <https://innovation.cms.gov/initiatives/mipcd/>



TEST YOUR KNOWLEDGE

- 1. Starting in 2014, children who turn 18 while in foster care are eligible for Medicaid until they are how old?**
 - a. 19
 - b. 21
 - c. 26
 - d. 28

- 2. Under the Affordable Care Act, if a state has opted to implement the Medicaid expansion, most people under 65 became eligible for Medicaid in 2014, if:**
 - a. They have a disability
 - b. They are under 21
 - c. They are a parent
 - d. They are an adult without children at home
 - e. They are any of the above (it doesn't matter which) and their income is under 138% of the federal poverty level

- 3. CHIP is different from Medicaid because:**
 - a. CHIP enrolls children and Medicaid does not
 - b. The amount of money a state receives for CHIP is capped, but Medicaid funds are not capped
 - c. The federal matching rate (FMAP) is lower for CHIP than for Medicaid
 - d. CHIP is only for children age 0 to 5, while Medicaid serves all ages

- 4. The opportunity for Medicaid programs to develop health homes for people with chronic conditions in the Affordable Care Act is funded with:**
 - a. 75% federal matching dollars over four years
 - b. 80% federal matching dollars over three years
 - c. 100% federal dollars over one year
 - d. 90% federal matching dollars over two years



FIND OUT IN YOUR STATE

- 1. How does your state coordinate enrollment in Medicaid, CHIP, and Marketplace?**
- 2. Has your state developed (or is it developing) a state plan amendment for health homes?**
- 3. What is the FMAP for Medicaid and CHIP in your state?**

ANSWER KEY

1. c 2. e 3. b 4. d

This document is part of Medicaid and CHIP: A Tutorial on Coverage for Children and Youth with Special Health Care Needs (CYSHCN). The document is available in its entirety at <https://ciswh.org/resources/Medicaid-CHIP-tutorial>

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