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IMPROVING FINANCING OF CARE for Children & Youth WITH SPECIAL HEALTH CARE NEEDS

What's the Deal with MOE?

States want to cut Medicaid spending. Are CYSHCN at risk?

Q: I've been hearing a lot about how states are pressuring the federal government to get rid of the maintenance of effort (MOE) provisions in health care reform. I'm worried that children with special health care needs might be at risk for losing their Medicaid coverage if that happens. What do I need to know about this issue?

A: It's a cruel fact that in times of high unemployment such as we are experiencing now, more people become eligible for coverage through Medicaid because of a loss of income. At the same time states are less able to afford higher numbers of enrollees because they are collecting fewer taxes and fees that help fund their share of the program. Most states (at least 45[1]) and the District of Columbia are facing serious budget deficits in FY12, and difficult cuts in state spending are being considered just about all over. Every past issue of our own Week in Review has highlighted state budget issues in some way, but the place where tension appears to be among the highest is in Medicaid. Why is Medicaid such a popular focal point for reducing state spending, especially if citizens who have lost not only their jobs but their access to employer-sponsored health insurance need it more than ever? It's often cited as the single biggest line item in any state's budget, so that understandably draws attention to it.[2] However, Medicaid isn't the "budget buster" it may appear to be. Funding for Medicaid is a federal-state collaboration. Once the federal government's contribution (also known as the "federal match") is factored in, Medicaid is no longer the largest single slice of the state budget pie.[3] However, it's still a substantial amount. As the enhanced Medicaid funding states have been receiving from the federal government under the American

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[1]McNichol, E., Oliff, J. and Johnson, N. Center for Budget and Policy Priorities (2011). *States continue to feel recession's impact*. Retrieved 2/28/11 from http://www.cbpp.org/cms/index.cfm?fa=view&id=711

[2]National Association of State Budget Officers (2010). *State expenditure report 2009*. Retrieved 2/28/11 from http://www.nasbo.org/publications/stateexpenditurereport/tabid/79/default.aspx

[3]Ibid.

Boston University School of Public Health • Health & Disability Working Group
715 Albany Street, Boston, MA 02118 • Tel: 617-638-1930 • Fax: 617-638-1931 • http://www.catalystctr.org

Recovery and Reinvestment Act (ARRA) comes to an end June 30th and the effects of the Great Recession continue, states are looking for savings everywhere they can.

Q: How do states want to cut back on Medicaid?

A: There are several strategies for reducing Medicaid spending that have worked for states during tough times in the past. One is cutting back on eligibility for Medicaid. The federal government requires that states cover certain populations (known as mandatory eligibility groups) in order to receive their federal funding match. States have flexibility in covering other populations if they choose to; these are called optional eligibility groups. (See the sidebar on page 3 for more information on mandatory and optional groups.) Many states want to drop optional groups from eligibility to reduce the number of enrollees, which in turn will reduce the state's Medicaid spending. The number of Medicaid and CHIP enrollees in optional populations is not insignificant. The Georgetown University Center for Children and Families (http://ccf.georgetown.edu) issued a report in February 2011 which estimated that approximately 35 percent of Medicaid and CHIP beneficiaries (including 14.1 million children) are members of optional groups and so would be at risk for losing their health care coverage if states were allowed to drop them. Children with special health care needs (CSHCN) who qualify for Medicaid through the Supplemental Security Income (SSI) program are safe, but those who qualify through waivers, buy-in programs, medically needy programs and other optional, disability-

What are the MOE Maintenance of Effort provisions?

The Maintenance of Effort (MOE) provisions under both the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA) require states to keep the eligibility criteria for their Medicaid and Children's Health Insurance Program (CHIP) that they had in place on March 23, 2010, the day the ACA was signed into law*. Under MOE, states cannot make it more difficult to enroll in or renew Medicaid or CHIP coverage. The MOE provisions under the ACA are in place for adults until 2014, when the state exchanges are scheduled to go into operation and income eligibility for Medicaid expands to 133 percent of the Federal Poverty Level (FPL). For children in Medicaid and CHIP, the MOE provisions are in effect for much longer; until September 30, 2019. States who violate the MOE provisions risk losing their federal funding match.

*States can expand eligibility and improve application, enrollment and renewal processes under MOE; they cannot reduce them or create new administrative barriers.

related pathways could be at risk, as would all children who are currently covered above the mandatory income limit for their age group. Recently, the Catalyst Center reviewed the Medicaid Statistical Information System (MSIS) State Summary Datamart[4] for the number of children under age 20 in medically needy programs and Home and Community-based Service (HCBS) waivers. The total was over 900,000 and didn't include all disability-related categories of eligibility or children currently enrolled above the mandatory income limits.

Q: Where do the maintenance of effort (MOE) provisions come in?

A: There's hope for protecting the hard-won gains of recent years in covering children. The maintenance of effort (MOE) provisions in both the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA) prevent states from reducing their eligibility criteria for both mandatory and optional popula-

[4]Retrieved 2/10/11 from http://msis.cms.hhs.gov/

Mandatory and optional eligibility populations:

What groups must states cover in their Medicaid programs?

What groups can they choose to cover?

Medicaid eligibility is complicated because it includes both categorical and financial eligibility criteria. It differs from state to state because there is also some flexibility around including optional groups and somewhat higher incomes. The foundation of Medicaid eligibility is the mandatory groups, which include several broad categories:

- Children under age 1 whose family income is at or below 133% of the FPL
- Children ages 1-5 whose family income is at or below 100% of the FPL
- Pregnant women whose family income is at or below 133% of the FPL
- Adults in very low income families with dependent children
- Children and adults with disabilities who receive Supplemental Security Income (SSI)*
- Recipients of adoption assistance and children in foster care under Title IV-E of the Social Security Act
- Persons with low income who are blind
- Some low income seniors

States that do not cover mandatory eligibility groups run the risk of losing their federal funding match. For a more comprehensive description of mandatory eligibility groups, visit the Centers for Medicare and Medicaid Services (CMS) website at http://www.cms.gov/MedicaidEligibility/03_MandatoryEligibilityGroups.asp

For a comprehensive description of optional eligibility groups, visit the CMS website at http://www.cms.gov/MedicaidEligibility/04_OptionalEligibility.asp

* SSI recipients are not automatically eligible for Medicaid in every state. In what is known as 209(b) states, there are stricter disability criteria for Medicaid coverage than in the SSI program. The following are 209(b) states: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia.

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tions[5]. Under MOE, states are also prohibited from making changes to their Medicaid application, enrollment and renewal processes that in effect put up barriers and keep otherwise eligible individuals out of Medicaid. (See the sidebar on page 2 for a more complete description of MOE.)

While advocates for health care coverage have viewed MOE as a vitally important protection in challenging economic times for vulnerable populations like children, seniors and people with disabilities, many policymakers confronting painful cuts in other areas of state spending have found it frustrating. In January of this year thirty-three governors got together and asked the U.S. Department of Health and Human Services (HHS) for an exemption from it. Some legislators have been pushing for outright repeal of MOE.

There is something of an 'out' within the MOE provision itself that you may have heard of. Section 1902(gg)(e) of the Social Security Act, amended by Section 2001(b) of the ACA gives states the option from January 1, 2011 to December 31, 2013 to submit a certification to HHS that they have a budget shortfall for the current state fiscal year and/or project one for the next. The Medicaid MOE provision could then be exempted only for adults who are not otherwise eligible for mandatory coverage because of pregnancy or disability and whose income is above 133 percent of the Federal Poverty Level (FPL). A letter dated February 25, 2011 from CMS to state Medicaid directors provides a template for submitting certification of a budget shortfall as well as additional guidance on aspects of MOE.

Q: So if almost every state has a budget shortfall, why don't they all just go for this certification?

A: There are limits both on what states can do under the budget shortfall certification and how many people it would apply to. In addition to submitting certification to HHS, a state plan or waiver amendment approved by CMS is still required to cut eligibility for this group, and all other applicable rules must still be followed, such as providing timely notice of coverage termination and the right to appeal. Currently, there appear to be only seven states[6] that cover adults who are not pregnant or disabled with income over 133% of FPL and who could be at risk for losing Medicaid coverage under this exemption of MOE[7] and not all of them are interested in cutting

[5]This article concentrates on the Medicaid MOE provisions in ACA. To learn more about how the ARRA and ACA MOE provisions intersect with one another, see the February 25,2011 letter from the Centers for Medicare and Medicaid Services to state Medicaid directors at http://www.cms.gov/smdl/downloads/SMD11001.pdf

[6]States that cover childless adults with income up to 133% of FPL include Arizona, Delaware, Hawaii, Massachusetts, Maine, New York and Vermont.

[7]Holohan, J. and Headen, I. Kaiser Family Foundation (2010). *Medicaid coverage and spending in health reform: National and state-by-state results for adults at or below 133% of FPL*. Retrieved 2/28/11 from http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf

Medicaid eligibility as a way to reduce spending. It's important to note that all children (whether covered through the state plan or a waiver) and adults who are enrolled in Medicaid based on disability are NOT subject to this MOE exemption; they must continue to be covered or states risk losing their federal matching funds.

Q: If HHS isn't giving waivers of MOE, how did Arizona get one?

A: Arizona didn't get an MOE waiver. The word "waiver" has been used in a couple of different contexts under this topic. The request by governors to HHS has been described in many places as a request for a waiver or exemption from the MOE provisions. This request has not been granted; in fact, there's uncertainty about whether HHS even has the authority to do so. What you've heard about Arizona is in the context of a Medicaid 1115 demonstration waiver, which is a type of Medicaid project.

The February 25th letter from CMS mentioned above included additional guidance to states on how the Medicaid MOE provisions apply to Section 1115 demonstration projects. Let's start with a little background information on what Medicaid waivers are. States are required to submit to CMS what is called a State Plan, describing in detail how they will meet their responsibilities under the federal-state partnership with regard to mandatory eligibility categories and benefits. They also include information on what eligibility and benefit options they've chosen to include in their Medicaid program. Waivers and demonstrations provide a mechanism outside the State Plan for policymakers to exercise some further flexibility in designing their Medicaid program to meet the particular needs of their citizens. Federal rules governing Medicaid require that states offer the same benefits to all enrollees, and the benefits must be provided throughout the state, not just in certain areas. But sometimes states want to offer more or different benefits to certain enrollees who have specific needs or as a way of saving the state money by providing the same or better care in a less expensive community setting. States can apply to CMS for a waiver of these rules, hence the term.

There are several kinds of Medicaid waivers, depending on which federal rule is being waived. A Section 1115 Research and Demonstration project is a type of waiver that can be thought of as an experiment – it's a way for states to try out certain kinds of benefits or ways of providing care to Medicaid enrollees while evaluating the pros and cons of doing so. Both waivers and demonstrations have expiration dates included in them when they are approved by CMS. The February 25th CMS letter stressed that Section 1115 demonstrations are subject to the Medicaid MOE provisions and the eligibility criteria or enrollment processes under them cannot be altered or terminated before they expire; however, it also clarified that states are not required to continue them once they have expired. According to the letter, cutting eligibility for enrollees who had been covered under an expired 1115 demonstration will not constitute an

MOE violation. **This is the situation in Arizona.** It currently has its entire Medicaid program under an 1115 demonstration that is scheduled to expire on September 30, 2011. The state plans to allow it to expire without renewal, leaving the approximately 240,000 childless adults (who are otherwise not eligible for Medicaid) effectively uninsured.

Q: How do other efforts to cut Medicaid affect kids with special health care needs?

A: The response from HHS to the Governor's January request for relief from the MOE provisions did not offer it, but it did provide suggestions for ways in which states could reduce Medicaid spending without changing eligibility or enrollment processes. Some of these suggestions, such as managing the care of high cost enrollees more effectively through implementation of the medical home model, providing better primary and preventative care to CSHCN and decreasing waste, fraud and payment error have the potential not only for reducing Medicaid spending but also increasing the quality of care provided to Medicaid enrollees.

But the response also suggested limiting coverage for optional benefits, increasing cost-sharing and further reducing provider rates. These strategies have the potential to negatively impact CSHCN. A reduction in optional benefits (like prescription drug coverage or speech therapy, which were specifically mentioned) should not in theory have negative consequences for children because of the provision in Medicaid known as Early, Periodic Screening, Diagnosis and Treatment (EPSDT). It requires that Medicaid enrollees under age 21 receive all medically necessary care and services, regardless of whether they are part of the state's formal Medicaid benefit package.

But in practice EPSDT is applied within states at varying levels of intensity, and it has never truly met its promise from a practical standpoint.[8] Families of CSHCN anecdotally report on a consistent basis being denied care their Medicaid-enrolled children should have access to under EPSDT. While the entitlement for children may not change, a reduction in optional benefits as a cost-saving measure by states may put CSHCN at increased risk for initial coverage denials. Even if those denials do not ultimately result in missed care, they may delay timely, cost-effective intervention (completely undermining the intent of EPSDT) and put unwarranted administrative burden on parents while they go through the appeals process.

Further reductions in provider rates also offer cause for concern. A shortage of providers who accept Medicaid (particularly in the areas of pediatric sub-specialists, mental health clinicians and dentists everywhere and even primary care in rural areas) is already attributed to low Medicaid reimbursement rates. A further reduction may

[8]Johnson, K. National Academy for State Health Policy (2010). *Managing the "T" in EPSDT services.* Retrieved 2/28/11 from http://www.nashp.org/sites/default/files/ManagingTheTinEPSDT.pdf

effectively prevent Medicaid-enrolled CSHCN from receiving care because there is no clinician available to provide it. Simple coverage is not enough. The good intentions behind the MOE provisions to protect vulnerable populations such as CSHCN would be significantly undermined if eligibility for an effectively hollow program was the only goal achieved.

Q: So what's the takeaway message?

A: The MOE provisions provide a vitally important set of protections for CSHCN in ensuring that those who are eligible for Medicaid coverage remain so and barriers to their enrollment in and renewal of coverage are prohibited. While CSHCN are not at risk for losing Medicaid coverage under a budget shortfall waiver, if MOE were repealed, a significant number in optional coverage categories would be. Other strategies for managing Medicaid spending such as reducing optional benefits, increasing cost-sharing and reducing provider rates offer additional cause for concern. The energy and attention currently being focused on repealing MOE would be better applied to implementing proven strategies that increase the cost-effectiveness of Medicaid spending and the quality of care provided under it. It would be more productive to view Medicaid spending not as a cost to be avoided but as an investment in children's health and well-being. Policymakers and advocates who are committed to holding on to the steady progress made in covering children in general and CSHCN in particular will have to watch this topic closely and be prepared to provide meaningful information and education on the consequences of repeal.

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About the Catalyst Center

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Contact Information

Meg Comeau, Project Director
The Catalyst Center
Boston University School of Public Health
Health & Disability Working Group
715 Albany St.
Boston, MA 02118
Tel: 617-638-1936
Fax: 617-638-1931
Web: http://www.catalystctr.org
E-mail: mcomeau@bu.edu

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