Section 9

CHANGES TO MEDICAID AND CHIP UNDER THE AFFORDABLE CARE ACT (ACA)

Eligibility for Medicaid and the Children's Health Insurance Program (CHIP)

Medicaid eligibility changes in the ACA are best understood in the context of the goal for health care reform: that nearly everyone would have either public or private health coverage after 2014. At that time a single system for eligibility screening, enrolling individuals and families 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.

Medicaid eligibility changes in the ACA are best understood in the context of the goal for health care reform: that nearly everyone would have either public or private health coverage after 2014.

Several important provisions of the ACA first went into effect in 2014. Medicaid programs could cover people with income below 138% of the federal poverty level (FPL).[65] Children who had been enrolled in CHIP and whose family income was under 138% of 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. In addition, young people who were in foster care at the time they turned 18 became eligible to maintain their Medicaid benefits until they turned 26. This should help ease the transition from foster care to adult lives, including access to higher education and employment, by guaranteeing continued health care coverage. Finally, states had the 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 was barred from enrolling in CHIP. Under the ACA, if a state can demonstrate that it has maintained its own contribution toward family coverage but the 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 included a "maintenance of effort" (MOE) provision that prohibits states from reducing Medicaid or CHIP eligibility limits below those in effect when the ACA was enacted on March 23, 2010. MOE was required for adults until 2014 and for children under 19 through September 30, 2019.[66]
Under the ACA almost everyone is required to enroll in some form of public

[65]The language of the ACA 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, Section 2001(a); Health Care and Education Reconciliation Act, Pub. L. No. 111-152 Section 1004(e).

[66]Center for Medicaid, CHIP and Survey & Certification. (2011). Maintenance of Effort. Retrieved August 16, 2016 from https://www.medicaid.gov/federal-policy-guidance/downloads/smd11001.pdf

or private coverage following 2014.[67] This is called the "individual mandate." People who are over income for Medicaid or CHIP and who do not have employer-sponsored insurance are able to purchase private coverage through a Health Insurance Marketplace (also known as an Exchange). Marketplace enrollees are eligible for federal help to pay for the cost of coverage if their income is below 400% of the FPL. If someone applies through the Marketplace and is found to be eligible for Medicaid or CHIP, he or she 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.[68] In 2014, states began determining whether most people are eligible for Medicaid or CHIP 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 (affecting whose income counts in the eligibility calculation) and what applicants can deduct from income in calculating eligibility.

The shift to MAGI in calculating eligibility for Medicaid and CHIP aligns with the calculation used to determine eligibility for premium subsidies within the Marketplaces. This makes any transition between Medicaid, CHIP and the Marketplaces, which are all income-sensitive, easier for both consumers and coverage administrators. Using a consistent definition of income for calculating eligibility for Medicaid, CHIP, and the Marketplace, a single application can be used to determine eligibility for any of these programs.

The change in calculating eligibility for Medicaid will NOT impact many people who have special health care needs, including:

- Children 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;
- Children who qualify for Medicaid under the TEFRA or Katie Beckett option (For more about TEFRA, please refer to Section 11 of this tutorial); or
- Children who qualify for Medicaid because they are in foster care.[69]

Finally, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the ACA also included provisions to simplify and improve enrollment in Medicaid and CHIP, including provisions requiring or allowing states to:

- Establish a system of enrollment and enrollment renewals via a website as well as by phone or in person;
- Coordinate eligibility determination for Medicaid and CHIP along with determination of eligibility for tax credits to purchase private insurance in the Marketplace;
- Conduct outreach to vulnerable populations, including families with CSHCN, to enroll in Medicaid and CHIP;
- Permit hospitals to make "presumptive eligibility" determinations for Medicaid, to be verified later by the state Medicaid program;
- Permit Medicaid and CHIP eligibility for children to be decided by public "express lane" agencies – agencies that use household income to determine eligibility for other programs such as WIC, subsidized housing, or school lunch programs.[70]

[67]Some people are exempt from any penalty if they fail to enroll. The most typical exemptions are for those with income too low to be required to file federal income tax returns and those for whom the lowest cost health plan available exceeds 8% of their income.

[68]The language of the ACA 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, Section 2001(a); Health Care and Education Reconciliation Act, Pub. L. No. 111-152 Section 1004(e).

[69]National Health Law Program. (n.d.). *Analysis of the Health Care Reform Law: PPACA and the Reconciliation Act*, Part II, p. 9. Retrieved August 16, 2017 from Retrieved August 16, 2017 from http://www.healthlaw.org/issues/health-care-reform/nhelp-analysis-of-aca-and-reconciliation-act-part-II-role-of-public-programs

[70]CHIPRA, P.L. 111-3, Section 203, codified in, 42 U.S.C. Sections 1396a(e)(13) and 1397gg(e)(1)(B).

Covered Services for CSHCN

Under the ACA, states are encouraged or required to adjust benefits in numerous ways. Significantly, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) became available to more children in 20 states in 2014,[71] because Medicaid eligibility for children ages 6 to 19 increased in those states to 138% of the federal poverty level, shifting children from CHIP to Medicaid.[72] The remaining states already covered these older children under Medicaid. Depending on the benefits covered by their state's CHIP program, this age group 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 enrolled in Medicaid or CHIP may elect to receive hospice care without having to forgo potentially curative care.

Financing Changes

As described above, many more people became eligible for Medicaid in 2014. Health coverage for people who were newly eligible in 2014 was financed at 100% by the federal government through 2016; then the federal matching rate began to phase down annually from 100% to 90% in 2020.

Unlike Medicaid, federal CHIP funds are capped and allotted for two years based on a formula that changes from year to year. Regardless of program design, states' CHIP spending is reimbursed by the federal government at a matching rate that is higher than Medicaid's.[73,74] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) extended federal CHIP funding for two years through FY 2017. As of September 2017, Congress is working on legislation that will extend CHIP funding over a longer period of time, potentially at a lower match rate. MACPAC estimates that all states would exhaust federal CHIP funding at some point in FY 2018.[75]

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;
- Creating "health homes" for people with certain chronic health conditions. Health homes are similar to medical homes - see more under the Service Delivery section below.

Service Delivery

Health reform offers state Title V programs opportunities to realign health care delivery for CSHCN, 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 adults and children with chronic conditions to better integrate physical and mental health and to coordinate care and promote efficienciess.[76]

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[71]The 20 states are 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., and Justice, D. (2011). *The Affordable Care Act and Children with Special Health Care Needs: An Analysis and Steps for State Policymakers,* p. 25. Retrieved Dec. 22, 2011 from http://cahpp.org/resources/the-affordable-care-act-and-children-with-special-health-care-needs-an-analysis-and-steps-for-state-policymakers/

[72]The language of the ACA 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. ACA, Section 2001(a); Health Care and Education Reconciliation Act, Pub. L. No. 111-152 Section 1004(e).

[73]For the enhanced federal match rate for CHIP in FY2018 by state, see http://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip

[74]For the federal match rate for Medicaid in FY2018 by state, see http://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier

[75]The Medicaid and CHIP Payment and Access Commission.(2017, July). Federal CHIP Funding: When Will States Exhaust Allotments?. Retrieved September 13, 2017 from https://www.macpac.gov/publication/federal-chip-funding-when-will-states-exhaust-allotments/

[76]Affordable Care Act (ACA), Section 2703, "State option to provide health homes for enrollees with chronic conditions." See also, U.S. Department of Health and Human Services, Center for Medicaid and Medicare Services. (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 Jan. 12, 2012 from https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10024.pdf

- Health homes 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 either through a contract with a managed care organization or through a contract 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 with serious and persistent mental health conditions or to people with two or more of the following conditions: a mental health condition, substance use disorder, asthma, diabetes, heart disease, or being overweight. With approval from CMS, states may specify additional conditions, such as autism or pediatric asthma. [77]

- The ACA also contains language to implement demonstration projects at the state level for pediatric Accountable Care Organizations (ACOs). ACOs are organizations of providers that are being developed to align the financial incentives of providers with better health outcomes for patients. For example, a hospital might combine 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.

- Many state Medicaid programs have applied for newly available grants designed to create incentives for healthy behaviors and prevent chronic diseases.[78]

- New measures to prevent fraud and abuse in Medicaid may affect the delivery of care for CSHCN. For example, patients must now have a face-to-face encounter with a physician to receive a prescription for durable medical equipment or home health services. This could become a barrier to care if providers and patients are not accustomed to meeting the new requirements. In addition, prescribed drugs and services will only be covered by Medicaid if the prescriber is enrolled as a Medicaid provider. This could cause serious problems for CSCHN and others who obtain prescriptions from doctors who are not enrolled in Medicaid as individual providers.

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[77] See U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services. (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]; Buxbaum, J. (2010). *Making Connections: Medicaid, CHIP, and Title V Working Together on State Medical Home Initiatives.* Retrieved Dec. 21, 2011 from the National Academy for State Health Policy website: http://www.nashp.org/publication/making-connections-medicaid-chip-and-title-v-working-together-state-medical-home-initiatives

[78] See the Center for Medicare and Medicaid Services Overview of Medicaid Incentives for Prevention of Chronic Diseases Program at https://innovation.cms.gov/initiatives/mipcd/

This document is part of *Public Insurance Programs and Children with Special Health Care Needs: A Tutorial on the Basics of Medicaid and the Children's Health Insurance Program (CHIP)*, available in its entirety at http://cahpp.org/resources/Medicaid-CHIP-tutorial

Is this tutorial helpful to you? Please take our survey at http://bit.ly/2gXLyuy-catalyst-survey

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

NATIONAL ACADEMY for STATE HEALTH POLICY

Test your knowledge

1. Since 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. On October 1, 2015, the federal matching rate for CHIP increased by how many percentage points?
   a. 3
   b. 13
   c. 23
   d. 33

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? Does it include children? If yes, which children?

3. Has your state received any grants to create incentives for healthy behaviors and prevent chronic diseases?

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