Residency Fellowship in Health Policy

Spring 2020

Medicaid and CHIP

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Medicaid and Children's Health Insurance Plan (CHIP)

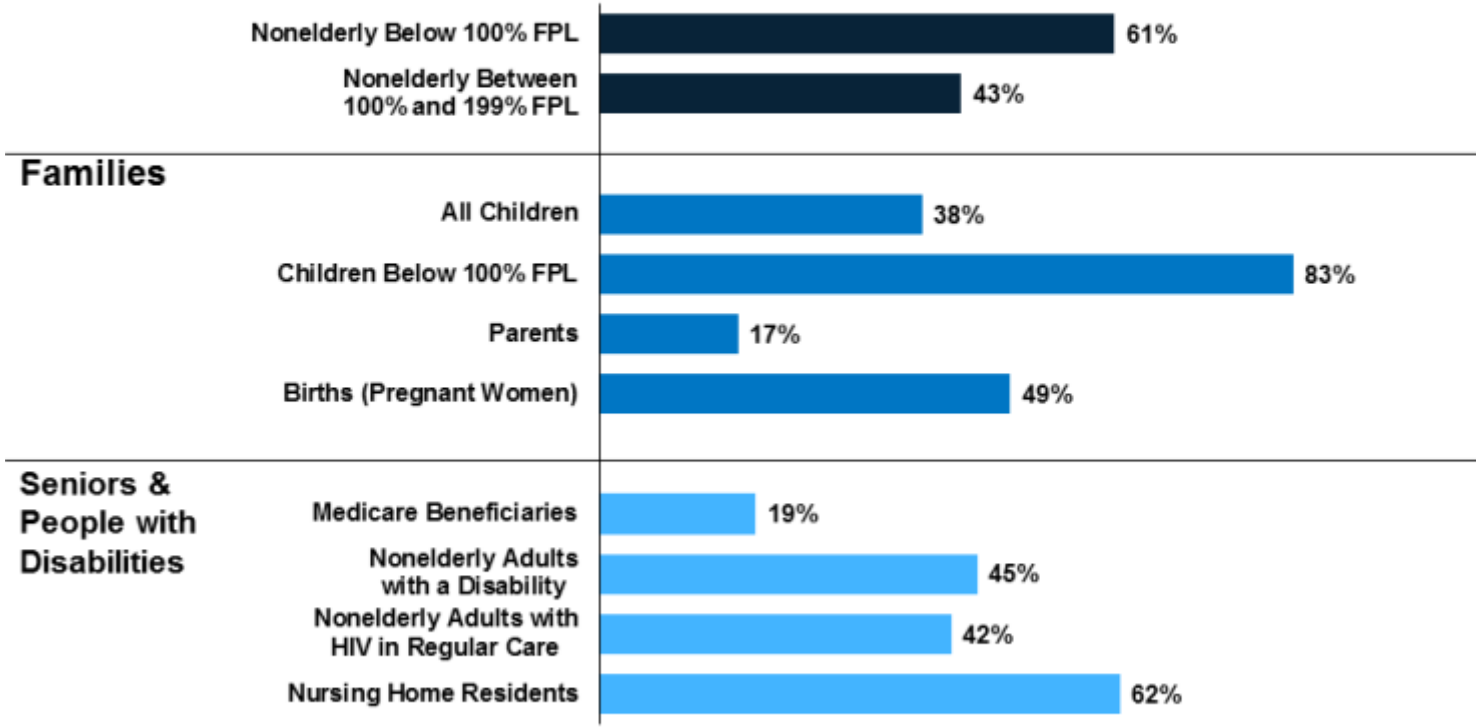
- Medicaid: Federal/State health insurance program for the poor
  - Entitlement program

- CHIP: Federal/State health insurance for (mostly) children who do not qualify for Medicaid
  - Block grant

Figure 4

Medicaid plays a key role for selected populations.

Percent with Medicaid Coverage:



NOTE: FPL-- Federal Poverty Level. The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $20,420 in 2017.
SOURCES: Kaiser Family Foundation analysis of the 2017 American Community Survey; Birth data-Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017, KFF, October 2016; Medicare data -Centers for Medicare & Medicaid Services (CMS), Office of Enterprise Data and Analytics, Chronic Conditions Data Warehouse, CY 2016; Disability - KFF Analysis of 2017 ACS; Nonelderly with HIV - 2014 CDC MMP; Nursing Home Residents - 2015 OSCAR/CASPER data.

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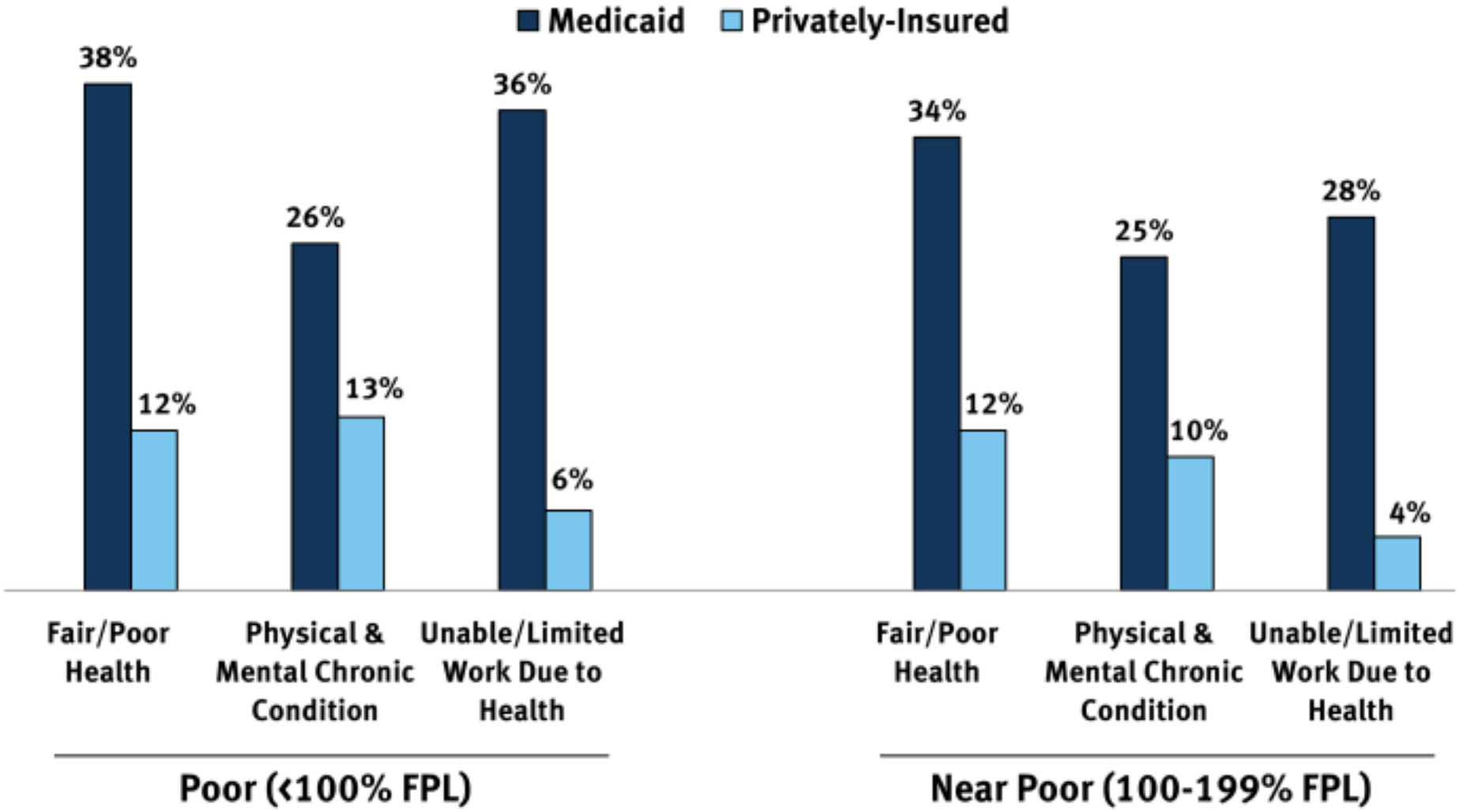
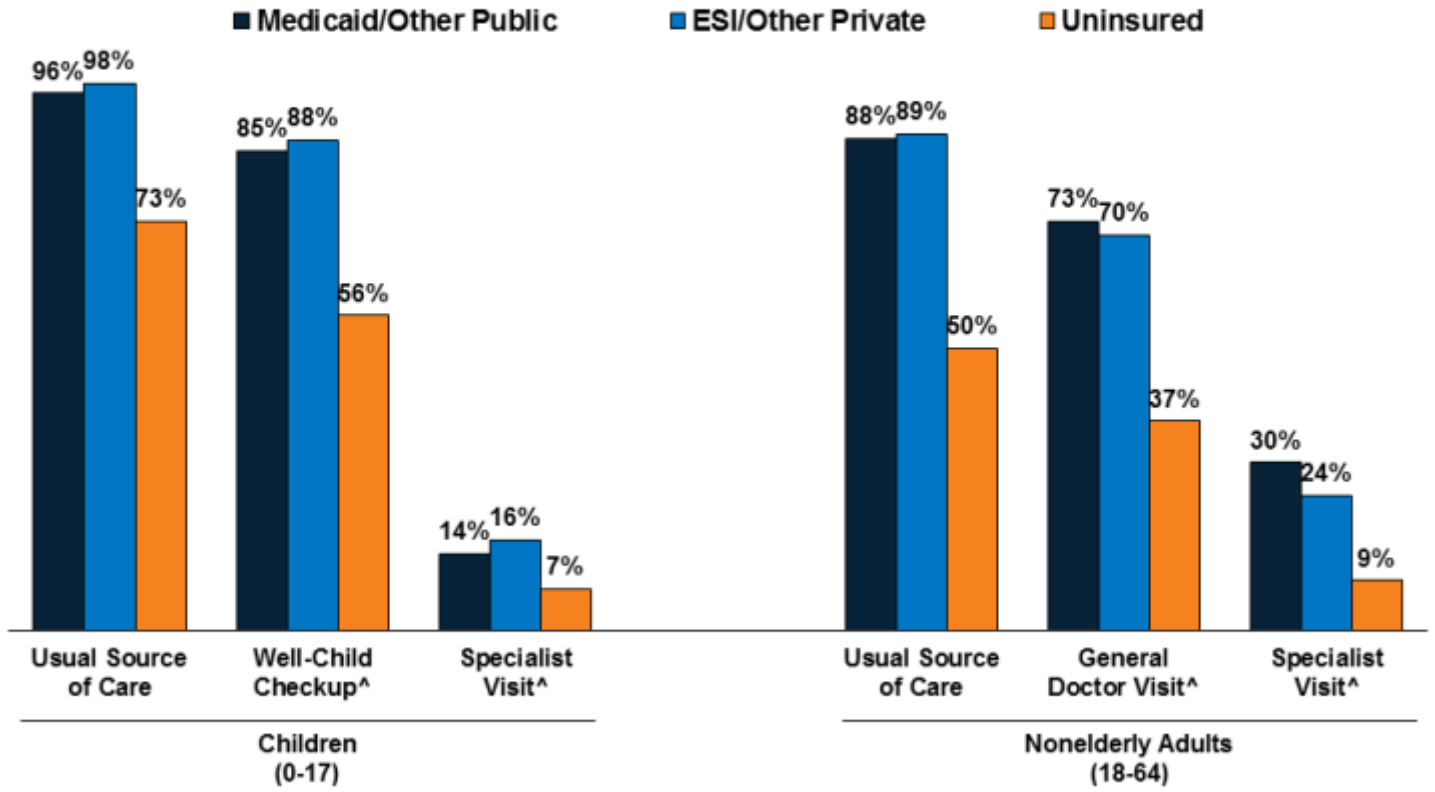
Medicaid Enrollees are Sicker and More Disabled than the Privately-Insured



NOTE: Adults 19-64.
SOURCE: KCMU analysis of MEPS 3-year pooled data, 2004-2006

Figure 7

Nationally, Medicaid is comparable to private insurance for access to care – the uninsured fare far less well.



NOTES: ^ Indicates in the past 12 months. Respondents who said usual source of care was the emergency room are not counted as having a usual source of care. All estimates are statistically significant from the uninsured group ($p<0.05$).
SOUCE: Kaiser Family Foundation analysis of the 2017 National Health Interview Survey (NHIS).

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Medicaid: Joint Program Administration

- Federal level
  - Sets program parameters (floors and ceilings)
  - Provides policy guidance
  - Provides funding
  - Approves waivers
  - Run through Centers for Medicare and Medicaid Services
- State level
  - Makes choices within program parameters
  - Provides funding
  - May seek waivers
  - Run through state Medicaid agencies

Medicaid: Traditional Eligibility

- 73 million enrolled (1 in 5)
  - 25% of children
  - Children are 43% of all enrollees
- Generally covers poor individuals who are also
  - Pregnant or disabled or elderly or children or adults in families with dependent children
    - Deserving poor
- Pre-Health Reform, generally did not cover
  - Low-income adults without disabilities
  - Women who are not pregnant
  - Near-poor
  - 30 million low-income individuals are uninsured

Medicaid: Traditional Eligibility

- Must meet all five criteria to be eligible
  - Category
  - Income
  - Resources
  - Residency
  - Immigration status
    - 31 states cover legal immigrant children, 23 cover legal immigrant pregnant women within 5-year bar under Medicaid and/or CHIP

Medicaid: Expansion Eligibility (ACA)

- All non-Medicare eligible adults under 65 who earn up to 133% (138%) FPL ($17,236 in 2019)
  - Was mandatory, now optional due to Supreme Court decision
- No categorical requirement, no asset or resource test in most cases
- CHIP Children between 100% and 133% FPL move to Medicaid
- If eligible for Medicaid, not eligible for state exchange subsidies
- Minimum eligibility of 138% for all children up to 19
- Must cover kids aging out of foster care to age 26

Medicaid Expansion: Supreme Court Decision

- Court ruled eligibility change was a change in “kind” not “degree”
  - Change from program for the poor to a “comprehensive national plan to provide universal health insurance coverage”
    - A change states could not have anticipated; created a new program
  - 7-2, only Ginsberg and Sotomayor upheld Medicaid provision
- Federal government may create an expansion option and lure states with additional money
- Federal government may not mandate expansion option and penalize states by withholding existing Medicaid funds if do not comply
  - Unconstitutional as undue coercion
  - Based on spending clause – spending programs like contracts between state and federal government
  - Preserves expansion while limiting federal powers

Medicaid Expansion

- 36 states plus DC expanded Medicaid under ACA (Feb. 2019)
  - https://www.advisory.com/daily-briefing/resources/primers/medicaidmap
  - Medicaid waivers used in some states
    - Federal funds to purchase private insurance
    - Increased cost-sharing
    - Lock out participants for 6 months if fail to pay premiums
- Over 2 million fall in coverage gap in non-expansion states
  - don’t qualify for Medicaid but too poor to qualify for subsidies (less than 100% FPL)

Medicaid Enrollment

- In 2017, 16 million more Medicaid enrollees than pre-ACA (8/17)
  - 2017-2019, 1.9 million enrollment decrease, split adults/kids
  - 15 states increase, 35 states/DC decrease
  - No increase in private insurance, employment gains
- Enrollment increase higher in Medicaid expansion states
- 11 million dual eligible enrollees
- Racial/ethnic distribution, 2016
  - 43% white, 30% Hispanic, 18% Black, 9% Other

Medicaid: Traditional Mandatory Benefits

- Physician services
- Lab and X-ray services
- Inpatient hospital services
- Outpatient hospital services
- EPSDT (under 21)
- Family planning
- FQHC and rural health clinic
- Nurse Midwife
- Certified nurse practitioner
- Nursing facility (21+)
- Home health for those in nursing facilities

Medicaid: Traditional Optional Benefits

Acute Care Benefits

- Prescription drug
- Medical/remedial care by non-physician
- Rehabilitation and other therapy
- Clinic services
- Dental services
- DME, prosthetics, eyeglasses
- Primary care case management
- TB services
- Other specified medical or remedial care

Long Term Care Benefits

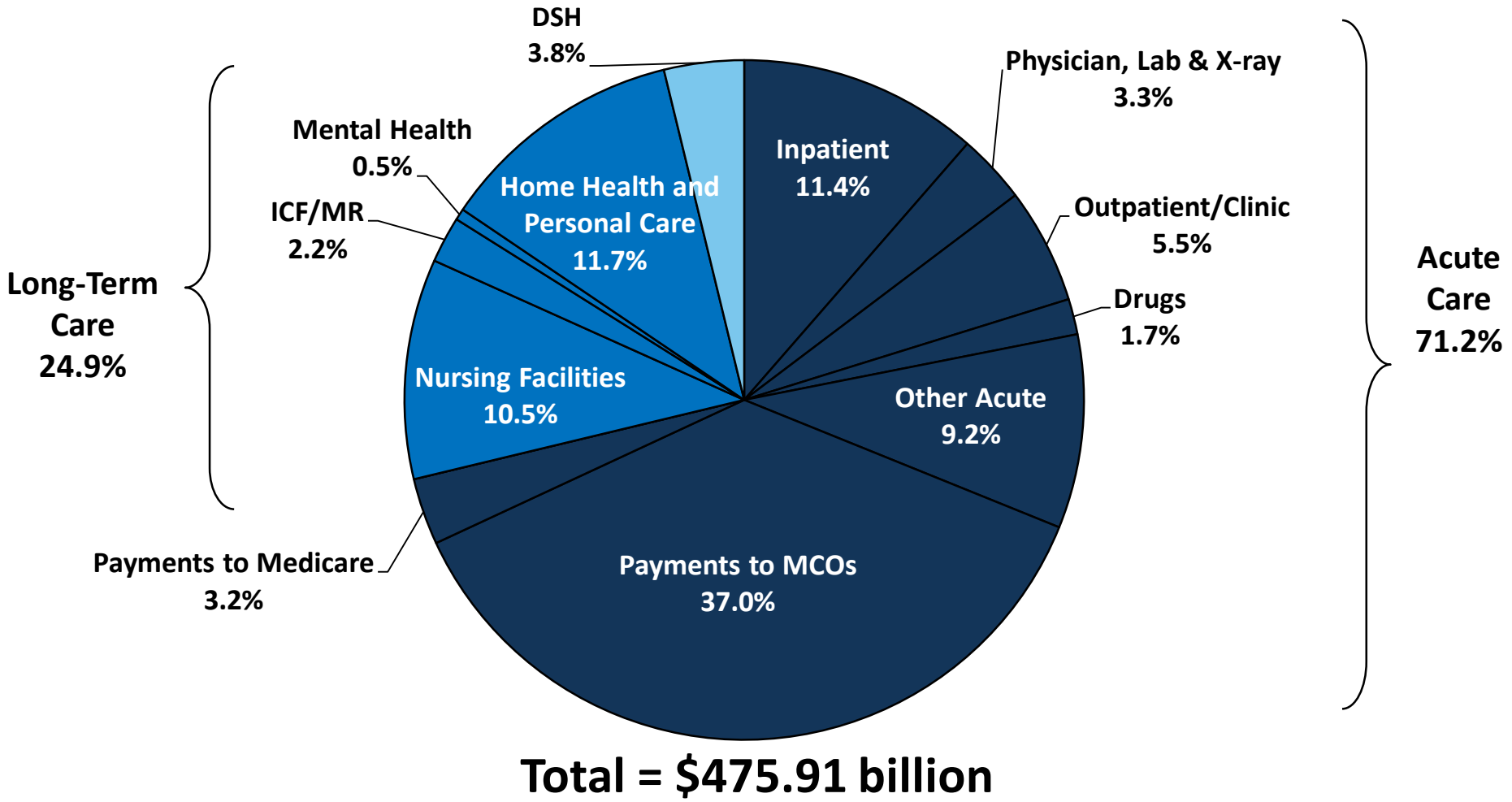
- Intermediate care facilities for mentally retarded
- Inpatient/nursing facilities in mental disease institution (65+)
- Inpatient psychiatric hosp (<21)
- Home/community based waiver
- Home health care
- Targeted case management
- Respiratory care
- Personal care services
- Hospice care
- PACE

Medicaid: Expansion Benefits

- Health Reform Changes (2014):
  - Newly eligible population receive benchmark equivalent of Essential Health Benefits through Alternative Benefit Plans (ABP)
    - States may choose to offer more generous benefits to traditional population
    - Adult dental not required in EHB
    - Require mental/physical health parity
    - Trump Admin expanded benchmark options
  - Requires smoking cessation for pregnant women without cost sharing
  - Incentive to cover USPSTF A&B rated services for traditional population

Figure 16

The majority of Medicaid expenditures are for acute care.



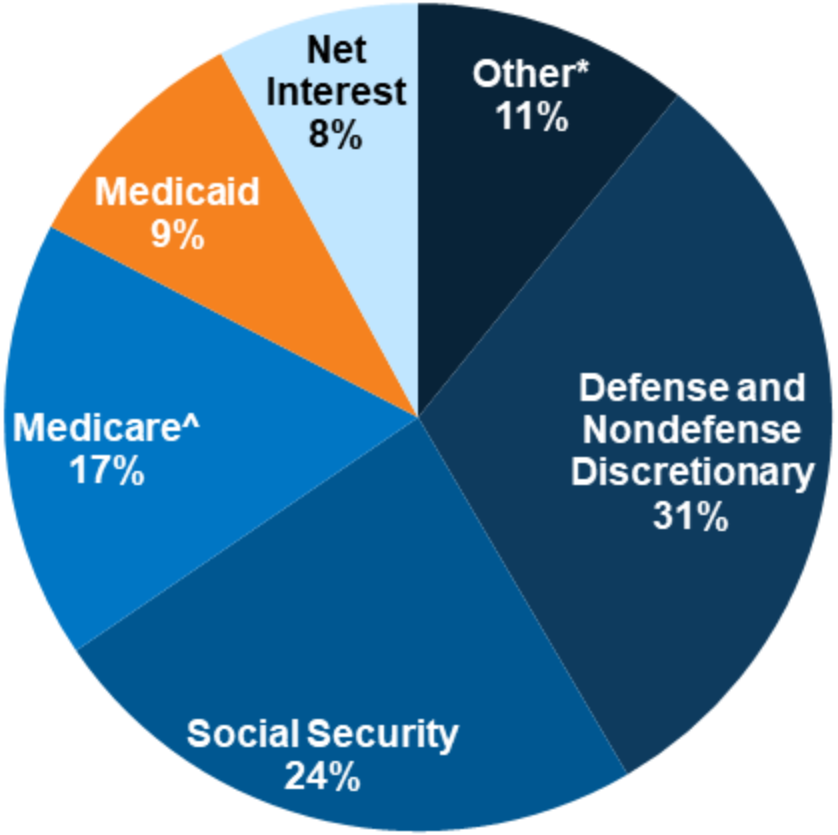
NOTE: Excludes administrative spending, adjustments and payments to the territories.
SOURCE: Urban Institute estimates based on FY 2014 data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured.

Medicaid: Financing

- 2017: $577 billion, 17% total national health expenditures
  - 9.7% of federal spending
  - Avg. about 30% of state budget
- Traditional: Federal Medical Assistance Percentage (FMAP)
  - Based on state's per capita income
  - Range from 50%-75%
  - Administrative match set at 50% for most services
  - Federal government pays for 63% of Medicaid
    - Medicaid = 26% of state funds
  - Nominal cost sharing under traditional Medicaid
- Expansion:
  - Federal gov't pay 100% costs of newly eligible 2014-2016, phase down to 90% by 2020
    - States may save money on uncompensated care with newly insured

Figure 9

Medicaid is the third largest mandatory spending program in the federal budget.



Actual FY 2018 Total Federal Outlays: $4.1 Trillion

NOTE: ^ Amount for Medicare is mandatory spending excluding offsetting receipts. * Other category includes other mandatory outlays (such as CHIP and Health Insurance Marketplace premium subsidies).
SOURCE: Kaiser Family Foundation based on Congressional Budget Office, Budget and Economic Outlook Fiscal Years 2019-2029, January 2019.

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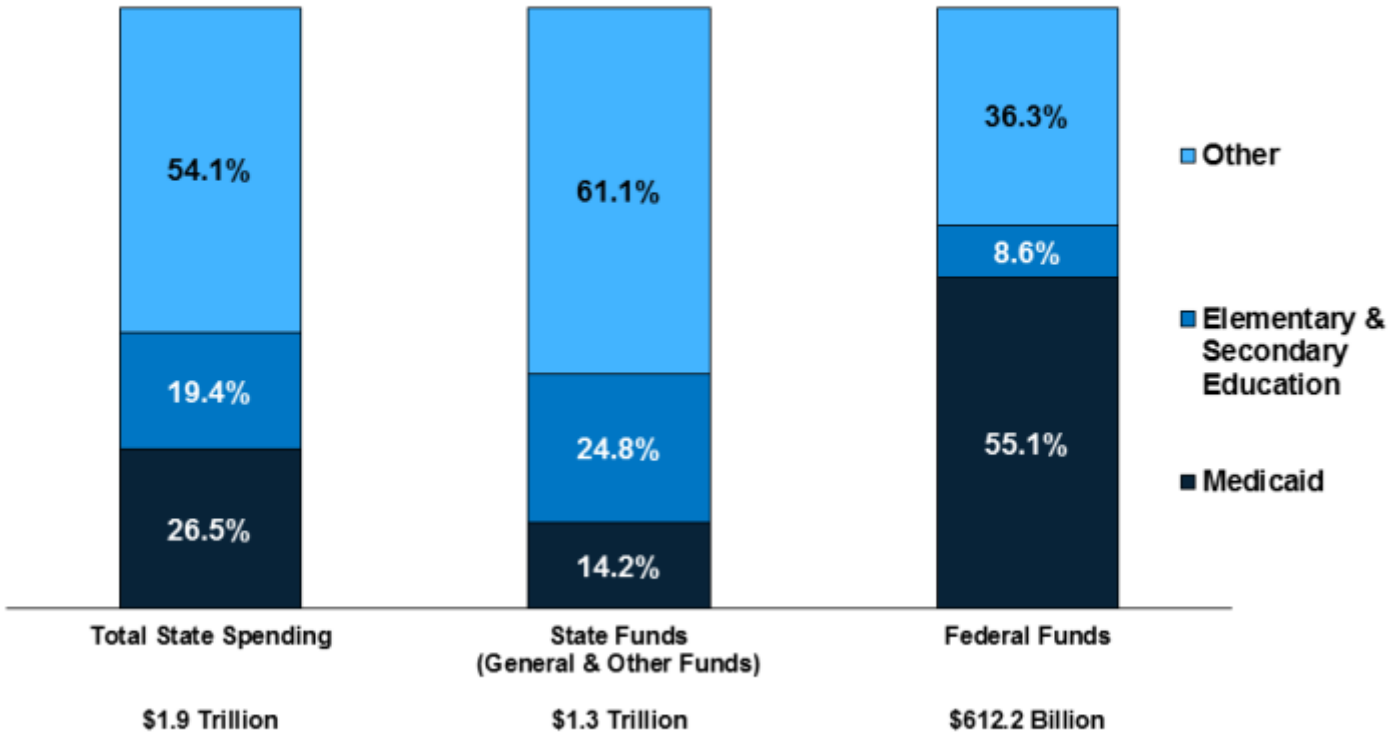
Figure 8

Medicaid is a budget item and a revenue item in state budgets.



SOURCE: Kaiser Family Foundation estimates based on the National Association of State Budget Officers (NASBO) 2018 State Expenditure Report: Fiscal Years 2016-2018 (data for Actual FY 2017).

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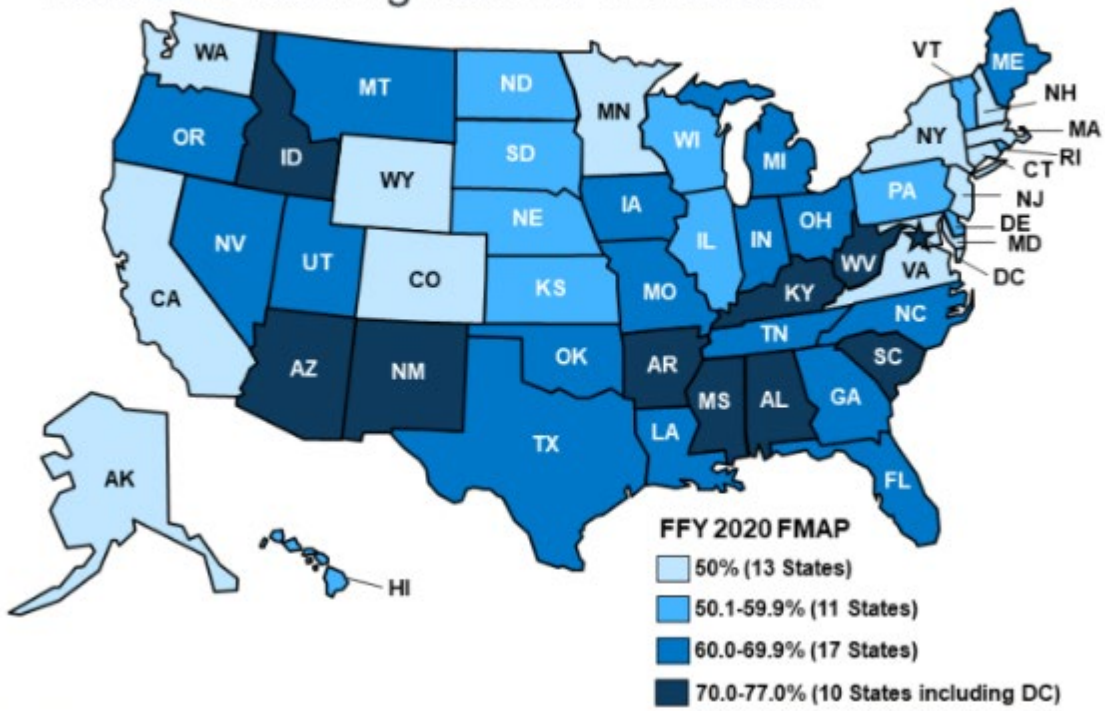
Figure 1

States with lower per capita incomes have a higher federal matching rate for Medicaid.



NOTE: FMAP percentages are rounded to the nearest tenth of a percentage point. These rates are in effect Oct. 1, 2019-Sept. 30, 2020.
SOURCE: Federal Register, November 28, 2018 (Vol 83, No. 229), pp 61159, available at: https://www.govinfo.gov/content/pkg/FR-2018-11-28/pdf/2018-25944.pdf.

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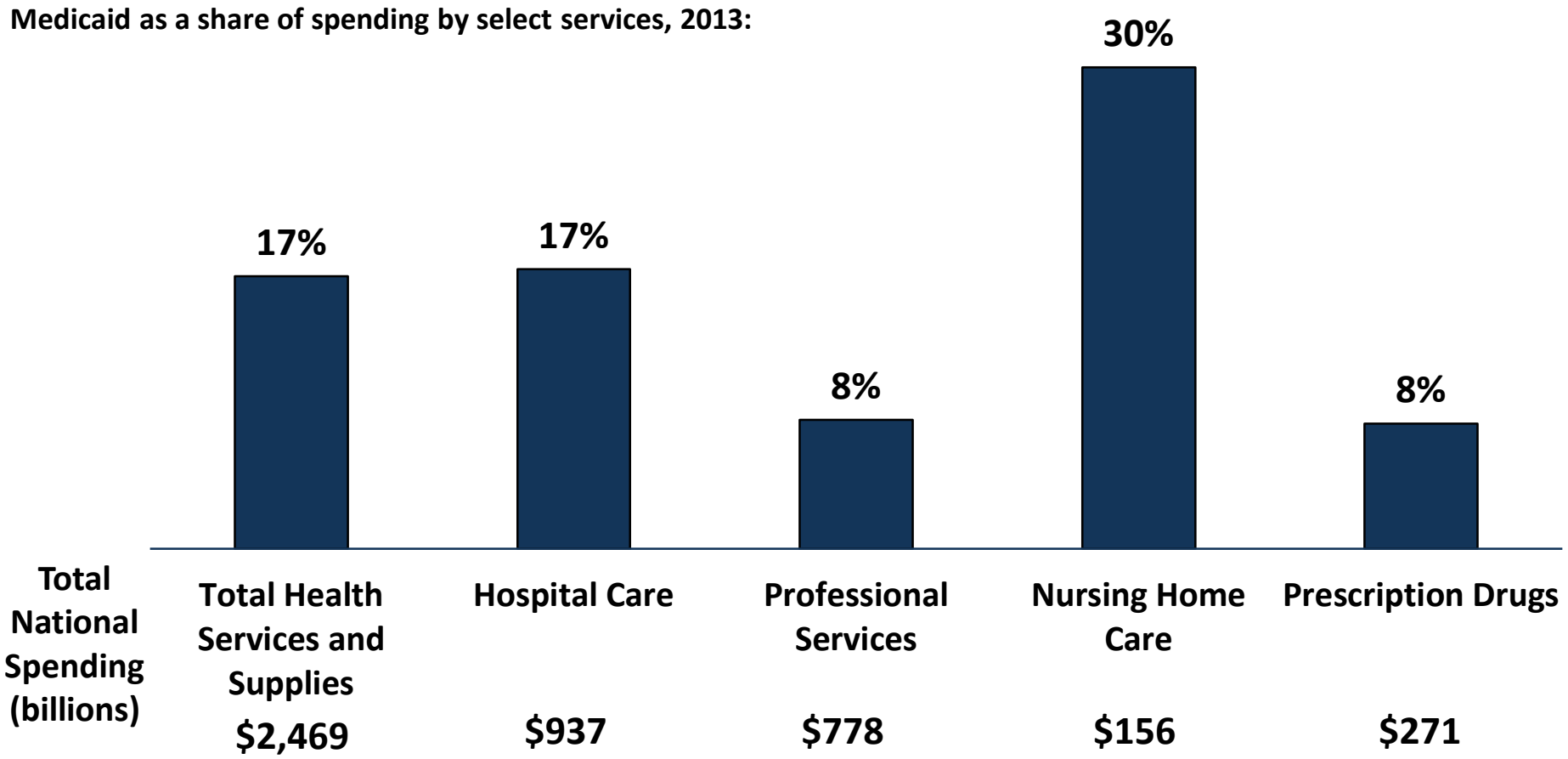
Figure 21

Medicaid is a major financing source for health care services.



NOTE: Includes neither spending on CHIP nor administrative spending. Definition of nursing facility care was revised from previous years and no longer includes residential care facilities for mental retardation, mental health or substance abuse. The nursing facility category includes continuing care retirement communities.
SOURCE: CMS, Office of the Actuary, National Health Statistics Group, National Health Expenditure Accounts, 2015. Data for 2013.

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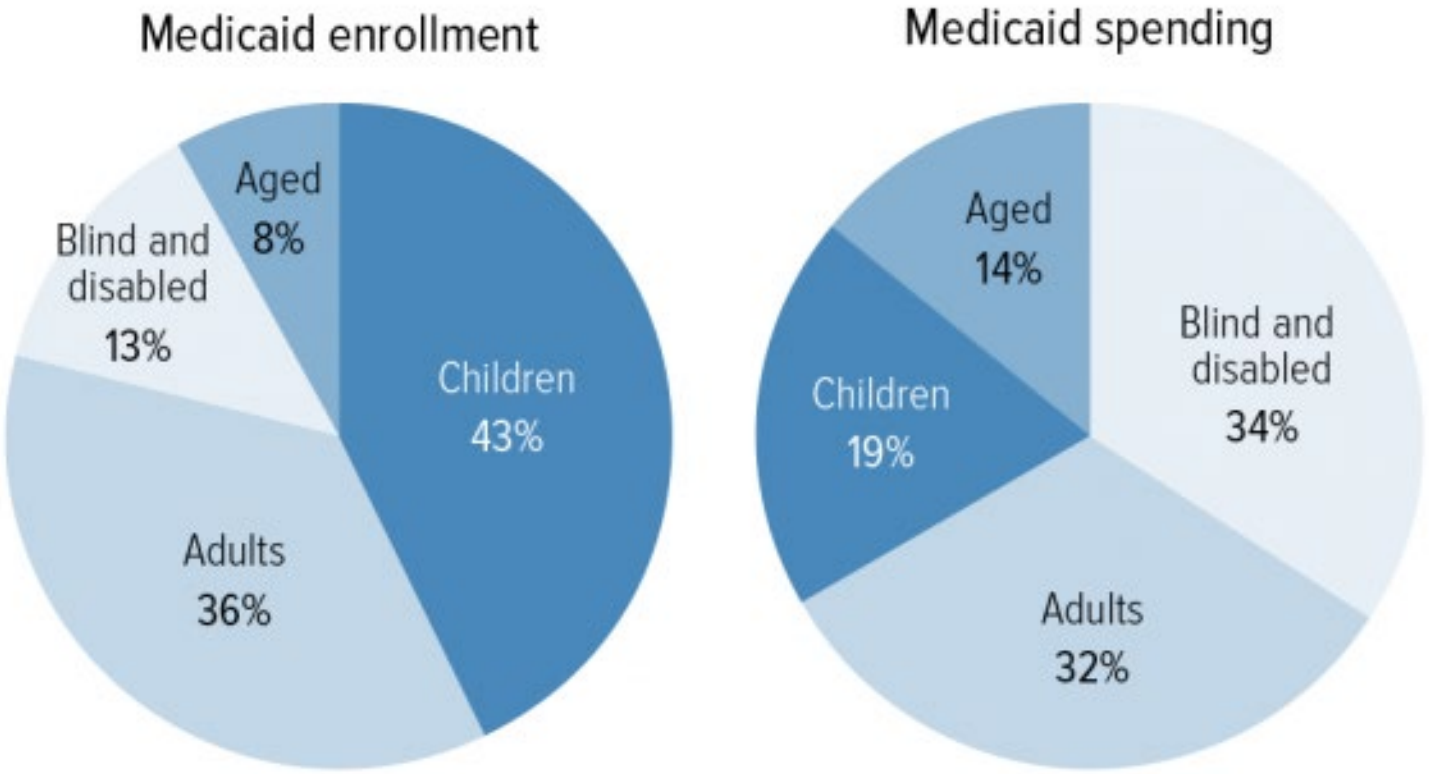
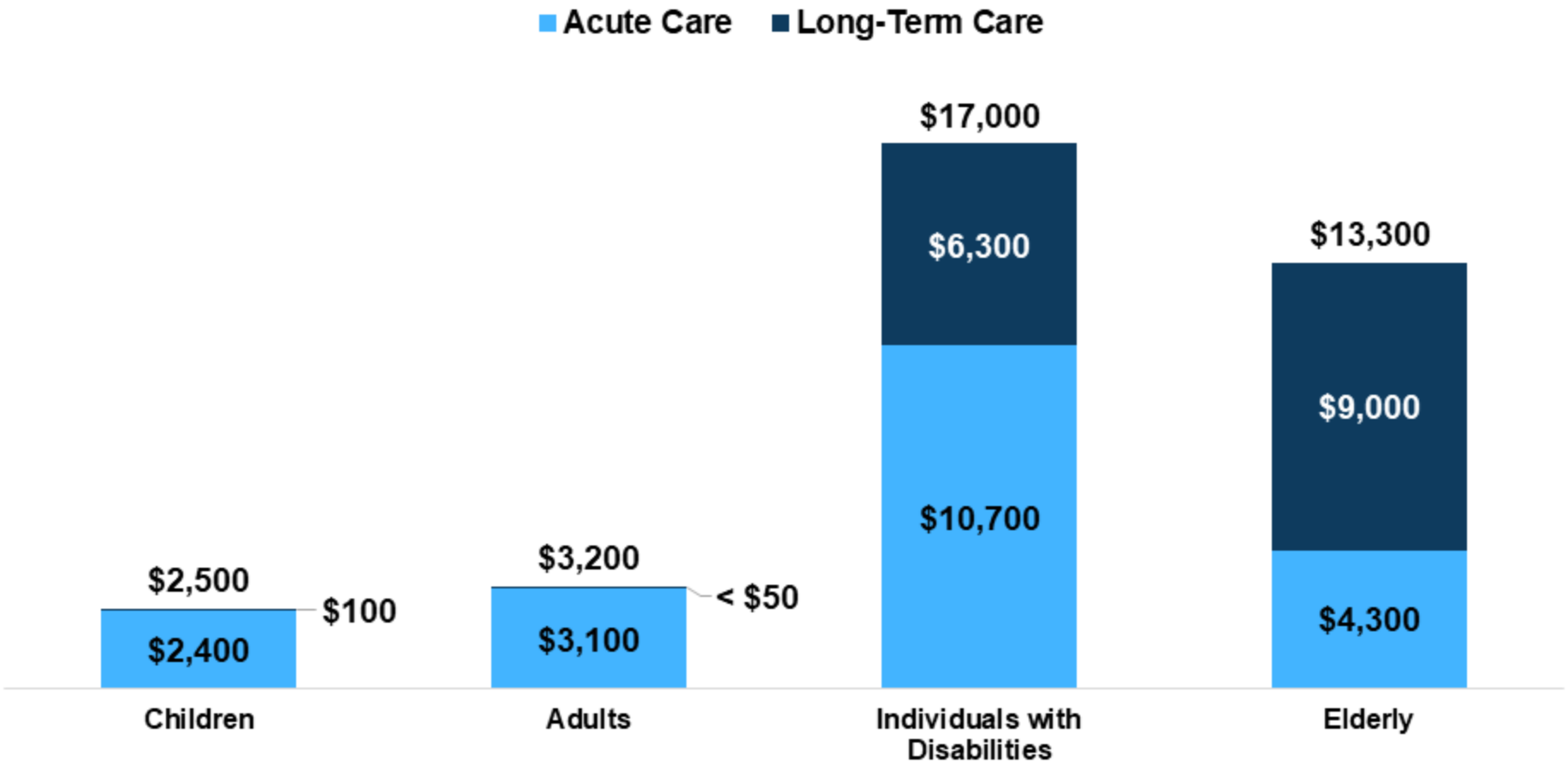
Enrollment and Spending in Medicaid



Source: Spending and enrollment estimates for FY2015 from the Congressional Budget Office's March 2016 Medicaid baseline. Figures may not sum to 100 percent due to rounding.

Figure 6

Medicaid per enrollee spending is significantly greater for the elderly and individuals with disabilities compared to children and adults, FY 2013.



NOTE: Rounded to nearest $100. Spending may not sum to totals due to rounding.
SOURCE: Kaiser Family Foundation and Urban Institute estimates based on data from FY 2013 MSIS and CMS-64 reports. Due to lack of data, does not include CO, KS, NC, or RI.

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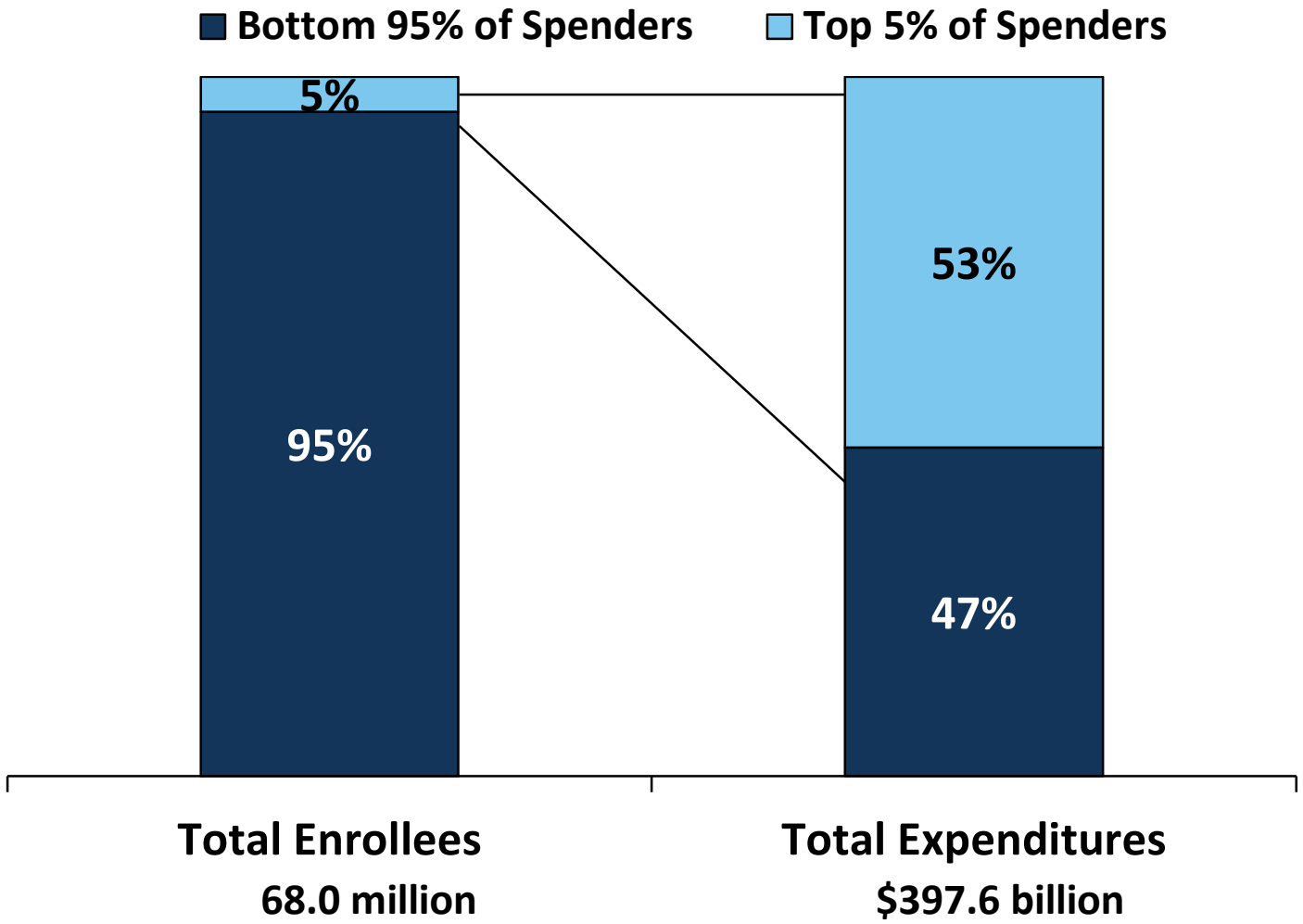
Figure 24

Top 5% of Enrollees Accounted for More than Half of Medicaid Spending, FY 2011



SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT, but adjusted to 2011 CMS-64.

Medicaid: Provider Reimbursement

- Pre-ACA Medicaid paid 59% of Medicare rates
- Unhelpful statutory language
- Cannot sue states for inadequate reimbursement
- Low reimbursement one reason fewer physicians accept new Medicaid patients
  - 68.9% Medicaid v. approx. 84% for Medicare & Private
    - Wide variation across country
- 20% physicians see 60% Medicaid patients
  - Physicians more likely to be: younger, foreign medical school grads, lower ranked med school grads, not board certified, work in larger practices

Medicaid: Waivers

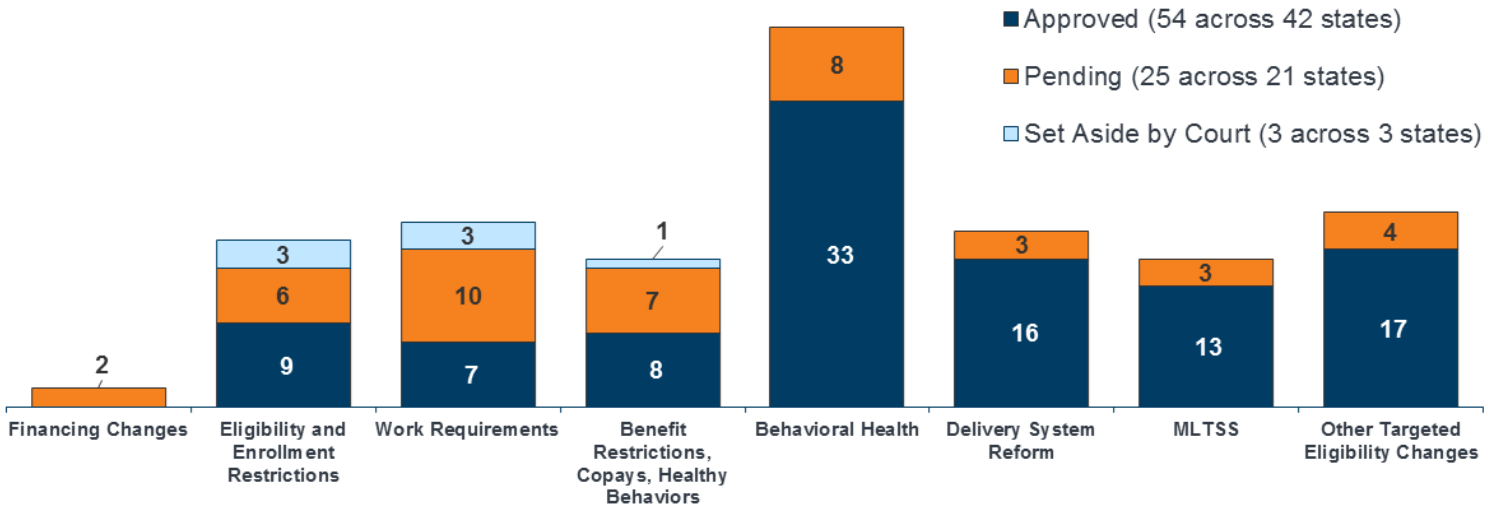
- 1115 Waivers
  - Test policy innovations
  - Health Insurance Flexibility and Accountability (HIFA)
  - IMD for SUD/SMI/SED – allow short term inpatient/residential

- Managed Care/Freedom of Choice (1915b)
  - Implement managed care
  - Limit freedom to select provider

- Home and Community Based Waivers (1915c)

  Provide LTC services in community setting

Landscape of Approved vs. Pending Section 1115 Medicaid Demonstration Waivers, February 28, 2020



NOTES: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. Pending waiver applications are not included here until they are officially accepted by CMS and posted on Medicaid.gov. For more detailed information on each Section 1115 waiver, download the detailed approved and pending waiver tables posted on the tracker page.

"MLTSS" = Managed long-term services and supports.

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Medicaid: Waivers

- Changing purpose of Medicaid program
  - Upward mobility, independence, responsible decision-making
  - Alignment with private insurance plans to smooth transition
- 1115 Waivers
  - http://www.commonwealthfund.org/interactives-and-data/maps-and-data/medicaid-expansion-map
  - Approve work requirements, higher premiums, enforceable premiums, pay initial premium before coverage starts, administrative lock-outs, premium surcharge for tobacco, eliminate retroactive eligibility
  - Possibilities: drug screening, time limited eligibility, block grants
  - Litigation (AR, KY, NH work waivers set aside)
  - Rejected: partial expansion, enrollment caps, closed Rx formularies

Medicaid: ACA § 1332 Waivers

- Allows states to modify key elements of ACA to use different strategies to reach ACA's goals
- New strategies have to provide as good access to affordable, quality health insurance at same or lower cost to federal government
- Some elements may not be waived
  - Ex: pre-existing condition protections

Other Medicaid Health Reform Changes

- New option to expand community based LTC
- New option for family planning services
- New funding for demonstration programs
- Opportunities for states to be innovative in payment and delivery
  - Grants to states to lower tobacco use, obesity rates, diabetes etc
  - Center for Medicare and Medicaid Innovation
- New coordination for dual eligibles
- Expands Medicaid and CHIP Payment Access Commission
- Financial incentive to provide preventive services
- Prohibits payments for certain hospital acquired infections
- Reduces DSH payments
- Increase Medicaid drug rebate
- Increased data reporting

Medicaid Expansion

- 2018 Mid-Term Elections
  - Successful ballot initiatives for expansion: ID, NE, UT
  - Pro-expansion governors elected: ME, KS, WI
  - Unsuccessful ballot initiative to fund expansion: MT
  - Anti-expansion governor elected: AK
- 2020
  - Possible ballot initiatives: OK, MO
  - Legislative expansion expected: KS
  - Legislative expansion possible: NC
  - Possible waiver expansion: NE,

Future of Medicaid

- Focus on changes through waivers
- Decrease enrollment
    - Employed but not obtaining private insurance
    - Increased eligibility checks
    - Reduced outreach and enrollment
    - Immigration policies
- Spending concerns
    - Increased Rx costs, elderly costs, provider rates
- 2020 election

Children's Health Insurance Program (CHIP)

- Created in 1997 after failed Clinton health reform
- Initial 10 year block grant of $40 billion
  - Reauthorized in 2008 and extended in ACA until 2019
  - Brief lapse in funding, now funded until 2027
- Target population
  - Children who are poor but earn to much to qualify for Medicaid in their state
  - Uninsured children fell 40% since CHIP began in 1997
    - 2017: 6.7 million enrolled, 5.5% children still uninsured
    - 75% of uninsured children eligible for Medicaid or SCHIP

CHIP Eligibility

- May cover over 300% FPL (reduced matching from feds over 300% FPL)
- Not eligible for Medicaid
- Not otherwise insured
- Under age 19
- May cover pregnant women without a waiver (5 states)
- May cover immigrant pregnant women and children within first 5 years
  - 33 states cover immigrant children, 25 states cover immigrant pregnant women
    - 16 states use unborn child option to cover immigrant pregnant women
- No new waivers for parents or childless adults
- Health Reform
  - If can't enroll because of funding shortage, must screen for Medicaid eligibility or will be eligible for tax credits in exchange

CHIP Financing

- CHIP higher matching rate than Medicaid
- Under ACA, CHIP match enhanced, E-FMAP
  - Fed gov't covered 92.5% of $15.6 billion spending in 2016
  - E-FMAP phasing out in 2020, back to regular CHIP match
    - Historically ranges from 65%-88%, Fed gov't covers about 70%
- Two-year state allocation formula
  - Health care inflation
  - Growth in children's population
  - Use of funds
  - Redistribute to states after two years

CHIP Benefits

- Required to provide “basic” benefits
  - Inpatient, outpatient, physician, lab, x-ray, well-baby/well-child and dental (new with reauthorization)
  - May use CHIP funds for dental cost sharing or dental only supplemental coverage
  - Not defined
  - Use benchmarks
- May provide other benefits
  - Mental health, vision, Rx, hearing, other needed services
  - If provide mental health, must have parity
- Generally less generous than Medicaid

Future of CHIP

- Bi-partisan support
- Can get tied up in ACA fight (funding lapse)
- Necessary while ACA at risk
- Necessary even with strong ACA
  - Especially without full Medicaid expansion
  - More affordable than marketplace plans