

Medicaid and CHIP - Outreach and Enrollment

Background

The Medicaid program is the primary source of insurance coverage for certain low-income individuals, including children, pregnant women, individuals with disabilities, and parents of minor children. Medicaid also provides coverage to low-income Medicare beneficiaries for services not covered by Medicare, such as cost-sharing, vision and dental care (where covered by states), and long-term care in nursing facilities and in community-care settings.

The Children's Health Insurance Program (CHIP) provides health insurance for uninsured children living in families with incomes below 300 percent of the federal poverty level (FPL), as well as certain low-income pregnant women, parents and other low-income adults ineligible for Medicaid.^[1] Under CHIP, states have the option of expanding their state Medicaid programs, establishing separate insurance programs, or combining both options, an approach that permits flexibility in both coverage guarantees and benefit design. Through waivers, states have also expanded eligibility beyond 300 percent of FPL. Separately administered CHIP programs typically cover fewer benefits than Medicaid and may cap enrollment of eligible children.

Medicaid entitles states to federal payments on an open-ended basis for qualifying state expenditures for both medical care and administrative costs.^[2] Under CHIP, the federal government contributes a fixed amount of federal dollars to states. As under Medicaid, states receive federal CHIP payments for qualifying expenditures (and at a higher federal contribution rate), but total federal allotments are fixed by law and a set amount is allocated to each state regardless of the number of children who qualify.

As of 2014, the health reform law both expands Medicaid to include low-income non-elderly adults, and sets uniform income and resource standards for determining eligibility.^[3] The law also requires nearly all individuals to have health insurance coverage. Although Medicaid-eligible individuals are not required to have health insurance coverage, the requirement underscores one of Medicaid's historic challenges, namely, how to address the number of individuals who are eligible under existing program standards but not enrolled. As recently as 2007, an estimated twenty-five percent of all uninsured adults, and seventy-five percent of uninsured children, were eligible but not enrolled in Medicaid or CHIP.^[4] By 2009, the number of eligible but not enrolled children had dropped to 64 percent.^[5]

Part of the challenge lies in the standards and procedures used to determine Medicaid and CHIP eligibility. Both programs accord states flexibility to adopt more generous financial eligibility standards by raising income eligibility levels, using more liberal asset levels, or disregarding assets entirely. States also have the option of adding coverage under Medicaid for optional groups of individuals whose coverage is not required under federal law and may extend “presumptive” (i.e., temporary) eligibility to certain populations under both Medicaid and CHIP. During periods of economic stress, states may reduce these optional groups or eligibility standards.

States also have considerable flexibility in the enrollment and retention procedures they use, with respect to the ease with which individuals can gain access to the enrollment process. State options extend to the simplicity or complexity of application forms, the screening procedures used to redetermine eligibility when coverage periods expire, and the use of procedures to assess whether enrolled beneficiaries whose circumstances have changed slightly in fact may continue to qualify under a different eligibility category without losing coverage.

These aspects of Medicaid and CHIP administration result in significant variation in outreach and enrollment from state to state. While some states have been successful in maximizing enrollment, in other states many eligible individuals may be missed. In the latter states, individuals who are eligible for Medicaid or CHIP may experience periods of interrupted coverage and thus are uninsured. Studies show that eligible individuals may not enroll in Medicaid and CHIP for a variety of reasons, including lack of accessible information regarding who is eligible for, or how to enroll in, the program, lengthy and complicated enrollment applications, which may include income and resource documentation requirements, and assessment of citizenship, identity, and residency. Beneficiaries may lose coverage because of the complexities of the redetermination process. Finally, because of Medicaid’s historical link to cash assistance, some individuals may resist enrollment because of concerns about stigma, and states themselves may exacerbate this sense of stigma through the eligibility standards, enrollment and retention procedures, and co-location of workers, application sites, and resources with welfare programs they use. State efforts to control their Medicaid and CHIP caseloads under Medicaid and CHIP also have a significant impact on state expenditures under Medicaid.^[6]

Recognizing the need for additional efforts to enroll children already eligible for Medicaid and CHIP and retain them in coverage arrangements, the Children’s Health Insurance Program Reauthorization of 2009 Act (CHIPRA) allocated \$100 million for a national outreach and enrollment campaign and for grants to states and localities to enroll eligible children in these programs.^{[7][8]}

Changes Made by the Health Reform Law

P.L. 111- 148, §§ [1413](#) [2001\(a\)\(4\)\(B\)](#) [2201](#) [2202](#)

State Exchange Requirements Relating to Medicaid and CHIP Outreach and Enrollment ([P.L. 111- 148, § 1413](#))

- Provides for the establishment of state-based health insurance exchanges, through which individuals and small businesses may enroll in health insurance coverage. To facilitate enrollment, the law directs the Secretary of Health and Human Services (HHS) to develop an integrated enrollment system that permits enrollment into Medicaid or CHIP through the exchange. Provides that the system must be coordinated with the federal subsidy program through the exchanges so that if individuals apply for federal subsidies (tax credits) for the purchase of health insurance coverage and are found to be Medicaid or CHIP-eligible, the system must enable enrollment into Medicaid and CHIP. The system must include a single application through which individuals can apply online, by mail or by phone. Individuals must be able to apply through an exchange or through state-operated subsidy enrollment process, and applications must be structured to maximize completion, taking into account the characteristics of individuals who apply. States may use an alternative streamlined form if it is consistent with standards established by the Secretary.

Medicaid Changes ([P.L. 111- 148, §§ 2001\(a\)\(4\)\(B\), 2201, 2202](#))

- Requires states, as a condition of participation in Medicaid, to simplify Medicaid enrollment and coordinate with state health insurance exchanges and CHIP. Specifically, states must establish procedures to:
 - allow individuals to apply for Medicaid, to enroll or reenroll in Medicaid through an Internet website;
 - allow individuals who are identified by a state's exchange as being eligible for Medicaid or CHIP to enroll through a website without any additional eligibility determination by the state^[9];
 - assure that individuals who apply for Medicaid or CHIP, but are found to be ineligible, are screened for eligibility for enrollment in qualified health plans offered through the exchange and for premium assistance and cost-sharing subsidy eligibility, so that enrollment can take place without a separate application to the exchange;
 - assure that the state agency or agencies responsible for administering Medicaid, CHIP and the state exchanges utilize a secure website to allow for an eligibility determination and enrollment in Medicaid, CHIP and for premium subsidies and enrollment in a qualified health plan offered through the exchange;
 - coordinate benefits for individuals who are enrolled in Medicaid or CHIP and also enrolled in a qualified health plan; and
 - conduct outreach and enrollment to vulnerable and underserved populations eligible for Medicaid and CHIP.
- Permits state Medicaid and CHIP agencies to enter into agreements with state exchanges to permit the state agency to conduct eligibility determinations for premium subsidies.
- Requires states to comply with streamlined enrollment procedures for Medicaid and

CHIP through state Exchanges as described above under Section 1413.

- Requires states to establish and operate an Internet website no later than January 1, 2014. The website must be linked to state Exchange, Medicaid and CHIP agencies allowing individuals who are eligible to receive benefits under Medicaid and eligible for premium credit assistance for a qualified health plan, to compare benefits, premiums, cost-sharing.
- Permits states to expand Medicaid “presumptive eligibility” to the expansion population, if the state has adopted presumptive eligibility for other populations permitted under current law, which include children, pregnant women, and women with breast or cervical cancer. If adopted by the state, a qualified provider, such as a pediatrician or community health center, may make a presumptive eligibility determination, based on the individual’s income. Presumptive eligibility permits providers to be reimbursed for Medicaid-covered services for a limited time until an official eligibility determination is made by the state.
- Permits hospitals that participate in Medicaid to make presumptive eligibility determinations for all categories of Medicaid-eligible individuals.

Implementation

Agency

HHS’s Center for Medicaid and CHIP Survey and Certification (CMCSC) (formerly the Center for Medicaid and State Operations), within the Center for Medicare and Medicaid Services will implement Medicaid and CHIP enrollment reforms as part of its authority over the Medicaid and CHIP programs. The statute does not specify which agency within the Department of Health and Human Services will be responsible for implementing rules or guidance related to the development of state level Exchanges, leaving the Secretary discretion to delegate authority as necessary. In all likelihood, these responsibilities will be delegated to the newly established Office of Insurance Oversight and Consumer Information.

Key Dates

State Exchanges and Internet websites must be operational by January 1, 2014. The Secretary is directed to submit an annual report to Congress beginning in April of 2015 on total enrollment and new enrollment in Medicaid.

Process

The health reform law does not provide specific direction to the Secretary regarding the administrative process used to implement the law. The agency therefore has the discretion to use a range of tools to implement the statute, such as publishing regulations in the Federal Register with a public notice and comment period, or using other types of approaches such as posted policy instructions, funding availability announcements (where applicable), official agency transmittals to affected entities, and posted rulings and notices. Agency websites can be checked regularly for updates. Typically, the Center for Medicare and Medicaid Services issues guidance to states in the form of letters to State Health Officials or State Medicaid Directors.

Key Issues

Income verification: The health reform law establishes a new uniform income eligibility standard for most populations eligible for Medicaid. For individuals applying online, how will income be verified? Will the Exchanges have access to verified income data to permit administrative verification?

To what extent will the federal government provide uniform platforms to enable states to make upgrades that work across state lines and with federal exchanges?

Citizenship verification: CHIPRA permits states to meet citizenship documentation requirements by conducting a data match with the Social Security Administration's database to verify U.S. citizenship, and that procedure will be used for determining status for individuals seeking coverage through Exchanges.

Application standards and procedures at the point of enrollment and redetermination: what standards will be established to assure the utility of applications and to promote continued eligibility without interruption?

Since most states do not currently provide for online, in person telephonic and email, how will states meet these requirements? How will the interface between public and private eligibility systems interface?

Minimum periods of enrollment: What procedures will be used in the case of individuals who, as a result of changed circumstances, become ineligible for Medicaid and must enroll in an exchange plan?

Exchanges: How will coordination requirements be addressed in states that choose not to operate Exchanges?

Recent Agency Action

No recent agency action as of the time of this writing.

Authorized Funding Levels

As an entitlement program, Medicaid is not limited to a specified appropriation level under federal law. Each year, Congress appropriates “such sums as may be necessary” for the federal government to meet its federal matching obligations to states. According to CBO, coverage expansions in Medicaid and CHIP will result in an increase of \$20 billion over 10 years, with most of this cost in the form of additional funding to states to cover the cost of the newly eligible individuals. (See entry on Medicaid: FMAP for more information). CBO did not provide separate estimates for Medicaid and CHIP.

[1] 42 U.S.C. § 1397aa et. seq.

[2] For additional information on federal matching assistance to states, see the [brief on Medicaid FMAP](#).

[3] For more information see the [implementation brief on Medicaid eligibility expansions](#)

[4] J. Holahan, A. Cook and L. Dubay, “Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?” Kaiser Commission on Medicaid and the Uninsured. Washington, DC. February 2007. Available online at <http://www.kff.org/healthreform/upload/8068.pdf> (Accessed May 17, 2010).

[5] G. Kenney, A. Cook and L. Dubay, “Progress Enrolling Children in Medicaid/CHIP: Who is Left and What are the Prospects for Covering more Children?” Urban Institute, Washington, D.C. December 2009. Available online at: <http://www.urban.org/url.cfm?ID=411981> (Accessed June 7, 2010).

[6] G. Kenney, J. Hadley, J. Pelletier. “Covering Kids & Families Evaluation: Health Care for the Uninsured: Low-Income Parents’ Perceptions of Access and Quality,” Urban Institute, Washington, DC. October 2009. Available online at: <http://www.rwjf.org/files/research/49969ckfparents1009.pdf>(Accessed May 12, 2010).

[7] P.L. 111-3, §201.

[8] CMS summaries of state efforts on outreach and enrollment activities funded through these grants for FY 2010 are available online at: <https://www.cms.gov/CHIPRA/Downloads/Grantees.pdf> (Accessed May 25, 2010).

[9] Additional requirements apply to state health insurance exchanges under § 1311(i) including the establishment of a “navigators” program to assist employers, employees, consumers or self-employed individuals who are likely to be qualified to enroll in a qualified

health plan.