Boston University School of Social Work
Center for Innovation in Social Work & Health

Medicaid 101 Webinar

Q&A Document

On June 14, 2022, the Catalyst Center hosted a national webinar entitled "Medicaid 101." The recording for this webinar is available here: https://ciswh.org/resources/medicaid-101-webinar/

During the webinar, participants shared questions in the chat. Catalyst Center staff have written responses to relevant questions for your reference.

Please feel free to reach out to the Catalyst Center at cyshcn@bu.edu with technical assistance questions related to health care coverage and financing for children and youth with special health care needs.

Q: Will we get this powerpoint?

The slide deck for the Catalyst Center's Medicaid 101 Webinar is available here: https://ciswh.org/resources/medicaid-101-webinar/

Q: How will the pending "medicaid purge" impact children? Children w/ special health care needs? What is the latest expected timeline?

Under the Families First Coronavirus Response Act, state Medicaid programs are eligible to receive an additional 6.2% federal funding match provided they meet specific Maintenance of Effort requirements, including providing continuous eligibility to those enrolled as of March 18, 2020, or at any time thereafter during the PHE.

When the PHE ends, states will need to redetermine the eligibility of over 80 million Medicaid enrollees, including an estimated 37.3 million children. An Urban Institute study estimates that 15 million people currently on Medicaid will no longer be eligible because their income has increased. Many children in families with increased incomes may now be eligible for CHIP or marketplace coverage, but it may be a complex process to transfer coverage between programs. There is also concern that children and families may lose coverage for administrative reasons (returned mail, for example) even if they might still be eligible for Medicaid. During the COVID-19 pandemic, many enrollees have lost housing or moved, resulting in out-of-date mailing lists.

The Biden Administration has indicated that it will give 60 days notice before declaring an end to the COVID-19 Public Health Emergency (PHE). The most recent renewal extended the PHE to July 15, 2022. Since July 15 is less than 60 days from the drafting of this document, and the administration has not announce that it intends to allow the PHE to expire, policy experts expect the PHE will be extended

another 90 days. [*Editor's note: the COVD-19 Public Health Emergency (PHE) was extended on July 15th and expires on October 15th if it is not renewed*]

The Centers for Medicare & Medicaid Services has released guidance to states related to the unwinding of the PHE, including recommendations for processing redeterminations and a toolkit for communicating with beneficiaries. Links to this guidance, as well as analysis and recommendations related to maintaining Medicaid for children during the unwinding can be found on the Catalyst Center website: https://ciswh.org/projects/the-catalyst-center/phe-resources

Q: Can you give an example of how [premiums under a Family Opportunity Act Medicaid Buy-In program] [work]? If a family of 3 makes $35k a year, is it full covered or would the family pay some?

Under the Family Opportunity Act, states have the option of implementing Medicaid Buy-In programs for children with disabilities whose families earn too much to qualify for Medicaid based on income. Under this option, adjusted family income must be below 300% of the Federal Poverty Level (FPL) – though states may choose to set the eligibility cap lower - and states may choose to charge families a premium.

For a family of three, $35k is roughly 152% FPL. In many states, though not in the states in the examples below, children would be eligible for Medicaid coverage based on income at this level.

To respond to the question, we will take the example of Louisiana, a state that has implemented a Medicaid Buy-In program under the Family Opportunity Act. To be eligible for coverage under this option, a child must be 18 or younger, meet disability criteria under the SSA listing of impairments, and have an effective family gross income at or below 300% FPL. Louisiana has a sliding scale for premiums based on income. Families making 200% FPL or below do not pay a premium, so with an income at 152% FPL, a family in Louisiana would not pay a premium.

As another example, North Dakota caps income eligibility for their Medicaid Buy-in program at 250% FPL, and all families are required to pay a premium equal to five percent of their gross countable income. A family making $35k would still be eligible at 152% FPL, and they would pay a monthly premium of roughly $145. However, in North Dakota, if the child has additional private insurance, this premium is reduced by the amount that the family pays for the private coverage premium.

Q: Another question: If a child needs to see a dermatologist and the only one who takes the child's Medicaid is 8 hours away, is Medicaid required to pay for a local dermatologist? Thank you!

[Gina Robinson, Senior Policy Advisor/EPSDT Administrator, Colorado Medicaid, contributed to this response]

Medicaid is not required to pay a non-contracted provider for a service simply because the non-contracted provider is closer to where the patient lives.

Generally, states have a great deal of flexibility in the design and implementation of their Medicaid programs, and each state sets its own policies and processes within federal guidelines.

According to a CMS 2014 guide for states on the EPSDT benefit[1], "Access to covered services is of course a critical component of delivering an appropriate health benefit to children. Accordingly, a number of Medicaid and EPSDT provisions are intended to assure that children have access to an adequate number and range of pediatric providers. For example, states are required to 'make available a variety of individual and group providers qualified and willing to provide' services to children. States must also 'take advantage of all resources available' to provide a 'broad base' of providers who treat children. Some states may find it necessary to recruit new providers to meet children's needs. In the event a child needs a treatment that is not coverable under the categories listed in section 1905(a), states are to provide referral assistance that includes giving the family or beneficiary the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family."

A state may try to locate a willing provider closer than 8 hours away. Of note, all state Medicaid programs are required to have a non-emergency transportation benefit, which may be relevant for helping the family travel to the available service provider.

Q: What is the definition of care coordination provided by the MMC?

Medicaid Managed Care (MMC) organizations often provide services to beneficiaries like care coordination and case management. Other entities such as health care provider practices, hospitals, state Title V programs, and commercial managed care companies may also provide care coordination.

There is no consensus regarding what activities comprise care coordination. For services provided by insurers, contracts describe the services that are included in care coordination. Member handbooks often include descriptions of services included in care coordination. Two resources related to care coordination for Children and Youth with Special Health Care Needs (CYSHCN) that we recommend are the National Center for Care Coordination, and the National Standards for Care Coordination for Children and Youth with Special Health Care Needs (CYSHCN).

[1] Page 31.EPSDT Coverage Guide. Accessed at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/epsdt_coverage_guide.pdf