Medicaid and CHIP Maintenance of Effort (MOE): Requirements and Responses

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Summary

State revenues declined during the recent economic recession (December 2007 through June 2009) and have not fully recovered. At the same time, the recession increased the number of individuals meeting Medicaid's income eligibility standards. States are faced with tough decisions about where to direct their increasingly limited funds.

This state fiscal condition is a reason the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5; and subsequently extended in P.L. 111-226) included a temporary increase to Federal Medical Assistance Percentage (FMAP) rates. As a condition of the receipt of the federal Medicaid matching funds made available under ARRA, states were required to maintain their Medicaid programs with the same eligibility standards, methodologies, or procedures for Medicaid through June 30, 2011. This provision is referred to as the ARRA Maintenance of Effort (MOE) requirement.

The ARRA MOE provisions were extended and expanded in the Patient Protection and Affordable Care Act as modified by the Health Care and Education Reconciliation Act of 2010 (ACA, P.L. 111-148 as modified by P.L. 111-152). ACA's MOE provisions were designed to ensure that individuals eligible for Medicaid or the State Children's Health Insurance Program (CHIP) did not lose coverage in the period between the date of enactment of ACA (March 23, 2010) and the implementation of the state health insurance exchanges (expected in 2014).

Because states are prohibited from curbing the cost of Medicaid through restricting eligibility standards due to the MOE requirements included in ARRA and ACA, states have focused cost containment strategies on reducing provider rates, making changes to their benefit packages, or implementing limitations on the use of benefits. However, states want greater flexibility to restrain their Medicaid expenditures through eligibility restrictions.

This report summarizes the MOE requirements enacted under ARRA and ACA and what these requirements have meant for states in terms of their actions to restrict Medicaid and/or CHIP eligibility. It also summarizes recent legislative activity to repeal the MOE requirements.

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Introduction

State revenues declined during the recent economic recession (December 2007 through June 2009) and have not fully recovered.[1] This decline in revenue continues to place considerable strain on state budgets. As a result, nearly all states made spending cuts—both to public programs and for public employees.[2] At the same time, the recession increased the number of individuals meeting Medicaid's income eligibility standards.[3] This resulted in higher program enrollment and therefore higher state spending on Medicaid benefits.[4] Given declining state tax revenue, in conjunction with requirements in all states but Vermont for balanced operating budgets, states are faced with tough decisions about where to direct the limited funds.

This state fiscal condition is a reason the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5 as extended) included a temporary increase to the Federal Medical Assistance Percentage (FMAP) rates to help states maintain their Medicaid programs and free up funds that states would have otherwise used for Medicaid to address other state budgetary needs.[5] As a condition of the receipt of the federal Medicaid matching funds made available under the ARRA FMAP provision, states were required to maintain their Medicaid programs with the same eligibility standards, methodologies, or procedures for Medicaid through June 30, 2011 (i.e., the end of the ARRA temporary FMAP adjustment period). This provision is referred to as the Maintenance of Effort (MOE) requirement.

With the enactment of the Patient Protection and Affordable Care Act as modified by the Health Care and Education Reconciliation Act of 2010 (ACA, P.L. 111-148 as modified by P.L. 111-152), the ARRA MOE provisions were extended and expanded. ACA's MOE provisions were designed to ensure that individuals eligible for Medicaid or the State Children's Health Insurance Program (CHIP) did not lose coverage in the period between the date of enactment of ACA (March 23, 2010) and the implementation of the state health insurance exchanges (expected in 2014).[6] Generally, beginning in 2014, Medicaid-eligible adults who were no longer protected by

[1] State tax revenues at the national level were still 7.5% lower in the third quarter of 2010 than in the same quarter of 2008. Source: L. Dadayan and D. Boyd, State Tax Revenues Gained New Strength in Fourth Quarter: Every Quarter of 2010 Showed Growth, But Recession's Harsh Impact will Linger, State Revenue Report Number 82, The Nelson A. Rockefeller Institute of Government, Albany, New York, February 2011.

[2] Vernon K. Smith, Ph.D., Kathleen Gifford, and Eileen Ellis (Health Management Associates), et al., Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011, Kaiser Commission on Medicaid and the Uninsured, Executive Summary, Washington, DC, September 2010, http://kff.org/medicaid/upload/8105_ES.pdf.

[3] Eligibility for Medicaid is means-tested. Applicants must meet certain income and sometimes asset tests to qualify. For more information about Medicaid eligibility see, CRS Report RL33202, *Medicaid: A Primer*.

[4] Source: Christopher J. Truffer, F.S.A, John D. Clemm, Ph.D., A.S.A., M.A.A.A., and Christian J. Wolfe, et al., *2010 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, Washington, DC, December 21, 2010.

[5] Medicaid is jointly funded by the federal government and the states. The federal government's share of most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), which varies by state and is determined by a formula set in statute. For more information on Medicaid FMAP, See CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by (name redacted) and (name redacted).

[6] Exchanges will not be insurers, but will provide qualified individuals and small businesses with access to private health insurance options. For information about the private insurance provisions in the federal health reform law, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by (name redacted) and (name redacted) .

MOE would presumably have access to subsidized coverage through state exchanges.[7] Under the ACA MOE, with certain exceptions, states are required to maintain their Medicaid and CHIP programs until 2014 with the same eligibility standards, methodologies, or procedures in place as of March 23, 2010. For Medicaid and CHIP-eligible children up to age 19, the MOE requirement extends through September 30, 2019.[8] Failure to comply with these requirements would result in the loss *all* federal Medicaid matching funds.

Because states are prohibited from curbing the cost of Medicaid through restricting eligibility standards due to the MOE requirements included in ARRA and ACA, over the past few years, states have focused cost containment strategies on reducing provider rates, making changes to their benefit packages, or implementing limitations on the use of benefits.[9] However, with the June 30, 2011, phase-out of the enhanced federal Medicaid funding under ARRA, states have been seeking congressional relief from the MOE requirements.[10] States want greater flexibility to restrain their Medicaid expenditures through eligibility restrictions.

This report summarizes the MOE requirements enacted under ARRA and ACA and what these requirements have meant for states in terms of their actions to restrict Medicaid and/or State Children's Health Insurance Program (CHIP) eligibility. It also summarizes recent legislative activity to repeal the MOE requirements.

Background on the Medicaid and CHIP Programs

Medicaid is a means-tested individual entitlement program that finances the delivery of primary and acute medical services as well as long-term care to more than 68 million people (FY2010) who meet both income and categorical eligibility criteria. While Medicaid is considered a mandatory program in federal budget terms, states choose whether to participate, and all 50 states, the District of Columbia, and the territories do. The federal and state governments share the cost of Medicaid. States are reimbursed by the federal government for a portion (the "federal share") of a state's Medicaid program costs. In FY2010, Medicaid spending totaled approximately $406 billion, with a federal share of $274 billion and a state share of $132 billion. As a condition of receipt of any federal financial participation (FFP), states must meet their state share requirements, have a plan for medical assistance approved by the Secretary of Health and Human Services (HHS), and comply with Medicaid program rules.

[7] ACA's coverage provisions related to the expansion of Medicaid eligibility and establishment of health insurance exchanges were designed to be mutually exclusive. In other words, as long as a person is eligible for Medicaid and can enroll in a state Medicaid program, that person may not enroll in an exchange plan, nor access the premium credits and cost-sharing subsidies available in the exchanges. See CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline*, by (name redacted) et al.

[8] This MOE provision does not prohibit states from cutting Medicaid in other ways, such as by reducing provider reimbursement rates or by eliminating optional benefits. States are not prohibited from expanding Medicaid coverage during the MOE period.

[9] The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2009 and 2010, Kaiser Commission on Medicaid and the Uninsured, September 2009, available at http://www.kff.org/medicaid/upload/7985.pdf.

[10] Under ACA, states that have, or are projected to have, a budget deficit, may be exempted from the ACA MOE requirements, but only with respect to individuals who are non-pregnant, non-disabled adults who are eligible for medical assistance under a state plan or waiver of a state plan, and whose income exceeds 133% of the federal poverty level (FPL). This action is referred to as the "Section 2001(b)(3) exemption."

CHIP was established by the Balanced Budget Act of 1997 (P.L. 105-33) and was recently reauthorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3). CHIP provides health coverage to uninsured, low-income children in families with annual income above Medicaid eligibility thresholds. When certain conditions are met, CHIP coverage is also available to pregnant women and parents. In FY2010, there were approximately 7.7 million children and 347,143 adults (ever enrolled) in CHIP, and the estimated annual cost to the federal and state governments was roughly $11.4 billion in FY2010, with a federal share of $8.0 billion and a state share of $3.4 billion.

As with Medicaid, CHIP is funded jointly by the federal government and the states, and is administered by the states. Also like Medicaid, CHIP is considered a mandatory spending program in terms of the federal budget. However, rather than being considered an individual entitlement, CHIP operates as a capped entitlement to states. States with approved CHIP plans that comply with program rules and that meet their state share requirements are entitled to a portion of a national annual appropriation. All 50 states, the District of Columbia, and the territories choose to participate in the CHIP program.

Maintenance of Effort Requirements Under ARRA, as Extended

During the most recent recession, Congress provided additional economic stimulus funding to states, including a temporary increase to the Federal Medical Assistance Percentage (FMAP) rate that defines the federal government's share of a state's expenditures for most Medicaid services. The temporary FMAP increase enacted under ARRA was later extended by P.L. 111-226. The temporary FMAP increase runs for 11 quarters, from the first quarter of FY2009 through the third quarter of FY2011 (i.e., October 2008 through June 2011), subject to certain requirements, including a Maintenance of Effort (MOE) requirement.[11]

The ARRA MOE provision generally requires states with Medicaid programs in effect on July 1, 2008, to maintain their programs with the same eligibility standards, methodologies, or procedures for Medicaid through June 30, 2011 (i.e., the end of the ARRA temporary FMAP adjustment period). Failure to comply with the MOE requirements means a state would lose its increase in its federal Medicaid matching funds made available under the ARRA FMAP provision. Section 5001(f)(1)(B) and (C) permits states that have restricted their "eligibility standards, procedures, or methodologies" to reinstate them in any quarter to begin receiving the temporary FMAP increase. In addition, those states that reinstated their "eligibility standards, procedures, or methodologies" prior to July 1, 2009, received the increase for the first three quarters of FY2009. States were required by HHS to attest that they met the eligibility requirements.[12] HHS indicated that four states (Mississippi, North Carolina, South Carolina, and Virginia) were ineligible when funding estimates were first released on February 23, 2009, but those states have since been cleared to receive the FMAP increase. A more recent study found that

[11] For more information on ARRA's temporary FMAP increase, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*. The ARRA MOE requirement is found in Section 5001(f) of the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) and was later extended by the Education, Jobs and Medicaid Assistance Act (P.L. 111-226).

[12] See http://www.hhs.gov/recovery/fmapprocess.html.

the ARRA requirements resulted in 14 states reversing and 5 states abandoning planned restrictions to eligibility.[13]

Under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, a number of states were required to move their childless adult populations out of CHIP by December 31, 2009, and could apply to have them enrolled under a Medicaid waiver. However, ARRA FMAPs were not originally available for these childless adults because they had not been eligible for Medicaid on July 1, 2008 (as stated above). Under P.L. 111-226, states can now receive ARRA FMAPs for non-pregnant childless adults in Medicaid who would have been eligible for CHIP based on standards in effect on December 31, 2009. It appears that Idaho, Michigan, and New Mexico will benefit from this provision.[14]

Medicaid Maintenance of Effort Requirements Under ACA

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), made significant changes to Medicaid and extended federal financing for CHIP through FY2015.[15] The most noteworthy change begins in 2014, or sooner at state option, when states are required to expand Medicaid eligibility to individuals under age 65 with income up to 133% of the federal poverty level (FPL) (effectively 138% FPL with the Modified Adjusted Gross Income or MAGI 5% FPL income disregard). At the same time, with certain exceptions, ACA requires states to maintain current Medicaid and CHIP eligibility levels.[16]

Under ACA, the ARRA MOE provisions were extended and expanded. ACA's MOE provisions were designed to ensure that Medicaid and CHIP-eligible individuals did not lose coverage in the period between the date of enactment of ACA (March 23, 2010) and the implementation of the state health insurance exchanges (expected in 2014). The ACA Medicaid MOE provision generally requires that states with Medicaid programs in effect on March 23, 2010, maintain their programs with the same eligibility standards, methodologies, or procedures until the health insurance exchanges are operational. Additionally, the Medicaid MOE for Medicaid-eligible children up to age 19 continues until September 30, 2019. Failure to comply with the ACA MOE requirements would result in a loss of *all* federal Medicaid matching funds for that state. This differs from the ARRA MOE requirement, under which states that do not comply would only lose access to the additional federal funds made available through the increase in the FMAP rate.[17]

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[13] See Kaiser Commission on Medicaid and the Uninsured, State Fiscal Conditions and Medicaid, September 2009, available at http://www.kff.org/medicaid/upload/7580-05.pdf.

[14] CRS analysis of eligibility information under their special terms and conditions (STCs) of the Section 1115 waivers associated with these states.

[15] For more information about the Medicaid provisions in ACA, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline*, by (name redac ted) et al.

[16] The ACA MOE requirements are found in Section 2001(b) of the Patient Protection and Affordable Care Act as modified by Section 10201 of the Health Care and Education Reconciliation Act of 2010 (ACA, P.L. 111-148 as modified by P.L. 111-152); and Section 2101(b) as modified by §10203(c)(2)(A)(i)- §10203(c)(2)(A)(iv) of ACA.

[17] For additional information on the interaction of ARRA MOE provisions and the ACA MOE provisions during the period between January 1, 2011, through June 30, 2011, see February 25, 2011, *CMS State Medicaid Director Letter*
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Section 2001(b)(3) provides for an exemption to this MOE requirement for states that have, or are projected to have, a budget deficit, but only with respect to individuals who are non-pregnant, non-disabled adults who are eligible for medical assistance under a state plan or waiver of a state plan, and whose income exceeds 133% FPL (or 138% FPL with the MAGI income counting disregard). This MOE provision does not prohibit states from cutting Medicaid in other ways, such as by reducing provider reimbursement rates or by eliminating optional benefits. States are not prohibited from expanding Medicaid coverage during the MOE period.

State Actions

Arizona had planned to "scale back eligibility" for parents and childless adults under its Medicaid Section 1115 waiver,[18] but the state did not take these actions. Initially, Arizona concluded that the changes would violate the MOE requirements in ACA.[19] However, later, in a February 15, 2011, letter to the governor of Arizona,[20] the Secretary of HHS ruled that the MOE provision in ACA does not require Arizona to renew its Section 1115 waiver demonstration as is, beyond its expiration date of September 30, 2011. According to Secretary Sebelius's letter, any reduction in eligibility associated with the expiration of Arizona's demonstration "for individuals whose eligibility derives from the demonstration" would not constitute a violation of ACA's MOE requirements.[21]

In March 2011, Governor Brownback, of Kansas, sent a letter to the Secretary of HHS requesting approval to block grant the state's Medicaid program, and seeking "a complete waiver of the Maintenance of Effort (MOE) requirements."[22] On March 30, 2011, the Secretary of HHS responded to the governor by saying, "I look forward to learning more details about your proposals."[23] To date, a formal waiver proposal submission detailing Governor Brownback's proposal is not publicly available.

With regard to states' actions using the "Section 2001(b)(3) exemption," no state has sought a state plan amendment to invoke the exemption under the Medicaid state plan authority. However, two states (i.e., Maine and Hawaii) have certified to CMS that the state is experiencing a budget shortfall under its Section 1115 waiver programs. Such certification represents the first in a two-step process for the state to begin scaling back its eligibility requirements. The second step of the

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Re: Maintenance of Effort SMDL# 11-001 ACA # 14 available at https://www.cms.gov/smdl/downloads/SMD11001.pdf.

[18] Letter from Maria Coury to Steven Rubio, CMS, March 18, 2010, available at http://www.azahcccs.gov/shared/Downloads/News/WaiverNotice_Final.pdf. Also see February 3, 2010, letter from Governor Brewer to Secretary Sebelius regarding the state's request to scale back on their Medicaid adult coverage, at http://azgovernor.gov/dms/upload/PR_020311_SebeliusLetter.pdf.

[19] See letter from Arizona Health Care Cost Containment System (AHCCCS) Director Thomas J. Betlach to Governor Janice K. Brewer, March 25, 2010, http://www.azahcccs.gov/reporting/Downloads/HealthCareReform/GovernorBrewerLetter_03-25-10.pdf.

[20] See http://azgovernor.gov/dms/upload/PR_021511_SebeliusLetter.pdf.

[21] Additional information on the interaction of Section 1115 waivers and the ARRA and ACA MOE requirements is addressed in the following State Medicaid Director Letter available at https://www.cms.gov/smdl/downloads/SMD11001.pdf.

[22] See http://media.khi.org/news/documents/2011/03/10/Health_Care_Waiver_Request_Letter.pdf.

[23] See http://media.khi.org/news/documents/2011/04/08/Secretary_Sebelius_Response_to_KS_Governor_Brownback_033011.pdf.

process involves the state seeking CMS approval to make a change in the state's upper income eligibility. According to CMS, Maine has CMS approval to scale back its eligibility requirements but has not formally applied for the eligibility change. By contrast, Hawaii is in the process of seeking CMS approval to scale back its childless adult coverage from 200% FPL to 133% FPL.[24]

CHIP Maintenance of Effort Requirements Under ACA

This CHIP-specific MOE provision generally requires states to maintain income "eligibility standards, methodologies and procedures" in effect as of March 23, 2010, through September 30, 2019, as a condition of receiving federal matching payments under Medicaid. Specifically, with the exception of waiting lists for enrolling children in CHIP or enrolling CHIP-eligible children in exchange plans when federal CHIP funding is no longer available, states cannot implement eligibility standards, methodologies, or procedures that are more restrictive than those in place on the date of enactment of ACA. However, states can expand their current income eligibility levels—that is, states can enact less restrictive standards, methodologies, or procedures.

State Actions

Prior to ACA, Arizona planned to "eliminate the KidsCare [CHIP] program effective June 15, 2010."[25] However, the state did not take these actions. Arizona does, however, have HHS approval to freeze its CHIP program enrollment because Arizona's CHIP enrollment freeze was in place prior to the enactment of ACA (i.e., effective January 1, 2010). In a letter dated May 17, 2010, from Victoria Wachino, the Director of the Family and Children's Health Programs Group at the Centers for Medicare and Medicaid Services (CMS), to Ms. Monica Coury, the Assistant Director of the Office of Intergovernmental Relations for the state's Arizona Health Care Cost Containment System (AHCCCS), CMS stated:

> Prior to the enactment of the Affordable Care Act, Arizona had an approved State Plan to freeze enrollment and had stopped enrolling new children in CHIP pursuant to its eligibility freeze. Since the enrollment freeze was an eligibility procedure in place as of the March 23, 2010, MOE date, we do not believe that the continuation of the enrollment freeze would be a change in Arizona's eligibility procedures that would trigger an MOE violation.[26]

Recent Legislative Activity

To obtain fiscal reprieve, some states have pondered either dropping out of Medicaid entirely or scaling back on eligibility.[27] Recently, states have been seeking congressional relief from the

[24] Conversations with CMS regarding state actions under the Section 2001(b)(3) exemption as of November 3, 2011.

[25] Letter from Arizona Health Care Cost Containment System (AHCCCS) Assistant Director Monica Coury to Moe Gagnon, CMS, March 18, 2010, http://www.azahcccs.gov/shared/Downloads/News/Cover_Letter_KC_Elim.pdf.

[26] See http://www.azahcccs.gov/reporting/Downloads/Legislation/2010seventh/12_7_2010AZ_CHIPltr0001.pdf, and http://www.azahcccs.gov/reporting/Downloads/Legislation/2009fifth/CMS_clarification_re_enrollment_freeze_5_17_10.pdf.

[27] For example, see "States' Woes Spur Medicaid Drop-Out Talk," Emily Ramshaw, The Texas Tribune, November 12, (continued...)

MOE requirements, to provide them with greater flexibility to restrain Medicaid expenditures through eligibility restrictions. On May 3, 2011, the House of Representatives introduced H.R. 1683, the State Flexibility Act, which would repeal the MOE requirements for Medicaid and CHIP included in ARRA and ACA.

CBO and the staff of the Joint Committee on Taxation (JCT) estimated that enacting H.R. 1683 would reduce the federal deficit by approximately $2.1 billion over the 2012-2021 period.[28] Their estimate includes the net impact on direct spending and revenues from changes in enrollment in Medicaid, CHIP, health insurance purchased through exchanges, and employer-based health insurance. Of this amount, CBO estimates that federal Medicaid spending would decline by roughly $1.5 billion over the five-year period (2012-2016), with no additional savings or costs occurring in the next five years of the budget window. For CHIP, CBO estimates that federal spending would decline by an estimated total of $8.8 billion over 10 years. The Medicaid and CHIP savings would be largely offset by increased enrollment in employer-sponsored plans and additional exchange subsidies.[29]

With regard to enrollment, CBO estimates that H.R. 1683 would reduce Medicaid and CHIP enrollment by about 400,000 individuals in 2013, of which approximately 300,000 would become uninsured and 100,000 would enroll in employer-based coverage. In 2014, individuals would be eligible for Medicaid based on the new income requirements established in ACA, eliminating the impact of repealing MOE requirements on Medicaid enrollment. In 2016, CBO estimates that CHIP enrollment would decline by about 1.7 million individuals, while employer-based insurance would increase by 700,000. Relative to current law projections, approximately 300,000 individuals would become uninsured in 2016.

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[28] CBO cost estimate of H.R. 1683, May 11, 2011, available at http://www.cbo.gov/ftpdocs/121xx/doc12184/hr1683.pdf.

[29] CBO's estimate includes increased costs of about $8.1 billion over 2012-2021 (numbers may not add due to rounding) for premium and cost-sharing subsides for health insurance offered through the exchanges, as well as reduced revenues reflecting the change in the mix of compensation provided to workers between taxable wages and salaries and nontaxable health insurance benefits.