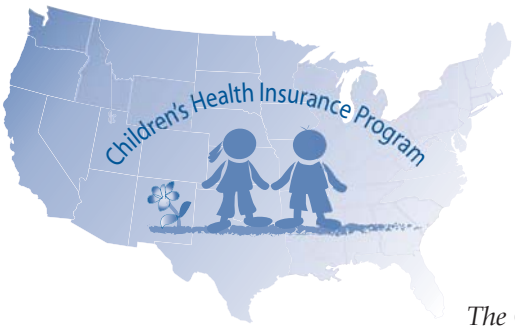


Covering More Children, Rewarding Success: State Performance Bonuses

The Children's Health Insurance Program (CHIP) was created in 1997 to provide affordable health coverage to low-income children in working families who make too much money to be eligible for Medicaid but not enough to afford private coverage. The program currently covers more than 7 million children. In February 2009, after a protracted political fight, Congress enacted, and President Obama signed, legislation that renewed CHIP through the end of 2013 and expanded its scope. This series of issue briefs examines the new provisions that were included in the reauthorization and how they will affect implementation in the coming months.

There are approximately 8.6 million uninsured children in this country, and an estimated two-thirds of them are currently eligible for Medicaid or CHIP. The Congressional Budget Office estimates that, because of the additional funding, tools, and incentives that were included in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), states will be able to cover nearly half these children—about 4.1 million children—two-thirds of them in CHIP, and one-third of them in Medicaid.[1]

One important goal of CHIP reauthorization was to help states find and enroll more uninsured children who are eligible for Medicaid rather than CHIP. These are children in families with lower incomes than those who qualify for CHIP—children who are often not the focus of state outreach and enrollment efforts. One key way to encourage states to focus on enrolling these lower-income children is to reward states for their efforts. This issue brief focuses on the new system of performance bonuses that is designed to encourage and reward states for improving uninsured children's participation rates in Medicaid.

The Matching Game

Both the CHIP and Medicaid programs are state-federal partnerships. From a financing perspective, this means that the states and the federal government share program costs. The federal government pays at least 50 percent of the costs for Medicaid and 65 percent of the costs for CHIP depending on the state (states pay the remainder). The federal share is based on the average per capita income in each state, and the federal government pays a higher share of the costs for both programs in those states with lower per capita incomes. It may seem perverse that the federal government shoulders a greater share of the cost for covering the relatively higher-income children in CHIP than the lower-income children in Medicaid. However, when the original CHIP legislation was passed in 1997, Congress established the higher CHIP matching rate in order to induce states to enact CHIP programs and expand coverage to more children. Now that states have robust CHIP programs, the performance bonus will provide states with additional funding for covering more of the lower-income children who are eligible for Medicaid.

Why Are Performance Bonuses Needed?

Performance bonuses are designed to fulfill two goals. First, they are designed to give states an incentive to get the lowest-income uninsured children—those who are eligible for Medicaid—covered, despite the fact that covering those children draws a lower federal matching rate than enrolling children in CHIP. Second, they are designed to offset the additional costs that states incur when they enroll children in Medicaid: Over the last decade, states have found that when they engaged in efforts to find and enroll uninsured children, they often discovered more children who were eligible for Medicaid—and thus would receive the lower federal matching rate—than children who were eligible for CHIP. Performance bonuses will help address both of these issues.

How Do States Earn Performance Bonuses?

There are two things that states must do in order to qualify for a performance bonus:

1. exceed their state-specific Medicaid enrollment target for children, and
2. implement at least five of eight designated strategies for increasing enrollment and retention of children in Medicaid and CHIP.

1. Increasing Children's Medicaid Enrollment

- **Medicaid Enrollment Baseline**: To qualify for a bonus, a state must demonstrate that it has enrolled more eligible children than it would have expected to enroll in a given year based on the growth in the number of children in the state. CHIPRA establishes a formula for each state's children's Medicaid enrollment "baseline," and the bonuses will be awarded based on how many children a state covers above its baseline. The more a state exceeds its baseline, the higher its bonus will be. See Table 1 for baseline calculations.

Table 1.
State Medicaid Baseline Formula

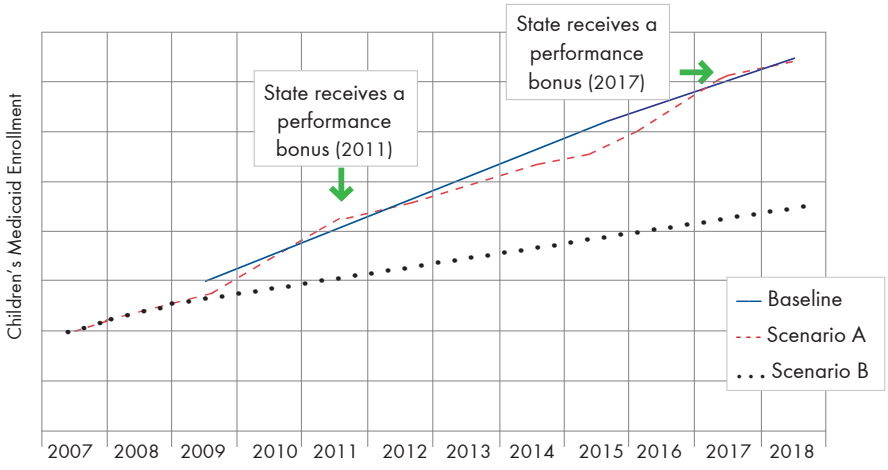
Federal Fiscal Year	Baseline Formula
2009	2009 baseline = Average monthly enrollment in children's Medicaid in federal fiscal year 2007 x (1.04 + child population growth rate in the state between 2007 and 2008) x (1.04 + child population growth rate in the state between 2008 and 2009)
2010-2012	Previous year's baseline x (1.035 + child population growth between previous and current year)
2013-2015	Previous year's baseline x (1.03 + child population growth between previous and current year)
2016 and Subsequent Years	Previous year's baseline x (1.02 + child population growth between previous and current year)

Source: Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

Unlike other measures in CHIP, the baseline measure is never readjusted: Every state's baseline will increase each year, regardless of how many children the state enrolls in Medicaid. That means that states must move quickly to take advantage of the performance bonus, because states that wait will have more difficulty achieving the kind of enrollment increase that is needed to qualify for a bonus.

Figure 1 provides a hypothetical example of how two states with different circumstances compare in their efforts to achieve a performance bonus. Scenario A shows a state that has presumably enacted at least five of the eight enrollment strategies and might also have expanded children's eligibility. Its growth in children's Medicaid enrollment increases accordingly. The state exceeds its Medicaid baseline in 2011 and 2017, so it would receive performance bonuses for each of those years. Scenario B shows a state with much slower enrollment growth that does not keep up with the baseline target. The longer the state waits to mount a significant outreach and enrollment campaign, the larger gains it will need to make to qualify for a performance bonus.

Figure 1. The Medicaid Enrollment Baseline



Note: Based on a hypothetical state. Scenarios A and B both begin with the same children's Medicaid enrollment, and annual growth in child population is assumed to be constant each year under both scenarios.

- **How Much Can My State Get?**

  Tier I Bonus: If a state exceeds its baseline by 10 percent or less, it will receive "Tier I" bonus payments. For every child enrolled in Medicaid above the state's baseline, the federal government will pay 15 percent of the state cost. For example, consider a hypothetical state where the annual per capita cost of covering a child in Medicaid (the total cost, including both the federal and the state's share) is $2,000. If the state has a 50 percent federal matching rate (FMAP—federal medical assistance percentage) in its Medicaid program, the state's share of the cost of covering each child is $1,000. The Tier I bonus payment for that state would be $150 per additional child (15 percent of the state's share of $1,000). So, if our hypothetical state enrolled 500 children above its Medicaid baseline, it would receive a total Tier I bonus payment of $75,000 ($150 x 500):

  Annual per capita cost = $2,000
  Federal share: $2,000 x 50% FMAP = $1,000
  State's share: $2,000 annual cost – $1,000 federal share = $1,000
  Tier 1 bonus payment: $1,000 x 15% = $150
  $150 per capita bonus payment x 500 children above baseline = $75,000

  Tier II Bonus: If a state exceeds its enrollment baseline by more than 10 percent, it also receives Tier II bonus payments. For each child enrolled above the Tier I cutoff (110 percent of its enrollment baseline), states get a bonus payment equal to 62.5 percent of the state portion of the per capita cost of Medicaid coverage. For example, if the same state from the example above actually exceeded its enrollment target by 750 children, it would receive the Tier I bonus shown above for the first 500 children over its Medicaid baseline and an additional Tier II bonus for the next 250 children. The state would thus receive $231,250 in federal bonus payments:

  Annual per capita cost = $2,000
  Federal share: $2,000 x 50% FMAP = $1,000
  State's share: $2,000 annual cost – $1,000 federal share = $1,000
  Tier I bonus payment: $1,000 x 15% = $150
  Tier II bonus payment: $1,000 x 62.5% = $625
  $625 per capita bonus payment x 250 children above 110% baseline = $156,250
  Tier I bonus ($75,000) + Tier II bonus ($156,250) = $231,250

- **How Much Is Available Altogether for the Performance Bonuses?** CHIPRA sets aside an initial $3.2 billion from the FY 2009 CHIP allotments to pay for these performance bonuses. In future years, any unspent federal CHIP funding will go toward paying performance bonuses. "Unspent federal CHIP funding" includes 1) unspent state allotments, 2) money that was available for redistribution but that did not get spent, and 3) extra funding from the Contingency Fund (which was created by CHIPRA to fill CHIP funding shortfalls). Ultimately, the amount of money that will be available for performance bonuses will depend on how successful states are at enrolling both children eligible for Medicaid and children eligible for CHIP.

2. Implementing Enrollment Simplifications and Other Best Practices

In order to increase the number of children enrolled in Medicaid and exceed their baseline enrollment targets, states will need to conduct outreach campaigns and simplify the policies and procedures they use when families apply for and renew Medicaid coverage. As an extra incentive for states to simplify their application and renewal procedures, CHIPRA requires states to implement at least five of eight specific policies in order to qualify for a performance bonus. These policies have proven effective at increasing enrollment of eligible children in Medicaid and CHIP and at ensuring that eligible children retain their coverage for as long as they are eligible. Implementing these practices will enable states to reach as many uninsured children as possible. With the exception of premium assistance, a state must adopt these policies in both its children's Medicaid program and its CHIP program in order for the policy to count as one of the state's five policies for the purpose of determining performance bonuses. Premium assistance needs only to be adopted in one program to "count."

While Table 2 on page 6 provides a general description of each of the eight enrollment strategies, it is not yet known how broadly states need to apply a given policy in order for it to count as one of a state's five of eight policies for performance bonus purposes. Currently, some states apply certain simplifications only to specific subsets of their children's Medicaid and/or CHIP populations. For example, Wisconsin applies presumptive eligibility only to children with family incomes below 150 percent of the federal poverty level, and in Florida, children under age five receive 12-month continuous eligibility in Medicaid, but those ages six and older have only six-month continuous eligibility.

Another question yet to be answered is whether a state must have adopted the policy for the entire fiscal year in order to qualify for a performance bonus in that year, or if a state can qualify if it adopts and implements simplification policies during the fiscal year. The Centers for Medicare and Medicaid Services (CMS) will likely answer these and other questions in official guidance letters in the coming months.

The policies enumerated in CHIPRA are not new ideas. In fact, more than a decade of experience has shown that these policies are effective at increasing the number of eligible children

Table 2.
Designated Enrollment and Retention Strategies for Medicaid and CHIP

Enrollment and Retention Practices	Description	Number of States Currently Implementing*	
		Medicaid	CHIP**
12-month Continuous Eligibility	This policy allows children who enroll in Medicaid or CHIP to retain coverage for a full 12 months, regardless of changes in family income over the 12-month period. This ensures continuous coverage and helps children get their health care needs met on an ongoing basis with fewer disruptions due to administrative barriers.	18	30
Remove/Simplify Asset Tests	Very few states still have an asset test in Medicaid or CHIP. Removing it, or allowing states to conduct it administratively, simplifies the process for families and saves states money.	47	36
Face-to-Face Interview Not Required	In most cases, states no longer require families to apply for or renew Medicaid or CHIP coverage in person. Families may submit applications via mail or online. States can conduct the interview over the phone or eliminate the interview requirement altogether. In-person interviews can be burdensome for working families who may not be able to get the time away from work, or who may have trouble physically getting to the interview location due to transportation constraints.	48	38
Combined Medicaid-CHIP Application	In most cases, states use a single application to determine a child's eligibility for both Medicaid and CHIP. This means less paperwork for families to complete if they apply for one program and are found ineligible, and it eliminates confusion about which program to apply for in the first place.	35 out of the 39 states with separate Medicaid and CHIP programs use a joint application.	
Passive/ Administrative Renewal	Passive renewal allows states to send pre-populated forms to Medicaid and CHIP enrollees' families and requires them to contact the eligibility office only if their information (income, household size, etc.) has changed. This improves retention enormously, and it reduces the number of eligible children who temporarily lose coverage for paperwork reasons. States can also conduct administrative renewals using information already available to them through other state databases to glean as much information as possible about whether the child is still eligible for coverage. If a determination cannot be made using this information, the state can contact the family by phone or mail to fill in the missing information and make a renewal determination.	14	14

Table 2. (continued)

Designated Enrollment and Retention Strategies for Medicaid and CHIP

Enrollment and Retention Practices	Description	Number of States Currently Implementing*	
		Medicaid	CHIP**
Presumptive Eligibility	This policy allows children who appear to be eligible for Medicaid or CHIP to be "presumed eligible" at certain qualified locations (such as doctors' offices, hospitals, and schools) and to receive up to 60 days' worth of coverage while a formal determination is made: Children are able to receive coverage immediately, and providers are paid for the services they provide to these children. However, to be effective, presumptive eligibility must be coupled with other simplifications that make it easy for these children to actually enroll in Medicaid or CHIP.	14	9
Express-Lane Eligibility	This policy allows states to use eligibility information from another means-tested program (such as Food Stamps; the National School Lunch Program; or the Women, Infants and Children (WIC) program) to determine children's eligibility for Medicaid or CHIP. This simplifies the application process for families and helps get more children covered. Because this is a new option under CHIPRA, it is not yet clear what will "count" as express-lane eligibility for purposes of awarding performance bonuses. Some states have been doing targeted outreach and linking Medicaid and WIC applications (among other programs) for years, but without the auto-enrollment option (CHIPRA allows auto-enrollment for the first time).	New Provision	New Provision
Premium Assistance	This option allows families to enroll children in their job-based coverage, with the state paying for a portion of the premiums for the coverage through either Medicaid or CHIP. This is the only enrollment strategy that states are not required to implement in both their Medicaid and their CHIP programs; for performance bonus purposes, implementing premium assistance in either program "counts" as one of the five strategies (although doing it in both programs does not count twice). In the past, cumbersome rules and documentation requirements prevented premium assistance programs from covering very many children, but CHIPRA changes some of the rules in order to make it easier for states to adopt this option. It is unclear how effective the new policies will be at getting children covered, especially since the availability of job-based coverage continues to decline and is already significantly lower among low-income populations than the general population.	14 states have premium assistance programs for children in Medicaid and/or CHIP.	

* These figures include states that have implemented these policies for at least some portion of their child population in Medicaid or CHIP. Some states have only applied the policies to a portion of enrollees (i.e., only children in a certain age or income group). Additional guidance is needed from the CMS to determine in what ways and how broadly states must apply these policies in order to receive credit toward performance bonuses.

** 39 states have separate CHIP programs, and the remainder operate CHIP as part of Medicaid; therefore, the universe for the CHIP column is 39, not 51.

Sources: All categories except premium assistance: Donna Cohen Ross and Caryn Marks, *Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009* (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2009); premium assistance row is from Dan Belnap and Sonya Schwartz, "Premium Assistance," *State Health Policy Monitor* 1, no. 3 (Portland, ME: National Academy for State Health Policy, October 2007).

who are enrolled in Medicaid and CHIP and at keeping those children enrolled for as long as they remain eligible. Most states have already eliminated asset tests and face-to-face interviews and use a single application for children's Medicaid and CHIP. Thus, meeting the requirement to adopt at least five of these eight policies and procedures should not be difficult for most states. What's more, in addition to vastly simplifying the enrollment process for families, these processes will also reduce administrative costs, making Medicaid and CHIP run even more efficiently.[2]

While each of the eight policies helps increase children's participation in Medicaid and CHIP, some of them are likely to have a greater impact than others. In particular, one policy that states have found to be very effective is known as "continuous eligibility."[3] Continuous eligibility guarantees that, once enrolled in Medicaid or CHIP, children can stay enrolled for an entire year, regardless of changes in family situation (family income, the number of people in the household, etc.). Continuous coverage allows children to have access to uninterrupted health care and all the essential screenings, preventive care, and health services that young children need for healthy development.

Like other enrollment and renewal simplifications, continuous eligibility has also been associated with reducing state administrative costs. This is partly because continuous eligibility increases the amount of time between renewals, which reduces the amount of administrative work necessary to process renewals. It is also because fewer children lose coverage and then reapply within a given year, which in turn reduces the amount of unnecessary administrative work that is involved in processing terminations and reenrollment. Combined with a "passive renewal" process (another one of the eight strategies listed in the CHIPRA statute), states can reduce administrative barriers that cause otherwise eligible children to lose coverage and interrupt their access to care.[4] The more enrollment and retention simplifications a state enacts, the better. Although it is difficult to quantify the effects of specific simplification strategies, states have found that simplifications lead to significant increases in Medicaid and CHIP participation.[5]

Action Steps for States

- Determine how many of the eight enrollment and retention practices your state has already implemented. States need not adopt five new policies, but they must get to at least five of the eight listed in the statute. And remember, six is better than five! States can adopt more than just five good enrollment practices to try to enroll even more eligible, uninsured children.

- Consider other simplifications and outreach strategies beyond the eight that are linked to performance bonuses. There are many other ways to improve outreach to low-income children and thereby increase the size of the performance bonus your state may receive.
  - Increasing the availability of translation and interpretation services for children, which now carry a higher federal matching rate than they have in the past (at least 75 percent, higher in some states). This will make the program more accessible to children in families with limited English proficiency, who may be more hesitant to enroll in the program or who may not know about it all. Expanding translation and interpretation services will also improve the quality of care that these children receive once they are enrolled.
  - Expanding income eligibility is likely to attract not only families in the expanded eligibility band, but also previously eligible families who may not have known that they were eligible or who attempted to apply in the past. Experience has shown that increasing CHIP eligibility in a given state typically also leads to increases in Medicaid enrollment.[6]
- Develop a relationship with the agencies in your state that administer Medicaid and CHIP if you have not already done so. They will be the gatekeepers for much of the data that are used to determine performance bonus awards, and it will be essential to work with the program administrators to simplify and streamline enrollment policies.

Conclusion

States have a wealth of experience in conducting outreach and simplifying the enrollment process for low-income families and their children. As they move forward in this new era of children's coverage, many policy makers and program administrators *know* the steps that they need to take to get even the hardest-to-reach children enrolled and keep them enrolled. Performance bonuses sweeten the deal for states that are already doing the right things to cover low-income children, and they give states that have not been as aggressive a clear incentive to change their ways. If state and national advocates ensure that state officials understand how this new system works, it will go a long way in getting more children, especially the poorest children, covered.

Endnotes

[1] Lisa Dubay, *H.R. 2 Children's Health Insurance Program Reauthorization Act of 2009* (Washington: Congressional Budget Office, February 11, 2009), available online at http://www.cbo.gov/ftpdocs/99xx/doc9985/hr2paygo.pdf.

[2] Victoria Wachino and Alice M. Weiss, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children* (Washington: National Academy for State Health Policy and the Robert Wood Johnson Foundation, February 2009).

[3] Cynthia Bansak and Steven Raphael, "The Effects of State Policy Design Features on Take-up and Crowd-out Rates for the State Children's Health Insurance Program," *Journal of Policy Analysis and Management* 26, no. 1 (November 29, 2006): 149-175.

[4] Margo Rosenbach, et al., *National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access: Final Report* (Cambridge, MA: Mathematica Policy Research, Inc., 2007).

[5] Victoria Wachino and Alice M. Weiss, op. cit.

[6] Lisa Dubay, Jocelyn Guyer, Cindy Mann, and Michael Odeh, "Medicaid at the Ten-Year Anniversary of SCHIP: Looking Back and Moving Forward," *Health Affairs* 26, no. 2 (2007): 370–381; Maureen Hensley-Quinn, Catherine Hess, Barbara Ladon, and Sharon Steadman, *Covering All Kids: Issues and Experience in State Policy Development* (Washington: National Academy for State Health Policy, April 2008).

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