**RON DESANTIS**
GOVERNOR

February 23, 2024

Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue Southwest
Washington, DC 20201

Dear Secretary Becerra:

Florida seeks to implement a five-year Section 1115 Research and Demonstration Waiver for the Children's Health Insurance Program (CHIP). Florida's CHIP, called Florida KidCare, provides health insurance for uninsured children in families with incomes up to 200 percent of the federal poverty level. CHIP is not an entitlement program, and families pay monthly family premiums depending on the family's income.

This waiver seeks to increase income eligibility up to 300 percent of the federal poverty level and to update and add monthly premium tiers to align with the increase in eligibility to higher income families.

Please find enclosed documentation as required in 42 CFR 431.412 to support this request. We appreciate your efforts in working with our State to implement the necessary federal authorities.

Sincerely,

[redacted]
Governor

Enclosure

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

# Children's Health Insurance Program Eligibility Extension

## Section 1115 Title XXI Research Demonstration
## New 5-Year Demonstration Request

Florida Agency for Health Care Administration

# Contents

## Program Application Overview

The Florida Agency for Health Care Administration (AHCA) is seeking federal authority from the Centers for Medicare & Medicaid Services (CMS) to implement a new section 1115 (Title XXI) Children's Health Insurance Program (CHIP) demonstration that offers program eligibility to children with family income above 200 percent of the federal poverty level (FPL)[1], up to 300 percent of the FPL, with enrollment subject to monthly premiums. This section 1115 demonstration will operate concurrently with the CHIP state plan which offers health insurance for uninsured children in families with incomes up to 200 percent of the FPL. The state is requesting authority for new premium amounts through this demonstration for all CHIP eligible recipients included in both the CHIP state plan and the section 1115 waiver authorities with incomes between 133 and 300 percent of the FPL. The State is seeking a proposed effective date of April 2024.

## I. Demonstration Purpose, Goals, and Objectives and CHIP Program Overview

### Demonstration Purpose, Goals, and Objectives

Florida is focused on ensuring that families have Pathways to Prosperity, which are individualized paths to prosperity, economic self-sufficiency, and hope through community collaboration between government entities, the private sector, community organizations, and the nonprofit sector. The Florida Legislature and Governor DeSantis recognized that parents who are working hard to improve their economic situation of their family could potentially lose access to subsidized CHIP health insurance for their children through even a small increase in their income, and that the potential loss of the subsidized coverage could be a disincentive to the parent in their pathway to prosperity and economic self-sufficiency. For example, a parent who worked more hours or received a promotion that increased annual income by $300 (approximately 1% of the FPL for a family of four with two children) would face an increase in premiums from subsidized CHIP coverage (with premiums of $240 per year per family) to $5,748 annually if they chose to participate in Florida's full-pay program.

In response, the Florida Legislature passed House Bill 121 (HB 121), signed into law in June 2023, to increase eligibility for the CHIP-subsidized KidCare programs above the current state plan threshold of 200 percent of the FPL up to 300 percent of the FPL. HB 121 also requires the State to establish new monthly premiums for CHIP enrollees. The new premium structure creates a graduated level of premiums that allows families with growing income to be able to continue to afford health insurance for their children.

This proposed demonstration is critical at this time as Florida's economy thrives, and more families are reporting increased income levels above those allowed for Florida Medicaid eligibility.

Florida's Medicaid redetermination process is already projected to increase enrollment in Florida's KidCare Full-Pay program, as current Medicaid enrollees with income levels too

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[1] 200 percent represents the percent of the FPL prior to the application of the modified adjusted gross income (MAGI) conversion.

high for Medicaid and too high for CHIP-subsidized KidCare disenroll and look for other coverage options. Florida estimates 16,328 children with household incomes under 300% FPL will enroll in Full-Pay KidCare in Fiscal Year 2023-2024.

This proposed demonstration is expected to enable Florida to continue to make strides in increasing access to creditable health insurance coverage for lower-income children within the State while supporting increased economic self-sufficiency and pathways to prosperity. Accordingly, the goals and objectives of this demonstration are to:

- Increase enrollment and access to CHIP-subsidized coverage; and,
- Improve or maintain the rate of uninsured children under age 19 in the State of Florida.

CHIP Background

The Florida KidCare Program (KidCare or Program) was created by the Florida Legislature in 1998 in response to the passage of the federal Children's Health Insurance Program (CHIP) in 1997. The federal CHIP provides funding for states who choose to subsidize health insurance coverage to uninsured children in families with incomes that are too high to qualify for Medicaid but who meet other eligibility requirements. Florida's KidCare program encompasses four partner programs, that together with the availability of full-pay options for those who do not qualify for subsidized coverage matched by the federal government, offers coverage for all children in the State of Florida. The four programs that comprise Florida KidCare are:

1. **Medicaid for children** – Title XIX medical coverage to eligible children up to 1-year-old with family income that does not exceed 200 percent of the FPL and to eligible children, ages 1-18, with family income that does not exceed 133 percent of the FPL.

2. **MediKids Program** – MediKids provides low-cost health insurance for children ages 1 through 4. The MediKids program is similar to Medicaid. Children enrolled in the MediKids program receive medical services and benefits from Medicaid providers through Medicaid's Managed Medical Assistance (MMA) program. The program charges monthly premiums but does not impose any other form of beneficiary cost-sharing (i.e., no deductibles, co-payments, or coinsurance).

3. **Children's Medical Services (CMS)** – CMS is a collection of programs that provides a statewide managed care system for children (under age 19) with special health care needs and provides essential preventive, evaluative, and early intervention services for at-risk children.

4. **Florida Healthy Kids Program** – Florida Healthy Kids offers quality, affordable, child-centered health and dental insurance for children ages 5 through 18. Florida Healthy Kids has a subsidized plan for families who exceed the income eligibility

threshold for Medicaid, as well as full-pay options for those who do not qualify for subsidized coverage.

KidCare is governed by part II of Chapter 409, Florida Statutes (F.S.) and is administered jointly by AHCA, the Department of Children and Families, the Department of Health, and the Florida Healthy Kids Corporation (Corporation) established in Chapter 624, F.S. Table 1 below delineates the roles of each agency and the Corporation:

**Table 1: Florida KidCare Organizational Structure**

| State Agency and Program(s) | Responsibilities |
|---|---|
| Agency for Health Care Administration (AHCA) (MediKids) | • Administers the Medicaid program (Title XIX)<br>• Administers the MediKids program (Title XXI, ages 1-4)<br>• Serves as lead Title XXI contact with the federal Centers for Medicare and Medicaid Services<br>• Distributes federal funds for Title XXI programs<br>• Manages the Florida Healthy Kids Corporation contract<br>• Develops and maintains the Title XXI Florida KidCare State Plan |
| Department of Children and Families (DCF)<br>(Medicaid for Children) | • Determines Medicaid (Title XIX) eligibility<br>• Administers the CMS Behavioral Health Network (Title XXI, ages 0-18) |
| Department of Health<br>(Children's Medical Services) | • Administers Children's Medical Services (Titles XIX and XXI, ages 0-18 with special health care needs) |
| Florida Healthy Kids Corp.<br>(Healthy Kids) | • Performs administrative functions for Florida KidCare (eligibility determination, premium collection, marketing, and customer service)<br>• Administers Florida Healthy Kids program (Title XXI, ages 5-18) |

## II. Demonstration Benefits, Eligibility and Cost-Sharing

### Benefits

Florida KidCare health and dental services are delivered through quality plans that offer a choice of local doctors, dentists, specialists, hospitals, pharmacies, and other health care providers. Florida KidCare benefits minimally include but are not limited to: doctor visits, surgeries, check-ups, immunizations, dental and vision care, prescriptions, hospital stays, behavioral health, and emergencies.

### Eligibility

Eligibility for Florida KidCare, including Florida Healthy Kids, is determined in part by age and household income, as a percent of the FPL, as indicated in Table 2 below:

**Table 2 – Florida KidCare Eligibility and Cost-sharing Structure**

| Program | Ages | Family Income Eligibility | | | Existing Monthly Premium Structure | Copay (some services) |
|---|---|---|---|---|---|---|
| | | FPL Threshold (Pre MAGI) | FPL Threshold (Post MAGI) | Annual Income[2] | | |
| Medicaid for Children | 0-1 | 185-200% FPL | 194-210% FPL | $55,000 – $60,000 | $0 | $0 |
| MediKids | 1-4 | 133-200% FPL | 140-210% FPL | $41,400 – $60,000 | $15 for 133-158% FPL<br>$20 for 158-200% FPL<br>(per household) | Up to $10 |
| Healthy Kids | 5 | 133-200% FPL | 140-210% FPL | $41,400 – $60,000 | | Up to $10 |
| | 6-18 | 100-200% FPL | 112-210% FPL | $30,000 – $60,000 | | Up to $10 |
| Children's Medical Services | 0-18 | Up to 200% FPL | Up to 210% FPL | $0 – $60,000 | | $0 |
| Full-Pay (MediKids & Healthy Kids) | 1-18 | Over 200% FPL | Over 210% FPL | Over $60,000 | $210 - MediKids<br>$259 - Healthy Kids (per child) | $10 or $15 |

The demonstration will not change CHIP state plan eligibility for uninsured children in households with income up to the threshold of 200 percent of the FPL. The CHIP state plan will continue to be the basis of eligibility for uninsured children up to and including 200 percent of the FPL.

The demonstration will be the basis of coverage for uninsured children with household income ranging from above 200 percent of the FPL up to 300 percent of the FPL. The demonstration will also be the basis of authority for the monthly premium structure that will be applied to CHIP enrollees in households with income over 133 percent of the FPL up to the new coverage threshold of 300 percent of the FPL. See Table 3 below for the proposed new monthly premium structure for the Florida KidCare program.

Cost-sharing – Monthly Premium Structure

Families contribute monthly premiums to the cost of the Florida KidCare program based on their household size, income, and other eligibility factors. The premium does not vary by the number of children in the household. In accordance with HB 121, Florida is proposing to establish new premium tiers for CHIP enrollees above 133 percent of the FPL, including the new income coverage band from above 200 percent of the FPL up to 300 percent of the FPL. The new monthly premium structure proposed for the Florida KidCare program is as follows:

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[2] Annual income based on 2023 federal poverty guidelines for a family size of 4 utilizing Pre-MAGI percentages

**Table 3 – Proposed New Monthly Premiums for Households**[3]

| Proposed Premium Tiers by Federal Poverty Level[4] | | | | | |
|---|---|---|---|---|---|
| **Tier 1 FPL Range** | **Tier 2 FPL Range** | **Tier 3 FPL Range** | **Tier 4 FPL Range** | **Tier 5 FPL Range** | **Tier 6 FPL Range** |
| **133-175%** | **175-210%** | **210-235%** | **235-255%** | **255-275%** | **275-300%** |
| $17 | $30 | $60 | $95 | $145 | $195 |

## III. Health Care Delivery System

Florida utilizes a managed care delivery system for all children enrolled in CHIP. Children in MediKids are enrolled in a Statewide Medicaid Managed Care program, Managed Medical Assistance plan. Children in Florida Healthy Kids are enrolled in one of three managed care plans contracted with the Florida Healthy Kids Corporation. Children in Children's Medical Services are enrolled in the Florida Department of Health's CMS plan. All plans are fully capitated plans that provide a comprehensive array of benefits to enrolled children.

## IV. Enrollment & Expenditures

### Projected Enrollment

The state's projected enrollment of uninsured children with household income ranging from above 200 percent of the FPL up to 300 percent of the FPL is listed in Table 4.

**Table 4 – Projected Enrollment**

| DY01 | DY02 | DY03 | DY04 | DY05 |
|---|---|---|---|---|
| 14,649 | 28,926 | 38,360 | 41,272 | 41,874 |

### Enrollment Impact

As of February 2024, 140,661 children were enrolled in KidCare. The State's 2023-2024 fiscal year projections assume that Medicaid redeterminations, which began in April 2023, will cause a growth in caseload for the KidCare program over the next year, as indicated by the graphs below.

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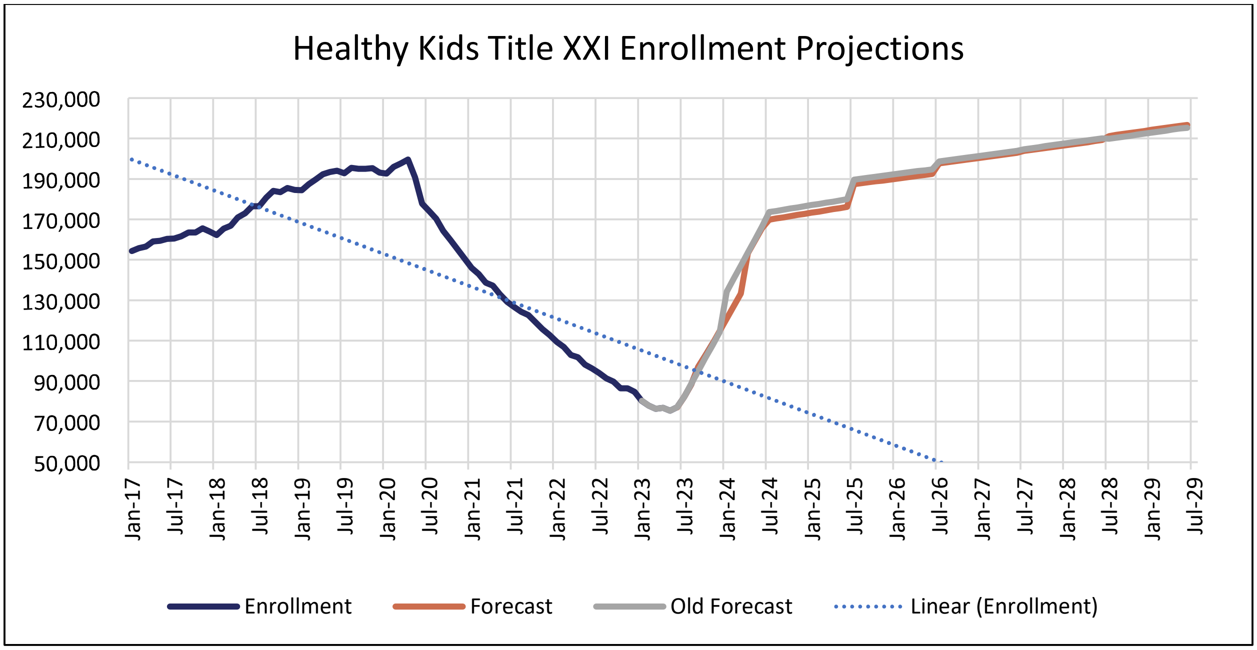
[3] Premiums will increase by three percent each year.

[4] Tiers were adjusted prior to the public meetings to align with operational changes due to MAGI.


Healthy Kids Title XXI Enrollment Projections
230,000
210,000
190,000
170,000
150,000
130,000
110,000
90,000
70,000
50,000
Jan-17
Jul-17
Jan-18
Jul-18
Jan-19
Jul-19
Jan-20
Jul-20
Jan-21
Jul-21
Jan-22
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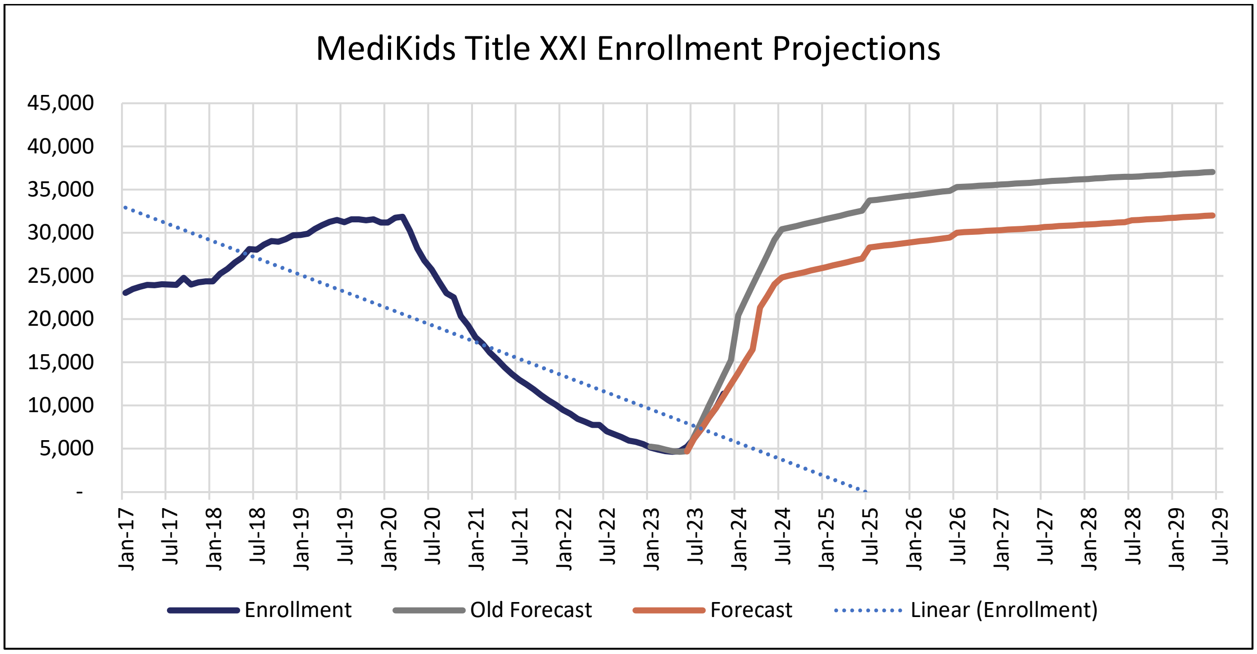
Jan-27
Jul-27
Jan-28
Jul-28
Jan-29
Jul-29
Enrollment
Forecast
Old Forecast
Linear (Enrollment)


MediKids Title XXI Enrollment Projections
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-
Jan-17
Jul-17
Jan-18
Jul-18
Jan-19
Jul-19
Jan-20
Jul-20
Jan-21
Jul-21
Jan-22
Jul-22
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Jul-23
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Jul-24
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Jul-25
Jan-26
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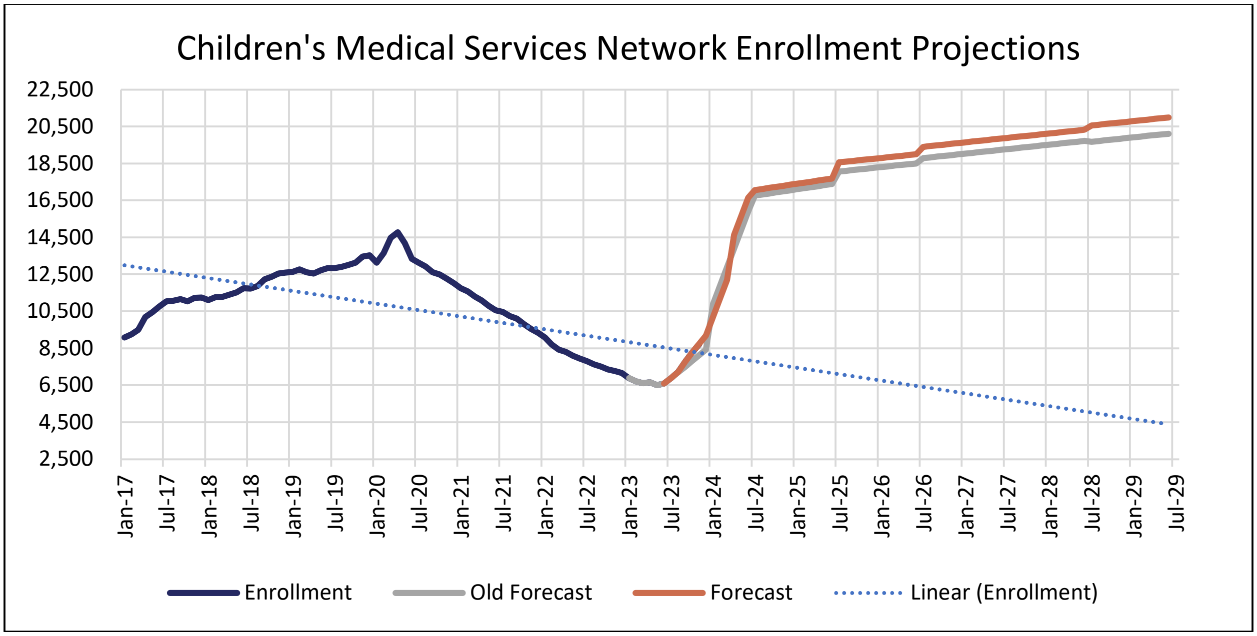
Jul-29
Enrollment
Old Forecast
Forecast
Linear (Enrollment)



Florida's current work to complete Medicaid redeterminations in the post public health emergency return to normal operations per CMS guidance, has resulted in an estimated 16,328 children in Fiscal Year 2023-2024 with household income under 300% FPL who would only be eligible for enrollment in Full-Pay KidCare at an approximate annual premium of $3,114 plus nominal co-pays for certain services. The proposed demonstration will increase the upper eligibility band for KidCare eligibility, thereby making many Full-Pay KidCare enrollees now eligible for (more affordable) subsidized-KidCare coverage. Accordingly, the proposed demonstration is expected to impact projected overall CHIP enrollment by increasing the number of lower-income uninsured children eligible for enrollment in KidCare by approximately 165,000 children over the initial five years of implementation.

This new premium structure is not expected to impact general disenrollment trends or processes. Total projected enrollment in KidCare, including disenrollments due to failure to pay the monthly premium, was utilized to calculate the total costs for the demonstration.

Historical Expenditures

The state's historical medical assistance expenditures for coverage of uninsured children with household income ranging from above 133 percent of the FPL up to 200 percent of the FPL are listed in Table 5.

**Table 5 - Expenditure History**

| FFY 18-19 | FFY 19-20 | FFY 20-21 | FFY 21-22 | FFY 22-23 |
|---|---|---|---|---|
| $ 496,675,888 | $ 504,716,531 | $ 397,374,075 | $ 318,181,593 | $ 298,635,527 |

Projected Expenditures

The state's projected medical assistance expenditures for coverage of uninsured children with household income ranging from above 200 percent of the FPL up to 300 percent of the FPL is listed in Table 6.

**Table 6 – Projected Title XXI (CHIP) Expenditures**

| DY01 | DY02 | DY03 | DY04 | DY05 |
|---|---|---|---|---|
| $16,999,053 | $69,794,099 | $106,984,015 | $125,152,604 | $135,457,940 |

The title XXI CHIP allotment neutrality analysis workbook for this 5-year request is provided as a separate attachment to this application.

## V. Evaluation Parameters

The State, in consultation with a to-be selected evaluator, will identify validated performance measures that will assess the impact of the demonstration on CHIP enrollees. In addition, the State intends to work with the selected evaluator to identify meaningful comparison groups in designing the evaluation plan. It is the intent of the State to follow all CMS evaluation design guidance in working with the State's selected evaluator to draft an evaluation plan. See the proposed evaluation parameters in Table 7 below.

**Table 7 – Proposed Evaluation Parameters**

| Proposed Hypothesis | Anticipated Measure(s) | Proposed Data Sources |
|---|---|---|
| The demonstration will increase enrollment and access to CHIP coverage. | Number of children with family income over 200% of FPL up to 300% of FPL enrolled in CHIP. | Florida CHIP claims and enrollment records |
| The demonstration will improve or maintain the rate of uninsured children under age 19 in the State of Florida. | Reported uninsurance rates: Number of children up to age 19 in Florida without health coverage | U.S. Census Bureau Data, American Community Survey (ACS) |

## VI. Waiver and Expenditure Authorities

**Table 8 – Proposed Waiver and Expenditure Authorities**

| | |
|---|---|
| **Section 1115(a)(1) Waiver Authorities** | *Florda does not anticipate needing any waivers of the provisions under Title XXI of the Social Security Act to implement this demonstration.* |
| **Section 1115(a)(2) Expenditure Authorities** | Expenditure authority to offer CHIP coverage (through Florida KidCare) to uninsured children in households with income above 200 percent of the FPL up to 300 percent of the FPL. |
| | Expenditure authority to implement a monthly premium structure to be imposed on CHIP enrollees with income above 133 percent of the FPL up to 300 percent of the FPL as a condition of enrollment. |

## VII. Documentation of State Public Notice Process

The abbreviated notice was published on January 23, 2024 via Florida Administrative Register. Notice for tribal consultation was sent on January 23, 2024 to the Miccosukee and Seminole Tribes via email. As outlined in these public notices, AHCA provided a 30-day public comment period from January 23, 2024 at 3:00 pm EST, through February 21, 2024 at 3:00 pm EST. The draft section 1115 demonstration application and related public notice materials were posted for the minimum 30-day public comment period starting January 23, 2024 at 3:00 pm EST, on the Federal Waivers Home page located on the AHCA website: https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers.

In addition to publishing notices, AHCA conducted two public meetings on the proposed application as outlined in the State's published public notices. These meetings were held:

**Public Meeting 1:**
Wednesday, January 31, 2024, 11:00 am – 12:00 pm EST
Medical Care Advisory Committee Meeting
Agency for Health Care Administration
2727 Mahan Drive, Building 3
Tallahassee, Florida 32308
Audio: (850) 792-4898, Phone Conference ID: 324 032 061#

**Public Meeting 2:**
February 1, 2024, 1:00 pm – 2:00 pm EST
DMS Orlando North Tower Conference Room
400 W. Robinson St., Suite N109
Orlando, FL 32801

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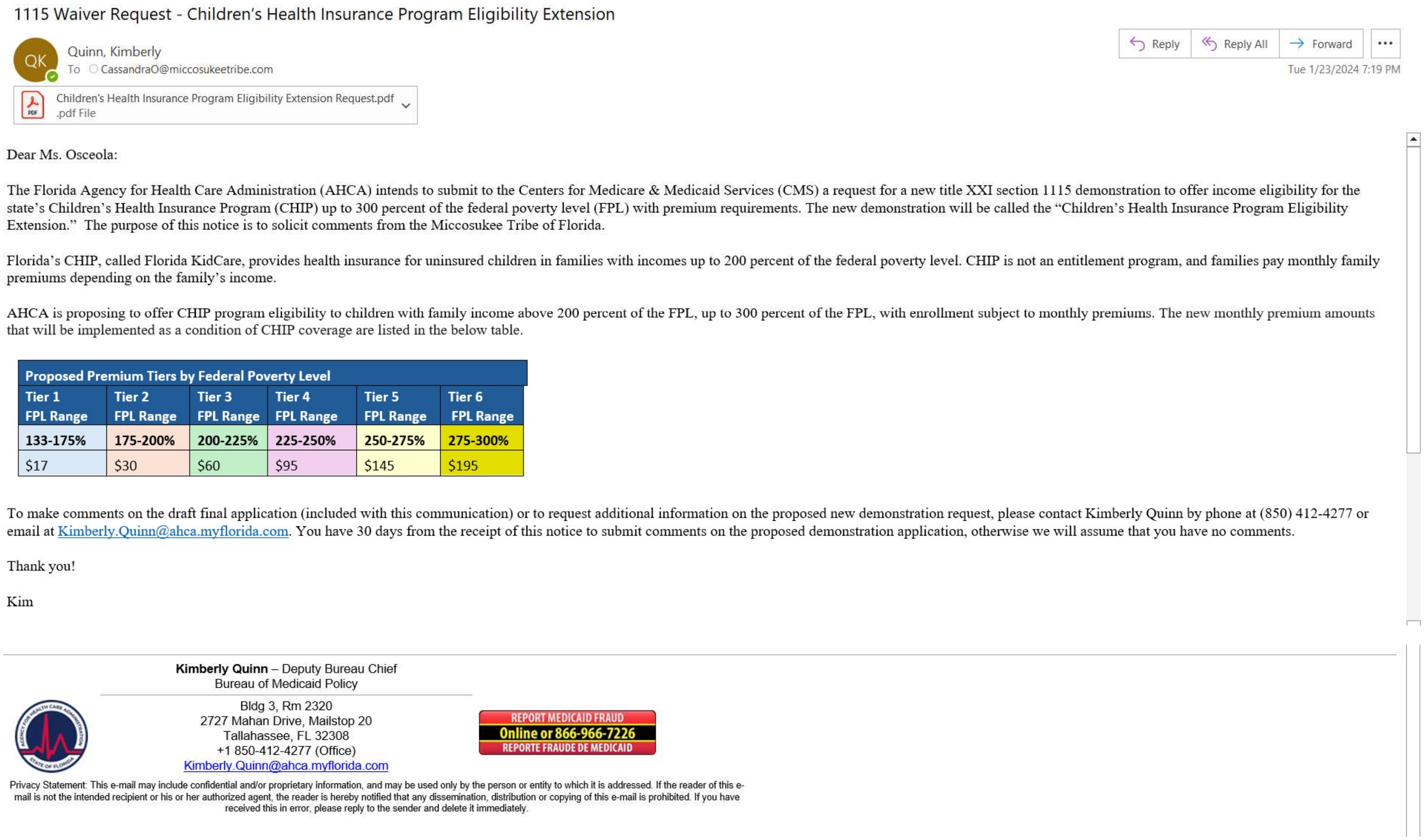
## Tribal Notifications



1115 Waiver Request - Children's Health Insurance Program Eligibility Extension

QK Quinn, Kimberly
To ○ CassandraO@miccosukeetribe.com

Tue 1/23/2024 7:19 PM

Children's Health Insurance Program Eligibility Extension Request.pdf
.pdf File

Dear Ms. Osceola:

The Florida Agency for Health Care Administration (AHCA) intends to submit to the Centers for Medicare & Medicaid Services (CMS) a request for a new title XXI section 1115 demonstration to offer income eligibility for the state's Children's Health Insurance Program (CHIP) up to 300 percent of the federal poverty level (FPL) with premium requirements. The new demonstration will be called the "Children's Health Insurance Program Eligibility Extension." The purpose of this notice is to solicit comments from the Miccosukee Tribe of Florida.

Florida's CHIP, called Florida KidCare, provides health insurance for uninsured children in families with incomes up to 200 percent of the federal poverty level. CHIP is not an entitlement program, and families pay monthly family premiums depending on the family's income.

AHCA is proposing to offer CHIP program eligibility to children with family income above 200 percent of the FPL, up to 300 percent of the FPL, with enrollment subject to monthly premiums. The new monthly premium amounts that will be implemented as a condition of CHIP coverage are listed in the below table.

| Proposed Premium Tiers by Federal Poverty Level | | | | | |
|---|---|---|---|---|---|
| **Tier 1 FPL Range** | **Tier 2 FPL Range** | **Tier 3 FPL Range** | **Tier 4 FPL Range** | **Tier 5 FPL Range** | **Tier 6 FPL Range** |
| **133-175%** | **175-200%** | **200-225%** | **225-250%** | **250-275%** | **275-300%** |
| $17 | $30 | $60 | $95 | $145 | $195 |

To make comments on the draft final application (included with this communication) or to request additional information on the proposed new demonstration request, please contact Kimberly Quinn by phone at (850) 412-4277 or email at Kimberly.Quinn@ahca.myflorida.com. You have 30 days from the receipt of this notice to submit comments on the proposed demonstration application, otherwise we will assume that you have no comments.

Thank you!

Kim

**Kimberly Quinn** – Deputy Bureau Chief
Bureau of Medicaid Policy

Bldg 3, Rm 2320
2727 Mahan Drive, Mailstop 20
Tallahassee, FL 32308
+1 850-412-4277 (Office)
Kimberly.Quinn@ahca.myflorida.com

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Online or 866-966-7226
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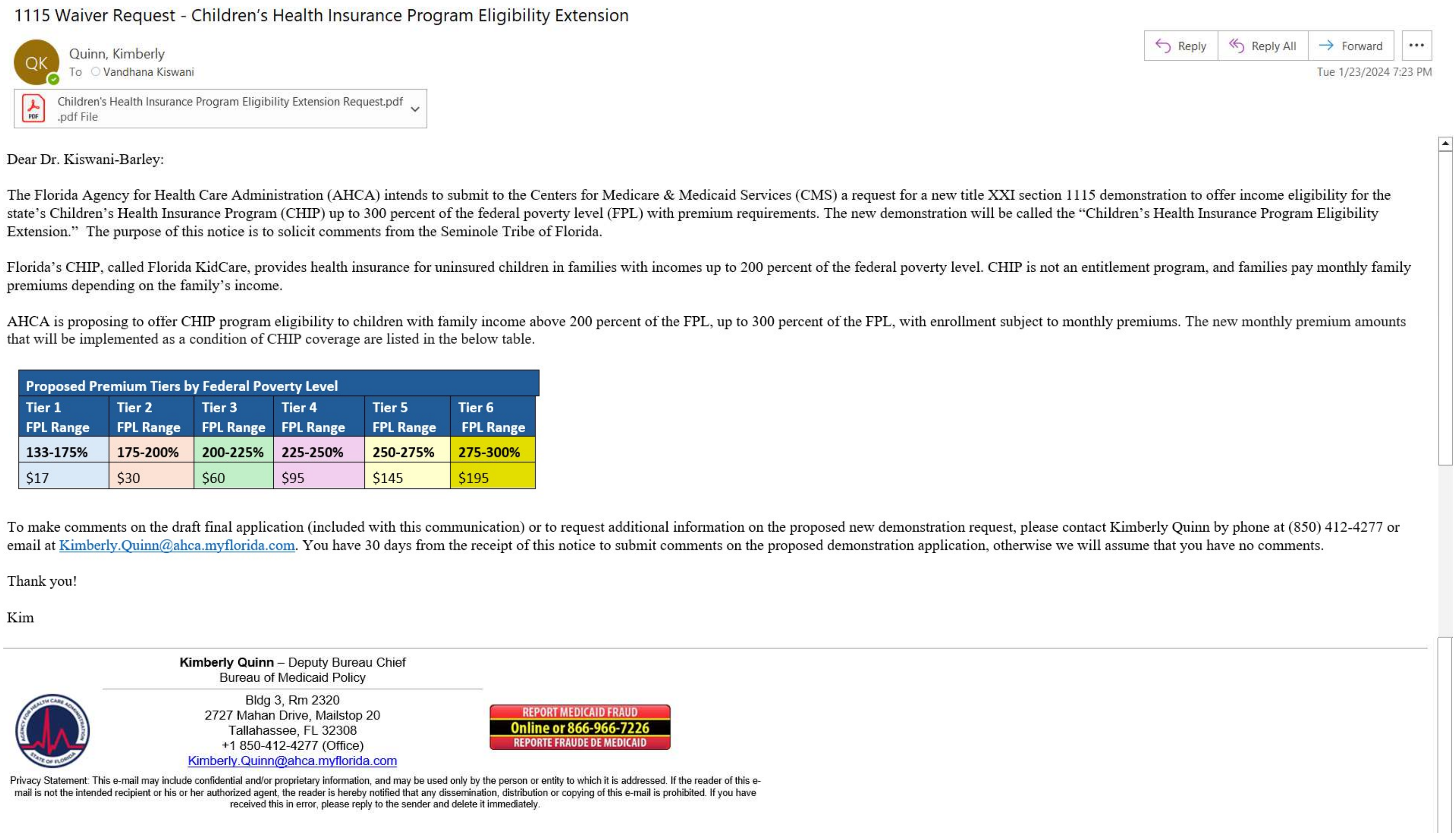

1115 Waiver Request - Children's Health Insurance Program Eligibility Extension

Quinn, Kimberly
To ○ Vandhana Kiswani

Tue 1/23/2024 7:23 PM

Children's Health Insurance Program Eligibility Extension Request.pdf
.pdf File

Dear Dr. Kiswani-Barley:

The Florida Agency for Health Care Administration (AHCA) intends to submit to the Centers for Medicare & Medicaid Services (CMS) a request for a new title XXI section 1115 demonstration to offer income eligibility for the state's Children's Health Insurance Program (CHIP) up to 300 percent of the federal poverty level (FPL) with premium requirements. The new demonstration will be called the "Children's Health Insurance Program Eligibility Extension." The purpose of this notice is to solicit comments from the Seminole Tribe of Florida.

Florida's CHIP, called Florida KidCare, provides health insurance for uninsured children in families with incomes up to 200 percent of the federal poverty level. CHIP is not an entitlement program, and families pay monthly family premiums depending on the family's income.

AHCA is proposing to offer CHIP program eligibility to children with family income above 200 percent of the FPL, up to 300 percent of the FPL, with enrollment subject to monthly premiums. The new monthly premium amounts that will be implemented as a condition of CHIP coverage are listed in the below table.

**Proposed Premium Tiers by Federal Poverty Level**

| Tier 1 FPL Range | Tier 2 FPL Range | Tier 3 FPL Range | Tier 4 FPL Range | Tier 5 FPL Range | Tier 6 FPL Range |
|---|---|---|---|---|---|
| **133-175%** | **175-200%** | **200-225%** | **225-250%** | **250-275%** | **275-300%** |
| $17 | $30 | $60 | $95 | $145 | $195 |

To make comments on the draft final application (included with this communication) or to request additional information on the proposed new demonstration request, please contact Kimberly Quinn by phone at (850) 412-4277 or email at Kimberly.Quinn@ahca.myflorida.com. You have 30 days from the receipt of this notice to submit comments on the proposed demonstration application, otherwise we will assume that you have no comments.

Thank you!

Kim

**Kimberly Quinn** – Deputy Bureau Chief
Bureau of Medicaid Policy

Bldg 3, Rm 2320
2727 Mahan Drive, Mailstop 20
Tallahassee, FL 32308
+1 850-412-4277 (Office)
Kimberly.Quinn@ahca.myflorida.com

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Online or 866-966-7226
REPORTE FRAUDE DE MEDICAID

VIII. Public Comments

The Agency carefully considered all comments received on the proposed waiver. No changes were made to the waiver request in response to submitted comments. A summary of comments is included below, and copies of the comments received are included with the submission of this application:

| **Summary of Comments<br>1115 CHIP ELIGIBILITY EXTENSION** | | |
|---|---|---|
| **Comment** | **Actioned (Y/N)** | **Notes** |
| Request for the budget neutrality workbook | Y | A copy was provided to the requestor. No changes were needed to the waiver. |
| Recommendation on amending goals of the demonstration | N | |
| Continuous coverage questions | N | |
| Concerns about imposing premiums and amount of premiums | N | |
| Recommendation on tier structure | N | |
| Concerns about availability of data | N | |
| Support for the waiver | N | |
| Provider enrollment question | N | |

**From:** [redacted]
**To:** FLMedicaidWaivers; Noll, Austin
**Subject:** Children"s Health Insurance Program Eligibility Extension Request
**Date:** Wednesday, January 31, 2024 2:53:11 PM

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Dear Mr. Noll,

This email is in follow-up to my oral comments and questions at today's public hearing on the above-referenced Section 1115 waiver.

On behalf of the Florida Health Justice Project, we are excited about the anticipated expansion of CHIP in Florida and believe it has the potential to improve access to healthcare for children in this state.

We do have some questions about the specific language of the waiver. As you suggested, I am submitting them here so the Agency can fully consider them prior to responding.

1. Would you please explain the meaning of and the reason for the second Expenditure Authority in Table 6? Specifically, what does it mean that the new premium structure is to be imposed on CHIP enrollees within the specified income categories "as a condition of enrollment"?

2. How does this proposed expenditure authority interact/comport with the requirement in the Consolidated Appropriations Act of 2023 that children enrolled in Medicaid and CHIP receive 12 months of continuous coverage regardless of a change in circumstances affecting eligibility, including non-payment of premiums? (More about this requirement is here).

Thank you for your consideration of these questions. Please feel free to contact me at any time if you need any clarification.

Sincerely,

Lynn

Lynn [redacted] H[redacted]
[redacted]
Florida Health Justice Project
[redacted]

**From:** [redacted]
**To:** FLMedicaidWaivers
**Subject:** Children’s Health Insurance Program Eligibility Extension Request”
**Date:** Tuesday, January 23, 2024 5:17:48 PM

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To Whom It May Concern,

As a single mother that has worked extremely hard to provide my kids a better lifestyle I often fall in a gray area where I make too much money to qualify for anything however I don’t make enough to provide my daughter with disabilities valuable services that could help improve her life. Increasing the income could drastically improve the lives of children in households where parents are working to provide a quality lifestyle and simultaneously being punished for doing so. The healthcare system is drastically broken in the United States often leaving many working class families without necessary services for their children with disabilities even though their hardworking tax dollars fund many programs like this. It’s imperative that we revisit program policies and adjust to keep up with inflation and societies changing needs. No family in America should have to choose between valuable healthcare services and paying the light bill. I urge you to pass this bill and increase the income guidelines to afford many working class citizens access to affordable and quality healthcare.

Thank you!

[redacted]

[redacted] [redacted]

[redacted] [redacted]

[redacted]

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[redacted]

[redacted]

REPORT MEDICAID FRAUD
Online or 866-966-7226
REPORTE FRAUDE DE MEDICAID

[redacted]

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**From:** Erica L[redacted]
**Sent:** Wednesday, February 21, 2024 2:39 PM
**To:** FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
**Cc:** Holly B[redacted]
**Subject:** 1115 Children's Health Insurance Program Eligibility Extension Request Comments
**Importance:** High

Hello!

Please see the attached comments and an additional resource cited in our comments.

Best,

Erica L[redacted]

--
**Erica [redacted] L[redacted]**
[redacted]
she/her/hers
www.floridapolicy.org
[redacted]

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website www.floridapolicy.org

February 21, 2024

Jason Weida, Secretary
Agency for Health Care Administration
2727 Mahan Dr. MS #20
Tallahassee, Florida 32308
FLMedicaidWaivers@ahca.myflorida.com

VIA ELECTRONIC SUBMISSION

**Re: Children's Health Insurance Program Eligibility Extension Request**

Dear Secretary Weida,

Florida Policy Institute (FPI) submits these comments in response to the Agency for Health Care Administration's (AHCA's) New 5-Year Section 1115 Children's Health Insurance Program (CHIP) Demonstration Request. FPI is an independent, nonpartisan, nonprofit organization dedicated to advancing policies and budgets that improve the economic mobility and quality of life for all Floridians. We are committed to public policies which ensure that all Floridians have access to quality affordable health care.

We applaud the agency for moving forward to implement the Florida Legislature's expansion of the KidCare program. This demonstration has great potential for ensuring that children in more moderate income families do not lose coverage when their families transition into higher wage employment. However, we cannot ignore that there continue to be significant barriers for Florida children in lower income working families to obtain and keep coverage. This demonstration should also focus on improving enrollment and continuous coverage for these children. We support federal approval of this waiver, but as further described below, we urge the agency to take specific actions to address these concerns.

**"Maintaining the rate of uninsured" is not a proper goal for a section 1115 demonstration**

One of the stated goals of the demonstration as specified in the section 1115 application is to "[i]mprove or maintain the rate of uninsured children under age 19 in the state of Florida." (p. 2). We urge the state to eliminate maintaining the rate as one of its goals. Florida is ranked 46th in the country for the percentage of its children who are uninsured. This demonstration must be consistent with the overall statutory objectives of CHIP — to enable states to "initiate and expand provision of child health insurance to uninsured low-income children..." 42 U.S.C. s.1397aa(a).

There has been a substantial enrollment decline in CHIP since the end of the COVID-19 pandemic. In June 2019, Florida's subsidized KidCare enrollment was about 230,000. By October 2023 it had decreased to about 119,000. (See attached Declaration of Austin Noll, Deputy Secretary Medicaid.) This demonstration provides the state an opportunity to test new strategies for increasing enrollment not only in the expanded group (200 percent to 300 percent of the federal poverty limit), but also for currently eligible children with family income below 200 percent of the poverty line.

**The demonstration's proposed premiums will be a hardship for many lower income Florida families**

Numerous studies show that premiums are a barrier to obtaining and maintaining health insurance coverage, particularly for lower income families. This includes ALICE households (Asset Limited, Income Constrained & Employed) which are a key targeted population in this proposed demonstration. These families have income above the Federal Poverty Level (FPL) but less than what it takes to make ends meet. Lower income families are generally defined as at or below 250 percent of the FPL. This would include most of the children the demonstration proposes to cover. We are concerned that Florida's proposed premium structure will be too high for many of these families.

A recent letter from the Centers for Medicare and Medicaid Services(CMS) to Indiana about their section 1115 demonstration highlights extensive research and findings from other states' experiences with premiums. That experience shows lower initial rates of enrollment and greater disruptions in coverage due to non-payment of premiums. Even small premium charges from $1- $5 for families can be a significant burden. Notably, under Florida's proposed premium tiers, monthly premiums for the lowest income families (133 percent to 174 percent FPL) would increase from $15-$17 per month and for other families (at or below 175 percent - 200 percent FPL) premiums would increase from $20-$30 per month.

CMS' Indiana letter also references research showing that 1115 premium requirements "…may exacerbate disparities in health coverage, as historically under-resourced populations may be disproportionately affected by these policies." The letter specifically refers to findings from several states where premium policies led to decreased enrollment and shorter enrollment periods for Black beneficiaries compared to their white counterparts, and for beneficiaries with lower income compared to those with higher income. (See pp. 9-10.)

Florida data collected from a 2012 Congressionally mandated Florida CHIP evaluation shows that even under the current KidCare premium structure, thousands of children lost coverage monthly due to non-payment of premiums. (See pp. 13, 24.) More recent data from the 2022 Florida CHIP evaluation report shows that during 2022, nearly 25,000 Florida children — 20 percent — determined eligible for CHIP could not initially enroll because a premium payment was not made. (See Table 79.)

Federal policy prohibits charging premiums for children in households at or below 150 percent of the FPL. Given decades of research documenting the harmful impact of premiums on lower income households, there is nothing novel or experimental with this proposal to justify inclusion of any premium charges for these families. Indeed, quite contrary to the statutory purpose of CHIP to increase coverage, these premiums are a barrier for children to initially enroll and stay enrolled. Florida is one of a handful of states in the country that charge premiums to children at these low income ranges.

Not only is Florida one of a very few states that charges premiums to children at income levels below 150 percent of the poverty line — children in Florida are now paying more for their coverage than their parents. Through the Inflation Reduction Act, parents with income up to 150 percent of FPL can obtain silver plan coverage for zero premiums through the Healthcare.gov Marketplace.

We are also concerned about the proposed annual increases in premiums. Such annual increases have not been implemented in the KidCare program in the past. It makes no sense to include this in the proposed demonstration given the troubling data which already exists showing thousands of Florida children not enrolling or falling off the program due to non-payment. Furthermore, we question whether or not this increase in premium payment violates the current federal maintenance of effort requirements outlining that states cannot raise premiums for CHIP or Medicaid children.

**Premiums add to the administrative costs of KidCare**

A Kaiser Family Foundation review of multiple studies show that there are limited state savings from charging premiums and cost-sharing. Potential revenue gains are offset by increased disenrollment, increased use of more expensive services such as emergency room care and other administrative expenses. Additional studies showed that increasing premiums leads to lower-cost enrollees disproportionately dropping out, raising the average cost of the remaining insured population, and contributing to increased average medical claims. It is noteworthy that multiple states have opted to eliminate premiums in their Medicaid or CHIP programs.

Without more Florida data that includes rates of nonpayment and the administrative costs of program churn, it is unclear whether the current costs to implement premiums are offset by premium collections. This data will be even more crucial if the state proceeds with a six-tier premium structure. Families will likely experience even more confusion over premium policies, including amounts owed and the ability to re-enroll.

**The proposed demonstration does not comply with federal continuous eligibility requirements**

Children who have health care coverage *throughout the year* are more likely to be in better health. Twelve months continuous eligibility is a key policy for ensuring stable coverage without disruptions in care.

The Consolidated Appropriations Act of 2023 establishes a new requirement that the state provide 12 months continuous eligibility in both the Medicaid and CHIP programs starting January 1, 2024. On October 27, 2023, CMS clarified that once a child is enrolled *states will not be permitted to disenroll children for failure to pay CHIP premiums during this 12 month continuous eligibility period.*

Florida's CHIP proposal fails to incorporate this vital coverage protection. This protection is essential to successfully accomplishing the demonstration's goal of decreasing the rate of uninsured children in Florida.

**The state should collect and report real-time data to help gauge the affordability of premiums**

Additional data collection on the affordability of premiums will help determine whether any premium adjustments should be made over the life of the demonstration to ensure that more children are enrolled and able to keep coverage. We ask that AHCA consider providing a real-time, public facing dashboard that shows monthly CHIP application denials due to non-payment of premiums, as well as monthly disenrollments due to failure to pay premiums within the renewal period. Data collection and evaluation should be disaggregated by race, ethnicity, county, and income.

## Conclusion

FPI is excited about the potential of this demonstration to significantly improve Florida's rate of uninsured children. We support approval of this application subject to the safeguards and conditions discussed above.

In sum, we urge AHCA to make the following modifications to the proposed demonstration:

- Eliminate premiums for children in households at or below 150 percent of the FPL.
- Align the proposal with federal law prohibiting termination of KidCare coverage due to non-payment of premiums during the 12-month continuous eligibility period.
- Implement rigorous real time monitoring of the demonstration, including monthly public reporting on the number of denied CHIP applications due to non-payment of the initial premium. If the state proceeds with disenrollments due to non-payment of premiums, the number of disenrollments should also be publicly reported. All this data should be disaggregated by race, ethnicity, county, and income and be posted on a public dashboard.
- Engage in ongoing robust evaluation over the lifetime of the demonstration and make modifications to the premiums as needed to ensure that more children get coverage and maintain it.

Our comments include numerous citations supporting research, including direct links to the research for AHCA's and the U.S. Department of Health & Human Services' (HHS') benefit in reviewing our comments. We direct AHCA and HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the state and federal Administrative Procedures Acts.

Thank you for the opportunity to submit these comments and please feel free to contact us if you need additional information or have questions.

Sincerely,

Erica [redacted] L[redacted]
Florida Policy Institute
[redacted]

# Exhibit 1

**IN THE UNITED STATES DISTRICT COURT**
**MIDDLE DISTRICT OF FLORIDA**
**TAMPA DIVISION**

**Case No. 8:24-cv-_____**

STATE OF FLORIDA; and
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

*Plaintiffs*,

v.

CENTERS FOR MEDICARE AND MEDICAID SERVICES; CHIQUITA BROOKS-LASURE, *in her official capacity as Commissioner of Centers for Medicare and Medicaid Services*; DEPARTMENT OF HEALTH AND HUMAN SERVICES; and XAVIER BECERRA, *in his official capacity as Secretary of Health and Human Services*,

*Defendants*.

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## DECLARATION OF AUSTIN NOLL

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I, Austin Noll, declare as follows:

1. My name is Austin Noll, I am over 18 years of age, of sound mind, and capable of making this declaration. This declaration is based on my personal knowledge and other information known to the Florida Agency for Health Care Administration ("AHCA"). I believe the facts stated herein to be true and correct. I would testify to the facts stated in this declaration in open court if called upon to do so.

2. I am the Deputy Secretary for Medicaid Policy, Quality, and Operations for AHCA. In this role, I oversee the bureaus of Medicaid Policy, Medicaid Quality, Medicaid Plan Management Operations, Medicaid Recipient and Provider Assistance, and Medicaid Third Party Liability. I have held this position since February 2023. Prior to my role as Deputy Secretary, I served as the Chief Operating Officer of the Florida Healthy Kids Corporation, which operates Florida's Children's Health Insurance Program ("CHIP") under the direction of AHCA. From November 2016 to February 2023, I oversaw CHIP eligibility and enrollment, plan management operations, quality, information systems, and data analytics.

3. As of October 2023, more than 119,000 children in low- and moderate-income families statewide receive subsidized health insurance through Florida CHIP.

4. In fiscal year 2019–2020, Florida collected over $30 million in premium payments from CHIP participants.

5. On June 22, 2023, Governor DeSantis signed into law Florida H.B. 121 to substantially expand the provision of subsidized health insurance to Florida children. *See* An Act Relating to Florida KidCare Program Eligibility, H.B. 121, § 1, 2023 Leg. (Fla. 2023). Florida anticipates that its expanded CHIP plan will provide subsidized health insurance to an additional 26,096 children in its first full year.

6. Florida anticipates that the expanded CHIP will cost an additional $90 million in its first full year. That cost is expected to be funded through approximately $23.1 million in additional premium payments from families, $19.7 million in additional state funds, and $47.2 million in additional federal funds.

7. Florida anticipates collecting more than $53 million in total premium payments from new and existing CHIP participants in the first full year of the expanded CHIP.

8. In October 2023, Centers for Medicare and Medicaid (CMS) issued a Frequently Asked Questions (FAQs) that prohibits states from disenrolling CHIP participants for failure to pay premiums during the continuous eligibility period.

9. In any given month, Florida anticipates approximately 3% of Florida CHIP participants will be disenrolled for failing to pay premiums.

10. Florida anticipates that if it complies with the CMS FAQs, it will spend approximately $1 million each month to provide benefits to CHIP participants who would otherwise have been disenrolled for failing to pay premiums.

11. Disenrollments from Florida CHIP occur monthly and become effective on the first day of the month after the unpaid premium was due. The next disenrollments will be effective February 1, 2024, for participants who have not paid premiums due January 1, 2024.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 31, 2024

[redacted]

AUSTIN NOLL

**From:** FLMedicaidWaivers
**To:** [redacted]
**Subject:** FW: Comments on CHIP Eligibility Extension Waiver
**Date:** Wednesday, February 21, 2024 12:15:39 PM
**Attachments:** FHJP Comments re KidCare 1115 Waiver 02.21.24 .pdf

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[redacted] update from Ms. H[redacted]

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**From:** Lynn H[redacted]
**Sent:** Wednesday, February 21, 2024 10:48 AM
**To:** FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
**Subject:** Comments on CHIP Eligibility Extension Waiver

Dear Sir or Madam,

Please see the attached letter.

Thank you.

Sincerely,

Lynn [redacted] H[redacted]
[redacted]
Florida Health Justice Project
[redacted]

FLORIDA HEALTH
JUSTICE PROJECT

*via email to FLMedicaidWaivers@ahca.myflorida.com*

February 21, 2024

Agency for Health Care Administration
2727 Mahan Drive, MS #20
Tallahassee, Florida 32308

Re: Section 1115 Research and Demonstration Waiver: Children's Health Insurance Program Eligibility Extension Request

Dear Sir or Madam:

Florida Health Justice Project appreciates the opportunity to submit these comments in response to the request by the Agency for Health Care Administration (AHCA) for a new 5-Year Section 1115 Title XXI Research Demonstration Waiver.

Florida Health Justice Project (FHJP) is a nonprofit organization engaged in comprehensive advocacy aimed at expanding health care access and promoting health equity for vulnerable and marginalized Floridians. We have worked extensively on issues connected to health care coverage for Florida children in low-income families. This work includes providing training and materials as well as extensive outreach and assistance for consumers whose children may be subject to termination or have lost Medicaid during the state's post-PHE redetermination process ("the unwind") which began in April 2023. Our website contains links to the consumer and advocate materials FHJP created regarding children's eligibility for KidCare programs. A sampling of the consumers we have assisted have shared their stories on this web page (*see*, *e.g.*, Laurie and Adam).

At the outset, we want to express our appreciation of the state's intention to expand access to subsidized health insurance for children. At the same time, we also must underscore that many Florida families are currently being harmed by the ongoing delay in implementing this expansion. When House Bill 121 was passed and enacted into law on June 22, 2023, the Legislature intended it to be fully implemented as of January 1, 2024. The legislative analysis for HB 121 identified over 42,000 currently uninsured children who would benefit from the expanded eligibility of subsidized KidCare. This number has surely risen dramatically, as since that time at least 461,000 additional children have been terminated from Medicaid through the unwinding process.[1]

There can be no question that there is a pressing need for expanded KidCare eligibility at this precise moment in time. Specifically, families with children with complex conditions, who are scheduled under Florida's Medicaid Redetermination Plan ("Plan") to undergo redetermination at the end of the unwind period, March-April 2024, have an immediate need for the expanded KidCare eligibility levels to be implemented. *See* Plan at 12. It is anticipated that a number of these children who are no longer eligible for Medicaid will need to transfer to one of the other Florida KidCare Programs. For example, Gillian's child Penelope was recently terminated from Medicaid. The family is over income for Medicaid, but they would qualify for the subsidy if/when the expansion is implemented. Gillian could have enrolled Penelope in her family's low-cost marketplace plan, but such a plan would not provide adequate coverage for a child with Penelope's complex conditions. She needs to be enrolled in a KidCare plan. The family will be struggling to pay the premium, but it is slightly less than the full cost plan available now. *See* Penelope, Chapter 2 story link.

We appreciate the opportunity to comment on certain elements of the proposed waiver, including the complex tier structure and amount of premiums, that we believe adversely impact the Legislature's intent to expand health care access to children.

While the proposed waiver application continues Florida's current policy of imposing premiums for KidCare, there is significant research showing that the imposition of premiums negatively impacts the ability of low-income individuals to obtain and maintain coverage in State Children's Health Insurance Programs (CHIP) such as KidCare.[2] This research shows that premiums in CHIP programs deter initial enrollment, shorten lengths of enrollment, and increase disenrollment of the very population the program is intended to serve. Indeed, when Florida last increased its KidCare premiums by just $5 per month, it experienced a 61% decrease in enrollment lengths in families under 150% of FPL, and a 55% decrease in enrollment length in families with incomes 150-200% of FPL.[3] Furthermore, as CMS recently addressed with

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[1] *See* Georgetown University McCourt School of Public Policy Center for Children and Families, "How many children are losing Medicaid." https://ccf.georgetown.edu/2023/09/27/how-many-children-are-losing-medicaid/

[2] *See, e.g.*, Kaiser Family Foundation (2017). The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[3] Herndon JB, Vogel WB, Bucciarelli RL, Shenkman EA. The effect of premium changes on SCHIP enrollment duration. Health Serv Res. 2008 Apr;43(2):458-77. https://doi.org/10.1111/j.1475-6773.2007.00777.x

respect to a Section 1115 Medicaid demonstration waiver pertaining to Indiana's Healthy Indiana Plan (HIP), premium requirements interfere with enrollment by causing confusion over the amounts owed, the available methods of payment, and the process and ability to re-enroll following disenrollment.[4]

In the face of this research, Florida's waiver application appears to seek to implement House Bill 121 in a manner likely to be disruptive to children's coverage. Although the legislation calls for "at least three but no more than six" premium tiers and is silent as to increases, the proposed waiver would maximize the complexity of the premium structure by having six premium tiers and imposing a three percent increase every year. We urge the state to reduce the tiers to the minimum of three tiers required by eliminating proposed Tiers 4-6. In addition to creating unnecessary complexity, the proposed premiums in these tiers are too high to be affordable for families in these income ranges. *See* Penelope, Chapter 2. For the same reasons, we oppose the proposed annual automatic increase in premium levels.

Moreover, the waiver application states that it seeks authority to implement these premiums "as a condition of enrollment" (Table 6). It is unclear whether Florida intends to require premiums only as a condition of *initial* enrollment, which is permissible, or also as a condition of *continuous* enrollment, which would contravene Section 5112 of the Consolidated Appropriations Act, 2023 (CAA). We urge AHCA to amend the waiver application to make clear that it will comply with the continuous enrollment provision of the CAA in the event of non-payment of premiums.[5]

We note that Arizona recently submitted a request for a Section 1115 Waiver to expand its CHIP program eligibility threshold from 200% to 225% of the federal poverty level, and this waiver was approved by CMS on February 16, 2024. Arizona's waiver does not impose enforceable premiums in contravention of the 2023 CAA. We urge Florida to follow Arizona's example.

Finally, as the purpose of a Section 1115 Waiver is to assist in promoting the objectives of the Social Security Act, the success of the waiver can only be measured

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[4] See CMS letter to Indiana, Dec. 22, 2023 pp. 4-5: https://www.medicaid.gov/sites/default/files/2023-12/in-cms-ltr-to-the-state-12222023_1.pdf

[5] We are aware that Florida has challenged the enforceability of Section 5112 of the 2023 CAA as interpreted by the Centers for Medicare and Medicaid Services (CMS) that Section 5112 prohibits disenrollment of children from CHIP programs for non-payment of premiums. *See State of Fla. v. Centers for Medicare & Medicaid Servs.*, Case No. 8:24-cv-317 (M.D. Fla) (filed Feb. 1, 2024). This lawsuit is entirely independent of the Section 1115 waiver application process and must proceed on its own course; the state may not simply incorporate into its waiver application the relief it is seeking to achieve through litigation. Florida was well aware of CMS's interpretation of Section 5112 of the CAA (issued Oct. 27, 2024) when it initiated its waiver application (Jan. 23, 2024).

through the capture and analysis of relevant data. We urge the state to commit to greater transparency regarding its KidCare programs, including timely public release of detailed enrollment data. Given the concerns identified above regarding the potential negative effects on enrollment due to the proposed level and complexity of premiums, this published data should include at a minimum the number of children enrolled each month, differentiating between new enrollments and re-enrollments, as well as the number of monthly disenrollments including the reason for the disenrollment.

Thank you for your consideration of these written comments. We welcome the opportunity to discuss these matters with you at any time.

Sincerely,

[redacted]__________
Lynn [redacted] H[redacted]
[redacted]
Florida Health Justice Project
[redacted]

[redacted]__________
Miriam H[redacted]
[redacted]
Florida Health Justice Project
[redacted]

**From:** FLMedicaidWaivers
**To:** [redacted]
**Subject:** FW: CHIP Eligibility Extension Request - Allotment neutrality analysis
**Date:** Tuesday, February 13, 2024 8:47:00 AM

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Please see the email below. Thank you

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**From:** Lynn H[redacted]
**Sent:** Monday, February 12, 2024 4:54 PM
**To:** FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
**Subject:** CHIP Eligibility Extension Request - Allotment neutrality analysis

Dear Sir or Madam:

The waiver request document states at page eight that "[t]he title XXI CHIP allotment neutrality analysis workbook for this 5-year request is provided as a separate attachment to this application."

However, the referenced workbook is not included with the application nor separately posted on the website, as far as I have been able to tell.

Would you please either provide me with this analysis or a link to a website where it is publicly available?

Thank you very much.

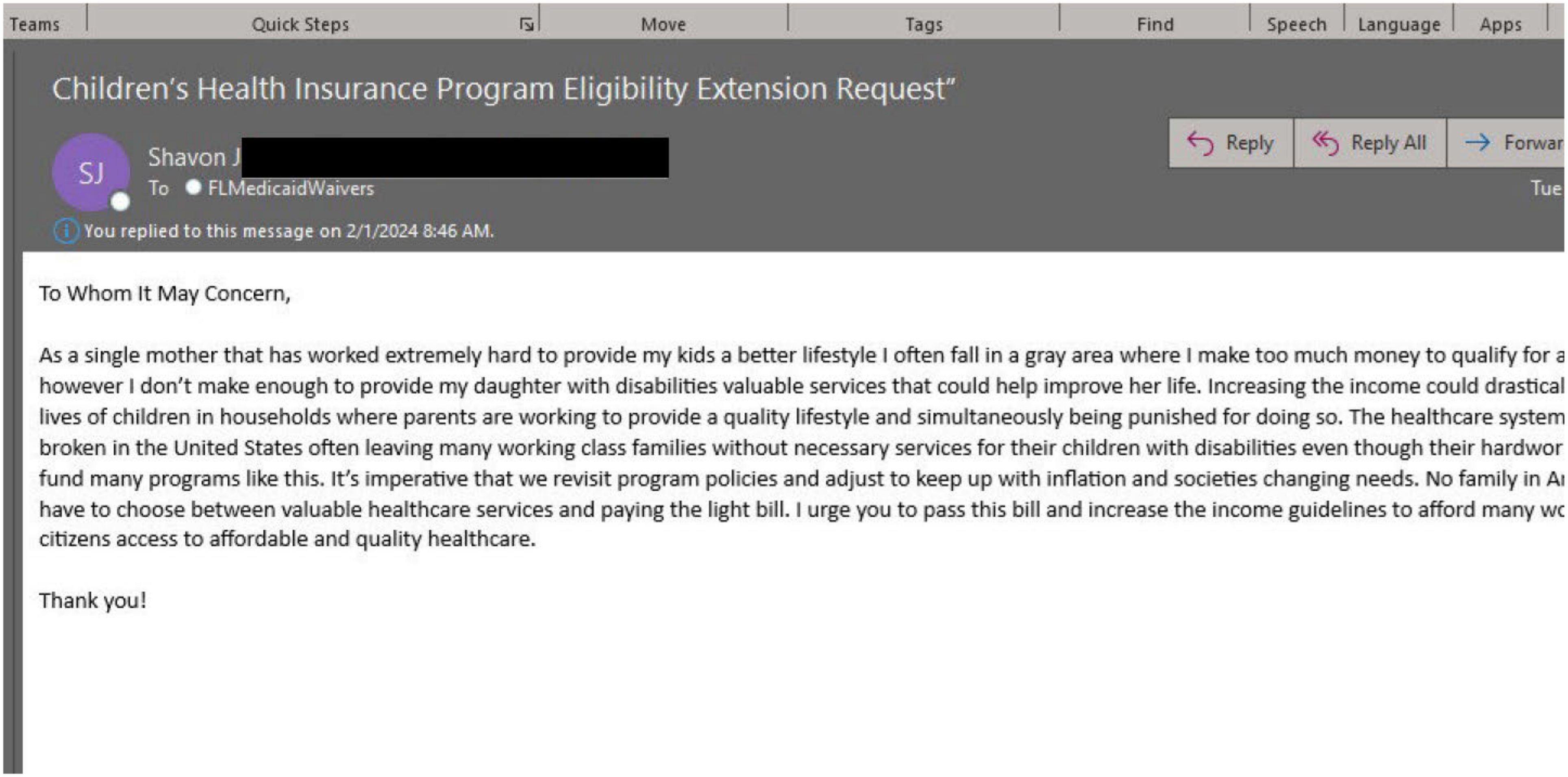
Sincerely,

Lynn [redacted] H[redacted]
[redacted]
Florida Health Justice Project
[redacted]
[redacted]

[redacted]

[redacted] [redacted]

There were two other public comments received regarding the CHIP Waiver, see screenshots below.



Children's Health Insurance Program Eligibility Extension Request"

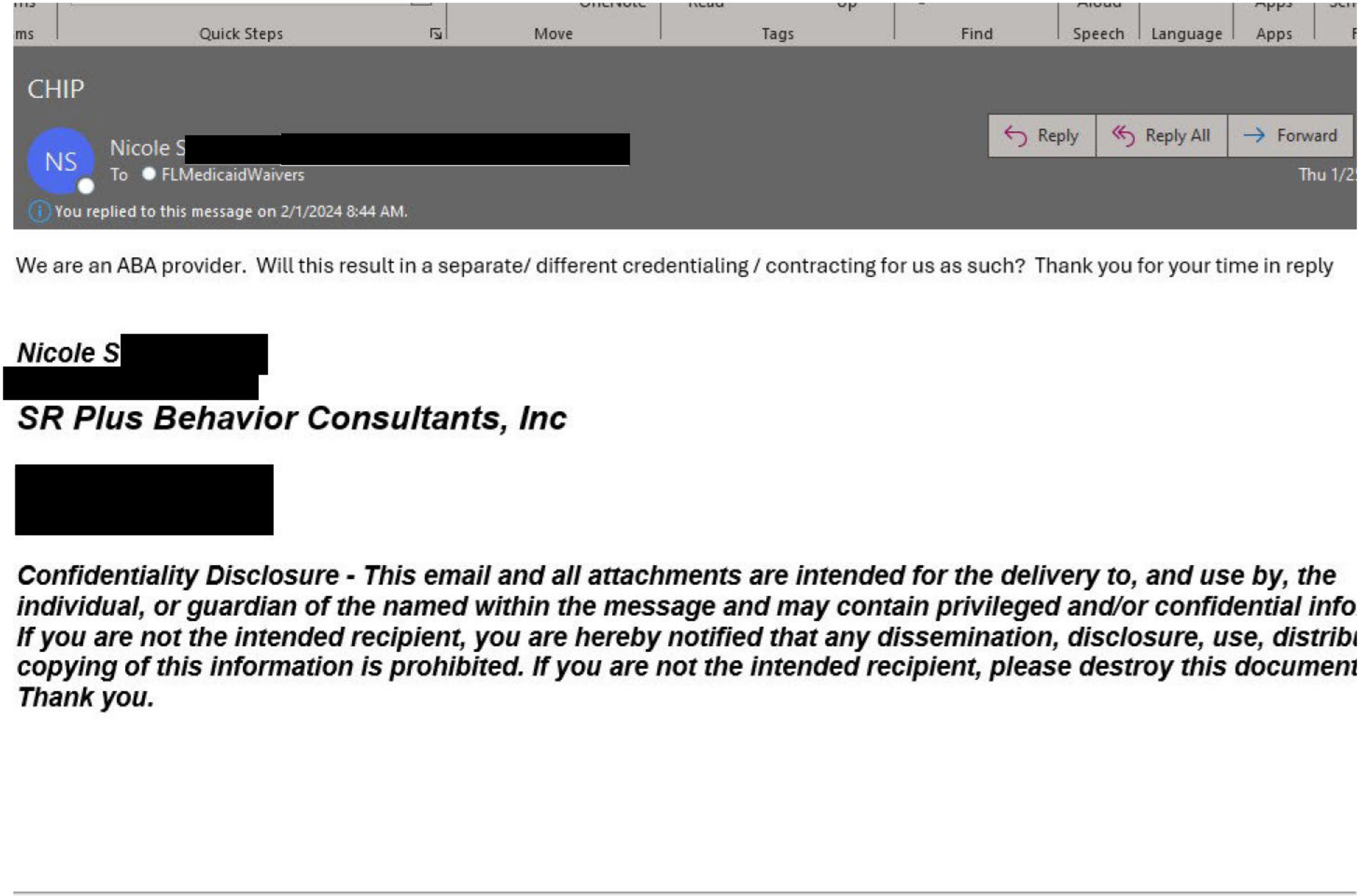
Shavon J [redacted]
To FLMedicaidWaivers

You replied to this message on 2/1/2024 8:46 AM.

To Whom It May Concern,

As a single mother that has worked extremely hard to provide my kids a better lifestyle I often fall in a gray area where I make too much money to qualify for a
however I don't make enough to provide my daughter with disabilities valuable services that could help improve her life. Increasing the income could drastical
lives of children in households where parents are working to provide a quality lifestyle and simultaneously being punished for doing so. The healthcare system
broken in the United States often leaving many working class families without necessary services for their children with disabilities even though their hardwor
fund many programs like this. It's imperative that we revisit program policies and adjust to keep up with inflation and societies changing needs. No family in A
have to choose between valuable healthcare services and paying the light bill. I urge you to pass this bill and increase the income guidelines to afford many wc
citizens access to affordable and quality healthcare.

Thank you!



CHIP

NS Nicole S [redacted]

To ● FLMedicaidWaivers

Thu 1/2

You replied to this message on 2/1/2024 8:44 AM.

We are an ABA provider. Will this result in a separate/ different credentialing / contracting for us as such? Thank you for your time in reply

***Nicole S*** [redacted]

[redacted]

***SR Plus Behavior Consultants, Inc***

[redacted]

***Confidentiality Disclosure - This email and all attachments are intended for the delivery to, and use by, the individual, or guardian of the named within the message and may contain privileged and/or confidential info***
***If you are not the intended recipient, you are hereby notified that any dissemination, disclosure, use, distrib***
***copying of this information is prohibited. If you are not the intended recipient, please destroy this document***
***Thank you.***

[redacted]

[redacted]

REPORT MEDICAID FRAUD
Online or 866-966-7226
REPORTE FRAUDE DE MEDICAID

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[redacted]
**Sent:** Wednesday, February 14, 2024 2:23 PM
[redacted]
**Subject:** CHIP Waiver

Hi [redacted]

Can you confirm if there have been any additional comments on the CHIP Waiver, aside from those from Lynn H[redacted]?

Thank you!

[redacted]

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[redacted]

[redacted]

REPORT MEDICAID FRAUD
Online or 866-966-7226
REPORTE FRAUDE DE MEDICAID

[redacted]

[redacted] [redacted]

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[redacted]

[redacted]

REPORT MEDICAID FRAUD
Online or 866-966-7226
REPORTE FRAUDE DE MEDICAID

[redacted]

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**From:** Ashley L[redacted]
**Sent:** Wednesday, February 21, 2024 1:58 PM
**To:** FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
**Subject:** Children’s Health Insurance Program Eligibility Extension Request

Hello,

Please accept the attached comments on Florida's CHIP Extension Request.

Sincerely,
Ashley L[redacted]

Ashley L[redacted]
[redacted]
American Lung Association

Get Outlook for iOS

American Cancer Society Cancer Action Network
American Lung Association
Epilepsy Foundation
Arthritis Foundation
National Multiple Sclerosis Society
American Diabetes Association
Cystic Fibrosis Foundation
NPAF National Patient Advocate Foundation
HFA Hemophilia Federation of America
PHA Pulmonary Hypertension Association Empowered by hope
WomenHeart The National Coalition for Women with Heart Disease
The AIDS Institute
NORD National Organization for Rare Disorders
CancerCare
MDA Muscular Dystrophy Association
Leukemia & Lymphoma Society
Child Neurology Foundation Creating a Community of Support

February 21, 2024

Jason Weida, J.D.
Secretary of Health Care Administration
Agency for Health Care Administration
2727 Mahan Drive, MS #20
Tallahassee, FL 32308

Re: Florida Children's Health Insurance Program Eligibility Extension

Dear Secretary Weida:

Thank you for the opportunity to submit state comments on the Florida Children's Health Insurance Program Eligibility Extension.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the state to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Florida's Medicaid program provides quality and affordable healthcare coverage. We support the state's proposal to expand the Children's Health Insurance Program (CHIP) coverage to 300% of the Federal Poverty Level (FPL). The state estimates that this demonstration will cover an additional 14,000 children in the first year of implementation, rising to 41,000 children in the fifth year.[1] Our organizations support this expansion of health coverage, particularly at a time when thousands of children and families in Florida have lost their healthcare coverage for procedural or paperwork issues.[2]

However, we remain concerned by the state's continued premium requirements. Our organizations have consistently supported the need for access to quality, affordable coverage.[3] The evidence is clear that premiums make it harder for individuals to obtain or keep healthcare coverage.[4] The inclusion of premiums can also exacerbate existing disparities in access to healthcare, as they have been shown to lead to lower enrollments for Black enrollees and lower-income enrollees, compared to their white and higher-income counterparts, respectively.[5] Premiums can be a significant barrier for individuals accessing care, and removing them increases equitable access to care for all enrollees.

Additionally, our organizations support continuous eligibility as a method to protect patients and families from gaps in care. Continuous eligibility promotes health equity,[6] and increases continuity of coverage. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[7] Our organizations support continuous eligibility in order to reduce these negative health outcomes for children in Florida, who face one of the highest uninsurance rates in the country.[8]

Our organizations support Florida's proposal to expand CHIP coverage to 300% of the FPL, and we urge the state to remove premium requirements to comply with the Consolidated Appropriations Act guidance, ensuring that children do not have gaps in coverage.

Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
American Diabetes Association
American Lung Association
Arthritis Foundation
Cancer*Care*
Child Neurology Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Muscular Dystrophy Association
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Pulmonary Hypertension Association
The AIDS Institute
The Leukemia & Lymphoma Society
WomenHeart

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[1] “Children’s Health Insurance Program Eligibility Extension.” Florida Agency for Health Care Administration. January 23, 2024. Available at: https://ahca.myflorida.com/content/download/23900/file/Children%27s%20Health%20Insurance%20Program%20Eligibility%20Extension%20Request.pdf

[2] Letter from Xavier Becerra to Governor DeSantis. Department of Health and Human Services. December 18, 2023. Available at: https://www.hhs.gov/sites/default/files/sec-becerras-letter-to-fl-governor.pdf

[3] Consensus Healthcare Reform Principles. Partnership to Protect Coverage, 2024. Available at: https://www.protectcoverage.org/ppc-consensus-healthcare-reform-principles

[4] Samantha Artiga, Petry Ubri, and Julia Zur, “The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings,” Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[5] University of Wisconsin-Madison Institute for Research on Poverty. (2019). Evaluation of Wisconsin’s BadgerCare Plus Health Coverage for Parents & Caretaker Adults and for Childless Adults 2014 Waiver Provisions. Available at https://www.irp.wisc.edu/wp/wp-content/uploads/2019/11/BC-2014-Waiver-Provisions-Final-Report-08302019.pdf

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# Children’s Health Insurance Program Eligibility Extension

## Section 1115 Title XXI Research Demonstration
## New 5-Year Demonstration Request

### Florida Agency for Health Care Administration

# Contents

## Program Application Overview

The Florida Agency for Health Care Administration (AHCA) is seeking federal authority from the Centers for Medicare & Medicaid Services (CMS) to implement a new section 1115 (Title XXI) Children's Health Insurance Program (CHIP) demonstration that offers program eligibility to children with family income above 200 percent of the federal poverty level (FPL)[1], up to 300 percent of the FPL, with enrollment subject to monthly premiums. This section 1115 demonstration will operate concurrently with the CHIP state plan which offers health insurance for uninsured children in families with incomes up to 200 percent of the FPL. The state is requesting authority for new premium amounts through this demonstration for all CHIP eligible recipients included in both the CHIP state plan and the section 1115 waiver authorities with incomes between 133 and 300 percent of the FPL. The State is seeking a proposed effective date of April 2024.

## I. Demonstration Purpose, Goals, and Objectives and CHIP Program Overview

### Demonstration Purpose, Goals, and Objectives

Florida is focused on ensuring that families have Pathways to Prosperity, which are individualized paths to prosperity, economic self-sufficiency, and hope through community collaboration between government entities, the private sector, community organizations, and the nonprofit sector. The Florida Legislature and Governor DeSantis recognized that parents who are working hard to improve their economic situation of their family could potentially lose access to subsidized CHIP health insurance for their children through even a small increase in their income, and that the potential loss of the subsidized coverage could be a disincentive to the parent in their pathway to prosperity and economic self-sufficiency. For example, a parent who worked more hours or received a promotion that increased annual income by $300 (approximately 1% of the FPL for a family of four with two children) would face an increase in premiums from subsidized CHIP coverage (with premiums of $240 per year per family) to $5,748 annually if they chose to participate in Florida's full-pay program.

In response, the Florida Legislature passed House Bill 121 (HB 121), signed into law in June 2023, to increase eligibility for the CHIP-subsidized KidCare programs above the current state plan threshold of 200 percent of the FPL up to 300 percent of the FPL. HB 121 also requires the State to establish new monthly premiums for CHIP enrollees. The new premium structure creates a graduated level of premiums that allows families with growing income to be able to continue to afford health insurance for their children.

This proposed demonstration is critical at this time as Florida's economy thrives, and more families are reporting increased income levels above those allowed for Florida Medicaid eligibility.

Florida's Medicaid redetermination process is already projected to increase enrollment in Florida's KidCare Full-Pay program, as current Medicaid enrollees with income levels too

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[1] 200 percent represents the percent of the FPL prior to the application of the modified adjusted gross income (MAGI) conversion.

high for Medicaid and too high for CHIP-subsidized KidCare disenroll and look for other coverage options. Florida estimates 16,328 children with household incomes under 300% FPL will enroll in Full-Pay KidCare in Fiscal Year 2023-2024.

This proposed demonstration is expected to enable Florida to continue to make strides in increasing access to creditable health insurance coverage for lower-income children within the State while supporting increased economic self-sufficiency and pathways to prosperity. Accordingly, the goals and objectives of this demonstration are to:

- Increase enrollment and access to CHIP-subsidized coverage; and,
- Improve or maintain the rate of uninsured children under age 19 in the State of Florida.

CHIP Background

The Florida KidCare Program (KidCare or Program) was created by the Florida Legislature in 1998 in response to the passage of the federal Children's Health Insurance Program (CHIP) in 1997. The federal CHIP provides funding for states who choose to subsidize health insurance coverage to uninsured children in families with incomes that are too high to qualify for Medicaid but who meet other eligibility requirements. Florida's KidCare program encompasses four partner programs, that together with the availability of full-pay options for those who do not qualify for subsidized coverage matched by the federal government, offers coverage for all children in the State of Florida. The four programs that comprise Florida KidCare are:

1. **Medicaid for children** – Title XIX medical coverage to eligible children up to 1-year-old with family income that does not exceed 200 percent of the FPL and to eligible children, ages 1-18, with family income that does not exceed 133 percent of the FPL.

2. **MediKids Program** – MediKids provides low-cost health insurance for children ages 1 through 4. The MediKids program is similar to Medicaid. Children enrolled in the MediKids program receive medical services and benefits from Medicaid providers through Medicaid's Managed Medical Assistance (MMA) program. The program charges monthly premiums but does not impose any other form of beneficiary cost-sharing (i.e., no deductibles, co-payments, or coinsurance).

3. **Children's Medical Services (CMS)** – CMS is a collection of programs that provides a statewide managed care system for children (under age 19) with special health care needs and provides essential preventive, evaluative, and early intervention services for at-risk children.

4. **Florida Healthy Kids Program** – Florida Healthy Kids offers quality, affordable, child-centered health and dental insurance for children ages 5 through 18. Florida Healthy Kids has a subsidized plan for families who exceed the income eligibility

threshold for Medicaid, as well as full-pay options for those who do not qualify for subsidized coverage.

KidCare is governed by part II of Chapter 409, Florida Statutes (F.S.) and is administered jointly by AHCA, the Department of Children and Families, the Department of Health, and the Florida Healthy Kids Corporation (Corporation) established in Chapter 624, F.S. Table 1 below delineates the roles of each agency and the Corporation:

**Table 1: Florida KidCare Organizational Structure**

| State Agency and Program(s) | Responsibilities |
|---|---|
| Agency for Health Care Administration (AHCA) (MediKids) | • Administers the Medicaid program (Title XIX)<br>• Administers the MediKids program (Title XXI, ages 1-4)<br>• Serves as lead Title XXI contact with the federal Centers for Medicare and Medicaid Services<br>• Distributes federal funds for Title XXI programs<br>• Manages the Florida Healthy Kids Corporation contract<br>• Develops and maintains the Title XXI Florida KidCare State Plan |
| Department of Children and Families (DCF) (Medicaid for Children) | • Determines Medicaid (Title XIX) eligibility<br>• Administers the CMS Behavioral Health Network (Title XXI, ages 0-18) |
| Department of Health (Children's Medical Services) | • Administers Children's Medical Services (Titles XIX and XXI, ages 0-18 with special health care needs) |
| Florida Healthy Kids Corp. (Healthy Kids) | • Performs administrative functions for Florida KidCare (eligibility determination, premium collection, marketing, and customer service)<br>• Administers Florida Healthy Kids program (Title XXI, ages 5-18) |

## II. Demonstration Benefits, Eligibility and Cost-Sharing

### Benefits

Florida KidCare health and dental services are delivered through quality plans that offer a choice of local doctors, dentists, specialists, hospitals, pharmacies, and other health care providers. Florida KidCare benefits minimally include but are not limited to: doctor visits, surgeries, check-ups, immunizations, dental and vision care, prescriptions, hospital stays, behavioral health, and emergencies.

### Eligibility

Eligibility for Florida KidCare, including Florida Healthy Kids, is determined in part by age and household income, as a percent of the FPL, as indicated in Table 2 below:

**Table 2 – Florida KidCare Eligibility and Cost-sharing Structure**

| Program | Ages | Family Income Eligibility | | | Existing Monthly Premium Structure | Copay (some services) |
|---|---|---|---|---|---|---|
| | | FPL Threshold (Pre MAGI) | FPL Threshold (Post MAGI) | Annual Income[2] | | |
| Medicaid for Children | 0-1 | 185-200% FPL | 194-210% FPL | $55,000 – $60,000 | $0 | $0 |
| MediKids | 1-4 | 133-200% FPL | 140-210% FPL | $41,400 – $60,000 | $15 for 133-158% FPL<br>$20 for 158-200% FPL<br>(per household) | Up to $10 |
| Healthy Kids | 5 | 133-200% FPL | 140-210% FPL | $41,400 – $60,000 | | Up to $10 |
| | 6-18 | 100-200% FPL | 112-210% FPL | $30,000 – $60,000 | | Up to $10 |
| Children's Medical Services | 0-18 | Up to 200% FPL | Up to 210% FPL | $0 – $60,000 | | $0 |
| Full-Pay (MediKids & Healthy Kids) | 1-18 | Over 200% FPL | Over 210% FPL | Over $60,000 | $210 - MediKids<br>$259 - Healthy Kids (per child) | $10 or $15 |

The demonstration will not change CHIP state plan eligibility for uninsured children in households with income up to the threshold of 200 percent of the FPL. The CHIP state plan will continue to be the basis of eligibility for uninsured children up to and including 200 percent of the FPL.

The demonstration will be the basis of coverage for uninsured children with household income ranging from above 200 percent of the FPL up to 300 percent of the FPL. The demonstration will also be the basis of authority for the monthly premium structure that will be applied to CHIP enrollees in households with income over 133 percent of the FPL up to the new coverage threshold of 300 percent of the FPL. See Table 3 below for the proposed new monthly premium structure for the Florida KidCare program.

### Cost-sharing – Monthly Premium Structure

Families contribute monthly premiums to the cost of the Florida KidCare program based on their household size, income, and other eligibility factors. The premium does not vary by the number of children in the household. In accordance with HB 121, Florida is proposing to establish new premium tiers for CHIP enrollees above 133 percent of the FPL, including the new income coverage band from above 200 percent of the FPL up to 300 percent of the FPL. The new monthly premium structure proposed for the Florida KidCare program is as follows:

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[2] Annual income based on 2023 federal poverty guidelines for a family size of 4 utilizing Pre-MAGI percentages

**Table 3 – Proposed New Monthly Premiums for Households**[3]

| Proposed Premium Tiers by Federal Poverty Level | | | | | |
|---|---|---|---|---|---|
| Tier 1 FPL Range | Tier 2 FPL Range | Tier 3 FPL Range | Tier 4 FPL Range | Tier 5 FPL Range | Tier 6 FPL Range |
| **133-175%** | **175-200%** | **200-225%** | **225-250%** | **250-275%** | **275-300%** |
| $17 | $30 | $60 | $95 | $145 | $195 |

## III. Health Care Delivery System

Florida utilizes a managed care delivery system for all children enrolled in CHIP. Children in MediKids are enrolled in a Statewide Medicaid Managed Care program, Managed Medical Assistance plan. Children in Florida Healthy Kids are enrolled in one of three managed care plans contracted with the Florida Healthy Kids Corporation. Children in Children's Medical Services are enrolled in the Florida Department of Health's CMS plan. All plans are fully capitated plans that provide a comprehensive array of benefits to enrolled children.

## IV. Enrollment & Expenditures

### Projected Enrollment

The state's projected enrollment of uninsured children with household income ranging from above 200 percent of the FPL up to 300 percent of the FPL is listed in Table 4.

**Table 4 – Projected Enrollment**

| DY01 | DY02 | DY03 | DY04 | DY05 |
|---|---|---|---|---|
| 14,649 | 28,926 | 38,360 | 41,272 | 41,874 |

### Enrollment Impact

As of January 2023, 117,092 children are enrolled in KidCare. The State's 2023-2024 fiscal year projections assume that Medicaid redeterminations, which began in April 2023, will cause a 76.54% caseload growth in the CHIP Florida Healthy Kids portion of the KidCare program over the next year, as indicated by the graph below.

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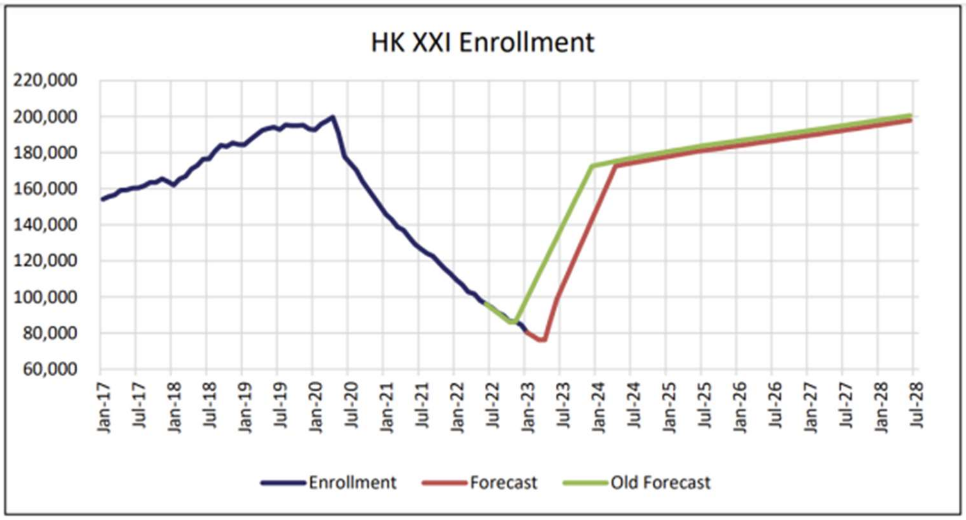
[3] Premiums will increase by three percent each year.



Florida's current work to complete Medicaid redeterminations in the post public health emergency return to normal operations per CMS guidance, has resulted in an estimated 16,328 children in Fiscal Year 2023-2024 with household income under 300% FPL who would only be eligible for enrollment in Full-Pay KidCare at an approximate annual premium of $3,114 plus nominal co-pays for certain services. The proposed demonstration will increase the upper eligibility band for KidCare eligibility, thereby making many Full-Pay KidCare enrollees now eligible for (more affordable) subsidized-KidCare coverage. Accordingly, the proposed demonstration is expected to impact projected overall CHIP enrollment by increasing the number of lower-income uninsured children eligible for enrollment in KidCare by approximately 165,000 children over the initial five years of implementation.

This new premium structure is not expected to impact general disenrollment trends or processes. Total projected enrollment in KidCare, including disenrollments due to failure to pay the monthly premium, was utilized to calculate the total costs for the demonstration.

Projected Expenditures

The state's projected medical assistance expenditures for coverage of uninsured children with household income ranging from above 200 percent of the FPL up to 300 percent of the FPL is listed in Table 5.

**Table 5 – Projected Title XXI (CHIP) Expenditures**

| DY01 | DY02 | DY03 | DY04 | DY05 |
|---|---|---|---|---|
| $16,999,053 | $69,794,099 | $106,984,015 | $125,152,604 | $135,457,940 |

The title XXI CHIP allotment neutrality analysis workbook for this 5-year request is provided as a separate attachment to this application.

## V. Evaluation Parameters

The State, in consultation with a to-be selected evaluator, will identify validated performance measures that will assess the impact of the demonstration on CHIP enrollees. In addition, the State intends to work with the selected evaluator to identify meaningful comparison groups in designing the evaluation plan. It is the intent of the State to follow all CMS evaluation design guidance in working with the State's selected evaluator to draft an evaluation plan. See the proposed evaluation parameters in Table 5 below.

**Table 5 – Proposed Evaluation Parameters**

| Proposed Hypothesis | Anticipated Measure(s) | Proposed Data Sources |
|---|---|---|
| The demonstration will increase enrollment and access to CHIP coverage. | Number of children with family income over 200% of FPL up to 300% of FPL enrolled in CHIP. | Florida CHIP claims and enrollment records |
| The demonstration will improve or maintain the rate of uninsured children under age 19 in the State of Florida. | Reported uninsurance rates: Number of children up to age 19 in Florida without health coverage | U.S. Census Bureau Data, American Community Survey (ACS) |

## VI. Waiver and Expenditure Authorities

**Table 6 – Proposed Waiver and Expenditure Authorities**

| | |
|---|---|
| **Section 1115(a)(1) Waiver Authorities** | *Florda does not anticipate needing any waivers of the provisions under Title XXI of the Social Security Act to implement this demonstration.* |
| **Section 1115(a)(2) Expenditure Authorities** | Expenditure authority to offer CHIP coverage (through Florida KidCare) to uninsured children in households with income above 200 percent of the FPL up to 300 percent of the FPL. |
| | Expenditure authority to implement a monthly premium structure to be imposed on CHIP enrollees with income above 133 percent of the FPL up to 300 percent of the FPL as a condition of enrollment. |

## VII. Documentation of State Public Notice Process

The abbreviated notice was published on January 23, 2024 via Florida Administrative Register. Notice for tribal consultation was sent on January 23, 2024 to the Miccosukee and Seminole Tribes via email. As outlined in these public notices, AHCA is providing a minimum 30-day public comment period from January 23, 2024 at 3:00 pm EST, through February 21, 2024 at 3:00 pm EST. The draft section 1115 demonstration application and related public notice materials are posted for the minimum 30-day public comment period starting January 23, 2024 at 3:00 pm EST, on the Federal Waivers Home page located on the AHCA website: https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers.

The rest of this application section will be completed in the final submission to CMS after the State completes the full state public notice process in alignment with CMS requirements. In addition to publishing notices, AHCA will conduct two public hearings on the proposed application as outlined in the State's published public notices as well as on AHCA's website. AHCA will also collect and analyze all public comments received during the 30-day comment period into a report summary reflecting common trends and themes for inclusion in the final submission to CMS.

**Partnership to Protect Coverage**

# CONSENSUS HEALTHCARE REFORM PRINCIPLES

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all. This is particularly important for populations that have been marginalized or underserved based on their race, ethnicity, geography, gender identity, sexual orientation, disability status, country of origin, and socioeconomic status.

In addition, any reform measure must support a health care system that addresses persisting inequities, provides affordable, accessible and adequate health care coverage to all, and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

## 1: Health Insurance Must be Affordable

Affordable plans ensure patients have equitable access to needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance must be available for people with low incomes and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

## 2: Health Insurance Must be Accessible

All people, regardless of socioeconomic status, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

## 3: Health Insurance Must be Adequate and Understandable

All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer in a culturally competent manner prior to purchasing the plan.

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# The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings

**Samantha Artiga (https://www.kff.org/person/samantha-artiga/), Petry Ubri, and Julia Zur**

**Published: Jun 01, 2017**

ISSUE BRIEF

## Key Findings

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. This brief reviews research from 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. This research has primarily focused on how premiums and cost sharing affect coverage and access to and use of care; some studies also have examined effects on safety net providers and state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts. Together, the research finds:

- **Premiums serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals.** These effects are largest among those with the lowest incomes, particularly among individuals with incomes below poverty. Some individuals losing Medicaid or CHIP coverage move to other coverage, but others become uninsured, especially those with lower incomes. Individuals who become uninsured face increased barriers to accessing care, greater unmet health needs, and increased financial burdens.
- **Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services.** Research also finds that cost sharing can result in unintended consequences, such as increased use of the emergency room, and that cost sharing negatively affects access to care and health outcomes. For example, studies find that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia and reduced treatment for children with asthma. Additionally, research finds that cost sharing increases financial burdens for families, causing some to cut back on necessities or borrow money to pay for care.
- **State savings from premiums and cost sharing in Medicaid and CHIP are limited.** Research shows that potential revenue gains from premiums and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured individuals; and administrative expenses. Studies also show that raising premiums and cost sharing in Medicaid and CHIP increases pressures on safety net providers, such as community health centers and hospitals.

## Introduction

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. Proponents of increasing premiums and cost sharing in Medicaid indicate that doing so will promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions.[1] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-1)

This brief, which updates an earlier brief "*Premiums and Cost-Sharing in Medicaid: A Review of Research Findings* (https://www.kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/)," reviews research on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. It draws on findings from 65 papers published between 2000 and March 2017, including peer-reviewed studies and freestanding reports, government reports, and white papers by research and policy organizations. This research has primarily focused on how premiums and cost sharing affect coverage and access to care; some studies also have examined effects on state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts.

## Premiums and Cost Sharing in Medicaid and CHIP Today

**Currently, states have options to charge premiums and cost sharing in Medicaid and CHIP that vary by income and eligibility group (Box 1).** Reflecting these options, premiums and cost sharing in Medicaid and CHIP vary across states and groups. As of January 2017, 30 states charge premiums or enrollment fees and 25 states charge cost sharing for children in Medicaid or CHIP.[2] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-2) Most of these charges are limited to children in CHIP since the program covers children with higher family incomes than Medicaid and has different premium and cost sharing rules. States generally do not charge premiums for parents in Medicaid, but 39 states charge cost sharing for parents and 23 of the 32 states that implemented the Affordable Care Act (ACA) Medicaid expansion to low-income adults charge cost sharing for expansion adults.[3] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-3) Six states have waivers to charge premiums or monthly contributions for adults that are not otherwise allowed.[4] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-4)

## Box 1: Medicaid and CHIP Premium and Cost Sharing Rules

### Medicaid

- States may charge premiums for enrollees with incomes above 150% of the federal poverty level (FPL), including children and adults. Enrollees with incomes below 150% FPL may not be charged premiums.
- States may charge cost sharing up to maximums that vary by income (Table 1). States cannot charge cost sharing for emergency, family planning, pregnancy-related services, preventive services for children, or preventive services defined as essential health benefits in Alternative Benefit Plans in Medicaid. In addition, states generally cannot charge cost sharing to children enrolled through mandatory eligibility categories. The minimum eligibility standard for children is 133% FPL, although some states have higher minimums.
- Overall, premium and cost sharing amounts for family members enrolled in Medicaid may not exceed 5% of household income. This 5% cap is applied on a monthly or quarterly basis.

### CHIP

- States have somewhat greater flexibility to charge premiums and cost sharing for children in CHIP, although there are limits on the amounts that states can charge, including an overall cap of 5% of household income.

Table 1: Maximum Allowable Cost Sharing Amounts in Medicaid by Income

| | <100% FPL | 100% – 150% FPL | >150% FPL |
|---|---|---|---|
| **Outpatient Services** | $4 | 10% of state cost | 20% of state cost |
| **Non-Emergency use of ER** | $8 | $8 | No limit (subject to overall 5% of household income limit) |
| **Prescription Drugs** | | | |
| **Preferred** | $4 | $4 | $4 |
| **Non-Preferred** | $8 | $8 | 20% of state cost |
| **Inpatient Services** | $75 per stay | 10% of state cost | 20% of state cost |

Notes: Some groups and services are exempt from cost sharing, including children enrolled in Medicaid through mandatory eligibility pathways, emergency services, family planning services, pregnancy related services, and preventive services for children. Maximum allowable amounts are as of FY2014. Beginning October 1, 2015, maximum allowable amounts increase annually by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U).

## Effects of Premiums (**Table 1** (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-1/))

**A large body of research shows that premiums can serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals.** Studies show that premiums in Medicaid and CHIP lead to a reduction in coverage among both children and adults.[5] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-5),[6] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-6),[7] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-7),[8] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-8),[9] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-9),[10] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-10) Numerous studies find that premiums increase disenrollment from Medicaid and CHIP among adults and children, shorten lengths of Medicaid and CHIP enrollment, and deter eligible adults and children from enrolling in Medicaid and CHIP.[11] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-11),[12] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-12),[13] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-13),[14] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-14),[15] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-15),[16] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-16),[17] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-17),[18] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-18),[19] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-19),[20] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-20),[21] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-21),[22] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-22),[23] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-23),[24] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-24),[25] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-25),[26] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-26),[27] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-27),[28] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-28),[29] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-29),[30] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-30),[31] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-31),[32] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-32),[33] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-33),[34] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-34),[35] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-35),[36] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-36),[37] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-37),[38] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-38),[39] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-39)

**Although some individuals who disenroll from Medicaid or CHIP following premium increases move to other sources of coverage, others become uninsured and face negative effects on their access to care and financial security.** Those with lower incomes and those without a worker in the family are more likely to become uninsured compared to those with relatively higher incomes or with a worker in the family, reflecting less availability of employer coverage.[40] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-40),[41] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-41),[42] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-42),[43] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-43),[44] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-44),[45] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-45),[46] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-46),[47] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-47),[48] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-48),[49] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-49) Studies also show that those who become uninsured following premium increases face increased barriers to accessing care, have greater unmet health needs, and face increased financial burdens.[50] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-50),[51] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-51),[52] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-52) ,[53] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-53),[54] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-54) Several studies suggest that these negative effects on health care are largest among individuals with greater health care needs.[55] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-55),[56] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-56)

**Premium effects are largest for those with the lowest incomes, particularly among those with incomes below poverty.** Given that most states limit premium charges to children in CHIP, most studies of premium effects have focused on children in CHIP, who generally have incomes above 100% or 150% of the federal poverty level. A range of these studies show that premium effects are larger among children at the lower end of this income range, who have greater disenrollment and increased likelihood of becoming uninsured.[57] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-57),[58] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-58),[59] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-59),[60] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-60),[61] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-61),[62] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-62),[63] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-63),[64] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-64),[65] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-65) Reflecting the more limited use of premiums among Medicaid enrollees with incomes below poverty, fewer studies have focused on this population. However, studies that have focused on poor Medicaid enrollees found substantial negative effects on enrollment from premiums.[66] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-66),[67] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-67),[68] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-68),[69] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-69) For example, in Oregon, nearly half of adults disenrolled from Medicaid after a premium increase with a maximum premium amount of $20, with many becoming uninsured and facing barriers to accessing care, unmet health needs, and increased financial burdens.[70] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-70),[71] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-71),[72] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-72) Similarly, a more recent study of the Healthy Indiana Plan waiver program for Medicaid expansion adults with incomes below 138% FPL, which requires premiums that range from $1-$100 to enroll in a more comprehensive plan, found that 55% of eligible individuals either did not make their initial payment or missed a payment.[73] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-73) Research also finds that premium effects may vary by other factors beyond income. For example, one study finds larger effects of premiums among families without an offer of employer-sponsored coverage.[74] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-74) Some research also suggests that increases in Medicaid and CHIP premiums may have larger effects on coverage for children of color and among children whose families have lower levels of educational attainment.[75] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-75),[76] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-76),[77] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-77)

**Research finds varying implications of premiums for individuals with significant health needs.** Overall, individuals with greater health needs are less likely to disenroll from Medicaid or CHIP coverage and are more likely to have longer periods of Medicaid or CHIP coverage compared to those with fewer health needs.[78] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-78),[79] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-79),[80] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-80),[81] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-81) However, findings vary regarding how individuals with health needs respond to premium increases. Some studies show that individuals with greater health needs are less sensitive to premium increases compared to those with fewer health needs, reflecting their increased need for services.[82] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-82),[83] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-83) These findings suggest that individuals with greater health needs are more likely than those with less significant health needs to remain enrolled following premium increases, but then face increased financial burdens to maintain their coverage. Other studies find that children with increased health needs are as likely or more likely than those with fewer health needs to disenroll from coverage following premium increases, suggesting premiums may lead to children going without coverage despite ongoing health needs.[84] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-84),[85] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-85)

## Effects of Cost Sharing (Table 2 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-2/))

**A wide range of studies find that even relatively small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services.** The RAND health insurance experiment (HIE), conducted in the 1970s and still considered the seminal study on the effects of cost sharing on individual behavior, shows a reduction in use of services after cost sharing increased, regardless of income.[86] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-86) Since then, a growing body of research has found that cost sharing is associated with reduced utilization of services,[87] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-87) including vaccinations,[88] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-88) prescription drugs,[89] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-89),[90] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-90),[91] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-91),[92] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-92) mental health visits,[93] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-93) preventive and primary care,[94] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-94),[95] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-95),[96] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-96),[97] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-97),[98] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-98) and inpatient and outpatient care,[99] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-99),[100] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-100) and decreased adherence to medications.[101] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-101),[102] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-102),[103] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-103) In many of these studies, copayment increases as small as $1-$5 can effect use of care. Some studies find that lower-income individuals are more likely to reduce their use of services, including essential services, than higher-income individuals.[104] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-104),[105] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-105) Research also suggests that copayments can result in unintended consequences, such as increased use of other costlier services like the emergency room.[106] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-106) Two studies have found that copayments do not negatively affect utilization.[107] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-107),[108] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-108) In one case, the authors suggest that increases in provider reimbursement may have negated effects of the copayment increases, particularly if not all copayments were being collected by providers at the point of care.[109] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-109)

**Research points to varying effects of cost sharing for people with significant health needs.** Some studies find that utilization among individuals with chronic conditions or significant health needs is less sensitive to copayments compared to those with fewer health needs. As such, these individuals face increased cost burdens associated with accessing care because of copayment increases.[110] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-110),[111] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-111) Other research finds that even relatively small copayments can reduce utilization among individuals with significant health needs.[112] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-112),[113] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-113),[114] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-114)

**Numerous studies find that cost sharing has negative effects on individuals' ability to access needed care and health outcomes and increases financial burdens for families.**[115] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-115),[116] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-116),[117] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-117),[118] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-118),[119] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-119),[120] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-120),[121] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-121),[122] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-122) For example, studies have found that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia[123] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-123) and reduced treatment for children with asthma.[124] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-124) Increases in cost sharing also increase financial burdens for families, causing some to cut back on necessities or borrow money to pay for care. In particular, small copayments can add up quickly when an individual needs ongoing care or multiple medications.[125] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-125),[126] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-126)

**Findings on how cost sharing affects non-emergent use of the emergency room are limited.** One study found that these copayments reduce non-urgent visits.[127] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-127) Other studies find that these copayments do not affect use of the emergency room.[128] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-128),[129] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-129)

## Effects on State Budgets and Providers (Table 3 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-3/))

**Research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited.** Studies find that potential increases in revenue from premium and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured individuals; and administrative expenses.[130] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-130),[131] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-131),[132] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-132),[133] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-133),[134] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-134),[135] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-135),[136] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-136) One state study found increased revenues from premiums without significant effects on enrollment, but authors note a range of program-specific factors that may have contributed to this finding, including it being limited to a Medicaid-buy in program for individuals with disabilities with incomes above 150% FPL who may be less price-sensitive to the increase and the state implementing administrative processes designed to minimize disenrollment.[137] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-137)

**Studies also show that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety net providers, such as community health centers and hospitals.** Several studies show that coverage losses following premium increases lead to increases in the share of uninsured patients seen by providers[138] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-138),[139] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-139),[140] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-140) and increased emergency department use by uninsured individuals.[141] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-141),[142] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-142) One study also found that increases in copayments led to community health centers having to divert resources for medications for uninsured individuals to help people who could not afford copayments and that copayments increased the rate of "no shows" for appointments at community health centers.[143] (https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/footnotes/#footnote-220856-143)

## Conclusion

Recently, there has been increased interest at the federal and state levels to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. This review of a wide body of research provides insight into the potential effects of increasing premiums and cost sharing for Medicaid enrollees. It shows that premiums serve as a barrier to obtaining and maintaining coverage for low-income individuals, particularly those with the most limited incomes, and that even relatively small levels of cost sharing reduce utilization of services. As such, increases in premiums and cost sharing result in increased barriers to coverage and care, greater unmet health needs, and increased financial burdens for families. Further, the research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited and that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety-net providers.

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STUDY TABLES (HTTPS://WWW.KFF.ORG/REPORT-SECTION/THE-EFFECTS-OF-PREMIUMS-AND-COST-SHARING-ON-LOW-INCOME-POPULATIONS-UPDATED-REVIEW-OF-RESEARCH-FINDINGS-STUDY-TABLES/) ›

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DEPARTMENT OF
HUMAN SERVICES

# Building Racial Equity into the Walls of Minnesota Medicaid

## A focus on U.S.-born Black Minnesotans

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All photos are stock photos

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## Contents

# Executive summary

> “Of all the forms of inequality, injustice in health is the most shocking and the most inhuman.”
>
> *– Dr. Martin Luther King, Jr.*

Racial health disparities result from centuries of policies that have structured opportunity along the lines of race in Minnesota. While several communities in the state have and continue to experience structural disadvantage, this report focuses primarily on U.S.-born Black Minnesotans. Black/African Americans account for 13% of Minnesota Medicaid enrollees vs. 7% of the general population. However, data shows that Medicaid has an even more significant impact on access to care for Black Minnesotans. Analysis of 2019 data by the University of Minnesota’s State Health Access Data Assistance Center showed that approximately 44% of African American Minnesotans under the age of 65 rely on Medicaid for health care coverage. Medicaid coverage for African American Minnesotans is higher outside the seven-county metro area, and 64% of Black Minnesotan children receive access to health care through Medicaid.

In Minnesota, Black communities have been the target, either directly or indirectly, of many policies that structure what are now widely known to be the social determinants of health, referenced in this report as social drivers of health. University of Minnesota economist Dr. Samuel Myers coined the term “Minnesota paradox” to describe how Minnesota can have one of the highest qualities of life for white Minnesotans, while “African Americans are worse off in Minnesota than they are in virtually every other state in the nation” (Myers, 2020). These ongoing disparities reveal a system not broken but accomplishing what it was designed to do. Medicaid is a key component of that system in Minnesota.

## A community-informed, iteratively developed report

This report aims to continue the evolution of how policy within the Minnesota Department of Human Services (DHS) is designed, proposed and considered by intentionally striving for community co-creation. Given the distinct current and historical contexts that have contributed to the health of Black communities in the United States, and in order to focus on specific community strengths and the opportunities to build racial equity from their perspective, this report focuses on U.S.-born Black communities. At the outset of drafting this report, staff met with individuals from the U.S.-born Black community, leaders of organizations that are a part of the community and those working to advance racial equity in health care for Black Minnesotans.

The report's team then aligned the input received from those initial meetings with community collaborators with policy areas within DHS. The team then met with specific DHS divisions involved in the creation and stewardship of those policy areas. Those conversations informed draft "Calls to Action" shared during two public Community Conversations. The team sought further guidance from community members through facilitated discussion at those sessions, and the reflections and recommendations from all of these conversations have been incorporated into this report.

## What levers Medicaid has to address racial equity for U.S.-born Black Minnesotans

**Eligibility and enrollment**

- **Who is eligible for Medicaid? What is the process for enrollment? For re-enrollment? How does someone get and keep their Medicaid insurance in the first place?**

**Access**

- **Once someone has Medicaid, can they access the care they need? Do they have access to primary care? Dental or behavioral health services? Do they have access to culturally relevant care or care from a provider who shares their cultural background? Do they have transportation or interpreter services?**

**Quality**

- **If they have access to care, are they getting quality care? Do the metrics Medicaid uses to determine quality care meet the community's definition of quality care?**

**Early opportunities**

- **Medicaid disproportionately covers pregnant people and children. Knowing the long term impact of the first years of a child's life, how can Medicaid ensure health and racial equity from the very start?**

When looking at how Medicaid can build racial equity for U.S.-born Black Minnesotans into its policies, the report team decided to approach the work by considering four key "levers" of Medicaid policy development: Eligibility/enrollment, access, quality and early opportunities.

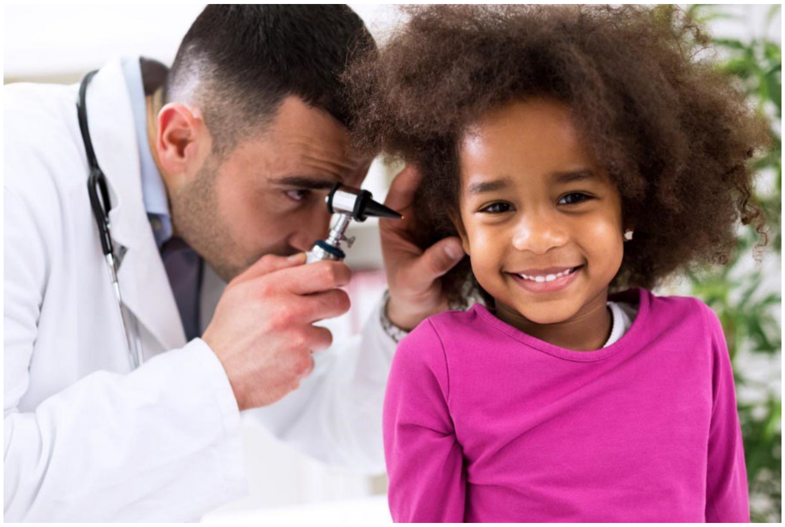
## What Medicaid can do now to continue to address racial equity for U.S.-born Black Minnesotans?

This iterative process resulted in **Calls to Action** for three Medicaid policies and programs that were most commonly cited by the U.S.-born Black Minnesotan community members the report team engaged with: Enrollment and renewal, access to culturally relevant care and, community engagement and co-creation. Importantly, since Medicaid services cannot currently be granted solely on the basis of an individual's racial background, none of the Calls to Action seek to create

Medicaid-funded services that are racially exclusive. Instead, there is recognition of the long overdue need to ensure policies, programs and the administration of each are done with awareness and action toward racial equity. With that frame as a guide, focusing the agency's efforts on changes available to all and the communication of these changes to communities most impacted by structural racism, can notably improve health and opportunity for U.S.-born Black Medicaid enrollees.

## Call to Action: Simplify and support enrollment and renewal

### *1. Pursue continuous eligibility policies*



Continuous eligibility allows Medicaid enrollees to maintain their enrollment regardless of changes in circumstances for up to 12 months at a time. The Social Security Act currently gives states the option to provide continuous eligibility to children under age 19 for a period of up to 12 months. **DHS should pursue the state plan option under the Social Security Act to provide continuous eligibility to children.** Given what is known about the importance of the first five years on early brain development, consistent access to health care, screenings and services is critical. The state also now has experience with decreasing enrollment churn during the past nearly two years of the COVID-19 pandemic. **DHS should therefore explore an 1115 Medicaid Demonstration Waiver to implement 72 months of continuous eligibility for children on Medicaid up to age 6 as well as establish 24-month continuous eligibility for all enrollees age 6 and older.**

### *2. Support navigators and simplify the enrollment and renewal process*

Given the complexity of enrolling and renewing one's application, the fact that many people in poverty lack a home computer with internet access and that navigators live in communities, increasing the availability and utilization of navigators remains an important option to help people to apply. **DHS should work with navigators and the U.S.-born Black community to develop a plan focused on**

**ensuring eligible Black Minnesotans gain and maintain Medicaid coverage throughout the year and in preparation for transitioning out of the federal public health emergency.**

## Call to Action: Increase investment in culturally relevant care for U.S.-born Black Minnesotans on Medicaid

### *1. Invest in an internal structure that has a specific focus on U.S.-born Black Minnesotans*

Addressing generations of structural inequity will require sustained intention. A dedicated internal structure could provide a direct connection to U.S.-born Black Medicaid enrollees, community-based organizations and other institutions to inform and co-create policy and programs that elevate strengths and address inequities. A division focused on Black Medicaid enrollee health could also ensure that efforts throughout DHS and other state agencies (e.g., the Minnesota Department of Health) leverage all available funding sources to close the gaps seen in health outcomes.

### *2. Continue to prioritize and align standardization and disaggregation of race, ethnicity and language data*

While an incomplete and imperfect proxy for culture, race, ethnicity and language data can serve as an important initial signal and help guide and inform conversation and collaboration with communities. One Community Conversation participant noted that there is a need to “proactively identify data — there’s not enough data, and the way we collect data is not moving at the same speed as how diversity is increasing.” Standardized and disaggregated race, ethnicity and language data will be important for identifying communities as well as holding accountable DHS, managed care organizations, counties, clinicians and others who serve Medicaid enrollees.

## Call to Action: Fund community conversations with U.S.-born Black Minnesotans on Medicaid

Community members noted that the COVID-19 pandemic has clearly demonstrated the impact of a fractured trust between state agencies and the U.S.-born Black community. A repair of this trust requires relationships be built over years and gives community the opportunity to “start a journey of trusting larger agencies that provide resources and services.” Therefore, **DHS should integrate not just community engagement in general but longitudinal, culturally specific engagement of enrollees and their families into its routine policy, budget and administrative activities.** Seeing community as true partners and co-creators at all times, not just during a pandemic or to address a specific, research-identified gap, will go a long way to repairing the trust that has been broken.

## Capturing the moment for change

While this report prioritizes some specific Medicaid policy solutions, there were other notable observations from our conversations. First, there is a clear sense of urgency from community and DHS staff alike. Second, DHS divisions seemed empowered by their ability to effect intrinsic change. Success feels within reach. There was widespread agreement that DHS could be doing much more around racial health disparities, and there were many ideas to bring forward to community for further conversation around solutions. A final and critical theme identified in these conversations is the shared concern that, as in the past, DHS' current focus on health disparities is again just another flash in the pan. Yet, despite the weariness, both the community and DHS staff shared a willingness to try again.

The Calls to Action detailed and justified in this report therefore not only serve as a guide to prioritize actions to improve racial equity for U.S.-born Black Minnesotans on Medicaid but also overlap with the needs of other historically under-resourced communities. The iterative process established in developing this report, its policy recommendations and the subsequent accountability for action set the expectation for other work within DHS. Next steps must include reports on building racial and health equity into Medicaid for Native and Indigenous Minnesotans, Hispanic/Latino Minnesotans, Asian-Pacific Islander Minnesotans, immigrants/new Minnesotans, Minnesotans who are LGBTQ+, Minnesotans living with disabilities, unhoused Minnesotans and incarcerated Minnesotans.

# I. Introduction

*“There has never been any period in American history where the health of blacks was equal to that of whites. Disparity is built into the system” (Evelynn Hammonds)*

Harvard science historian Evelynn Hammonds’ reflection on who our health care systems have (Interlandi, 2019) and have not, been designed to serve has become inescapable in the wake of COVID-19. A novel viral respiratory illness that spreads quickly by symptomatic and asymptomatic individuals, COVID-19 has been indiscriminate in its transmission. However, as noted in the early weeks of the pandemic by social and public health epidemiologists and clinicians with extensive experience in health inequity, COVID-19’s “propagation within a society steeped in structural racism will undoubtedly … lead to disproportionate impacts among marginalized racial groups in this country” (Bailey et al., 2020).

Before and throughout the pandemic, Black and Latino Minnesotans have worked in industries identified as “essential services or businesses” at disproportionate rates. They earn lower wages, have less access to adequate health care and experience higher exposure to COVID-19 since they are unable to work from home. MDH data has consistently revealed that Black, Indigenous and Latino Minnesotans have had the highest age-adjusted rates of COVID-19 cases, hospitalizations, intensive care unit (ICU) admissions and deaths (MN Gov, 2021)

**Racial disparities in Minnesota**

- The state of Minnesota as a whole has the second biggest income inequality gap between Black and white people in the entire nation. Compared to white Minnesotans, Asian people earn 94 cents on the dollar, Black people earn 71 cents, Latino people earn 70 cents and Indigenous people earn 68 cents (Minnesota House of Representatives, 2020).
- Minnesota has one of the widest homeownership gaps in the nation. While 77 percent of white households own their home, 57 percent of Asian, 46 percent of Native American, 45 percent of Latino and just 24 percent of Black households own their home (Minnesota House of Representatives, 2020).
- In Minnesota, Indigenous students are ten times more likely to be expelled or suspended than their white peers. Black students are eight times more likely to be expelled or suspended than their white peers (Minnesota House of Representatives, 2020).
- Black and Latino Minnesotans have reported food insecurity at more than double the rate of white Minnesotans (Wilder Foundation, 2020).
- Black Minnesotans have been disproportionately affected by a loss of employment during the COVID-19 pandemic (MN Gov, 2021)
- Black, Indigenous and Latino Minnesotans have lower COVID-19 vaccination rates statewide (Minnesota Department of Health, 2021a) and among age-eligible Minnesota Medicaid enrollees (Infogram, 2021)
- Total mortality increased in 2020 by 14 percent for non-Hispanic White Minnesotans and 41 percent for BIPOC (Black, Indigenous, and people of color) Minnesotans (Wrigley-Field et al., 2021).

These disparities result from centuries of policies that have structured opportunity along the lines of race in Minnesota. While several communities in the state have and continue to experience structural disadvantage, this report will focus primarily on U.S.-born Black Minnesotans. As noted in DHS' 2020 report on deep poverty (DHS, 2020), "historical atrocities, such as slavery and the Jim Crow era in the case of African-Americans, have huge effects on families through the formation of identity, values, attitudes, beliefs, and parenting practices developed over generations (Lichtman, 1984; Evans-Campbell, 2008) as well as clinically observable intergenerational health effects in current generations (Yehuda & Lehrner, 2018)." The historical and ongoing trauma experienced by U.S.-born Black Minnesotans, and its resultant impact on health and on the relationship and trust between the community and the state, is distinct from other communities in Minnesota who also identify as Black and from other historically oppressed communities, such as Native Americans.

In Minnesota, Black communities have been the target, either directly or indirectly, of many policies that structure what are now widely known to be the social determinants of health, referenced in this report as social drivers of health. Examples include:

- What is your level of education?
- Are you housed? Do you have access to a car?
- How easy is it for you to get fresh fruits and vegetables?
- Are members of your community disproportionately incarcerated?
- Do you have ample opportunity for employment with a livable wage?
- Do you experience the stress of institutionalized racism and unconscious bias?
- Do you live in a safe community, far from industrial sources of pollution and high crime rates?

Though it has not always been intuitive, answers to these questions influence people's health — as much or more than access to a doctor's office or hospital. The consistent denial to the same opportunities for housing (Horowitz et al., 2021), education (Grunewald & Nath, 2019), nutrition (Wilder Foundation, 2020), healthy neighborhoods (Reconnect Rondo, 2020) and justice under the law (Beckett & Ajasa, 2021) makes the resultant health disparities experienced by Black Minnesotans less surprising. University of Minnesota economist Dr. Samuel Myers coined the term "Minnesota paradox" to describe how Minnesota can have one of the highest qualities of life for white Minnesotans, while "African Americans are worse off in Minnesota than they are in virtually every other state in the nation" (Myers, 2020). These ongoing disparities reveal a system not broken, but accomplishing what it was designed to do. As noted in the 2020 Minnesota House Select Committee on Racial Justice Report to the Legislature, "Understanding that racially discriminatory public policy decisions shaped these disparities, the Legislature will need to consider and implement racially conscious policy changes to overcome these disparities" (Minnesota House of Representatives, 2020). Medicaid in Minnesota is an important program to begin ensuring racial equity.

Medicaid and related programs like Minnesota Care provide essential health care to people across Minnesota. Roughly 1.3 million people were enrolled in 2021. Medicaid serves more than half a million children each year, covering almost one- third of all Minnesota children before the COVID-19 pandemic. Geographically, the percent of Minnesotans served by Medicaid in Greater Minnesota is the same or slightly higher than those served in the Twin Cities metro area (Fig 1).

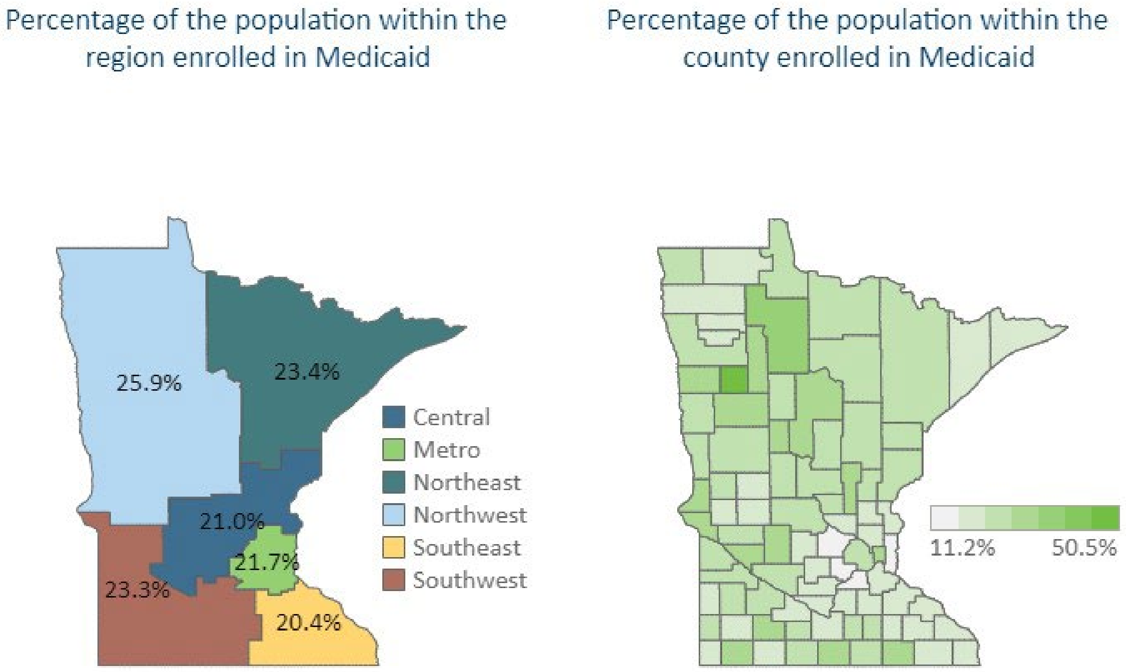


Fig 1. Percent of Minnesotans served by Medicaid based on geography, 2021

Enrollment data source: Minnesota Department of Human Services, December 2021. Population data source: U.S. Census Bureau, 2020. 2021 population estimates are not available yet. The denominator for the 2021 percentage enrolled by region and county is the 2020 population estimate.

These numbers are even more significant when examining the racial demographics of Minnesota's Medicaid program. Only about 73% of enrollees currently report their race and ethnicity upon enrollment in Minnesota's public health care programs, however racial demographic data provided to other public programs gives insight into around 93% of enrollees' identified race/ethnicity. From this, the data shows a disproportionate representation in Minnesota's Medicaid program among Black/African American people when compared to the general Minnesota population. Black/African American Minnesotans account for 18% of Medicaid enrollees vs. 7% of the general population (Fig 2).

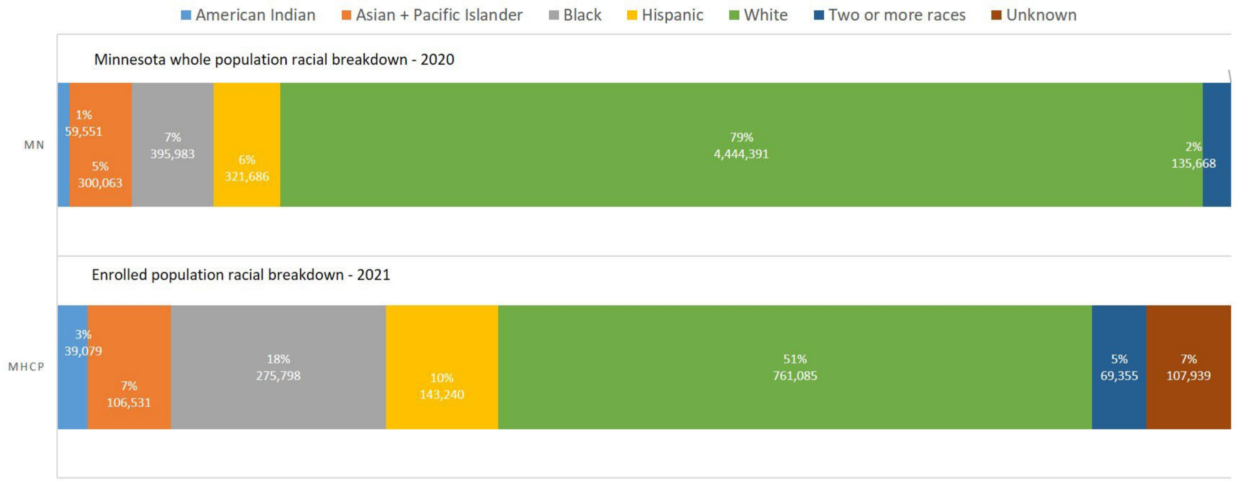


Fig 2. State of Minnesota demographics compared to Medicaid enrollee demographics, by race/ethnicity, 2021

*Enrollment data source: Minnesota Department of Human Services, December 2021. Population data source: U.S. Census Bureau, 2020.*

Data on how different racial/ethnic communities in Minnesota access care makes clear the significant impact Medicaid has on addressing racial health equity in the state. Data from a 2021 analysis of 2018-2019 data by the University of Minnesota's State Health Access Data Assistance Center (SHADAC) showed that approximately 41.5% of Black, 39% of Native American/Alaskan Native, 29.5% of Hispanic and 20.2% of Asian Minnesotans rely on Medicaid for health care coverage (Fig 3). Analysis of 2018-2019 data on Minnesotan children 0-18 years old who rely on Medicaid revealed that 64% of Black children, 59% of Native American/Alaskan Native children, 49% of Hispanic children, and 33% of Asian Minnesotan children rely on Medicaid, percentages that likely increased during the pandemic.

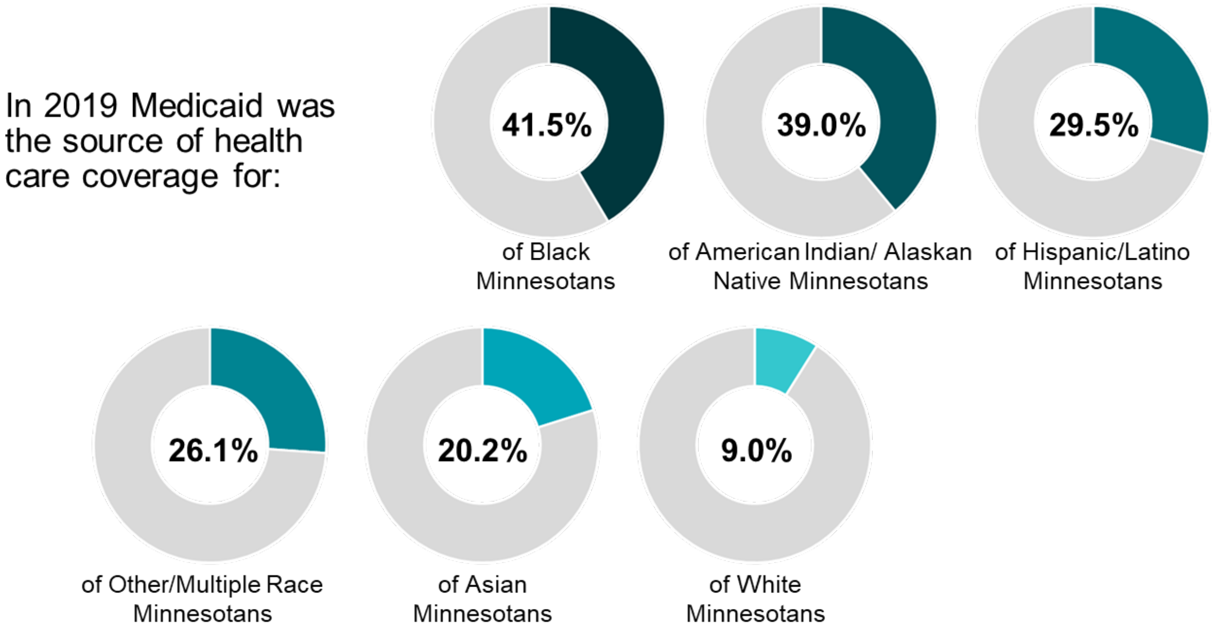
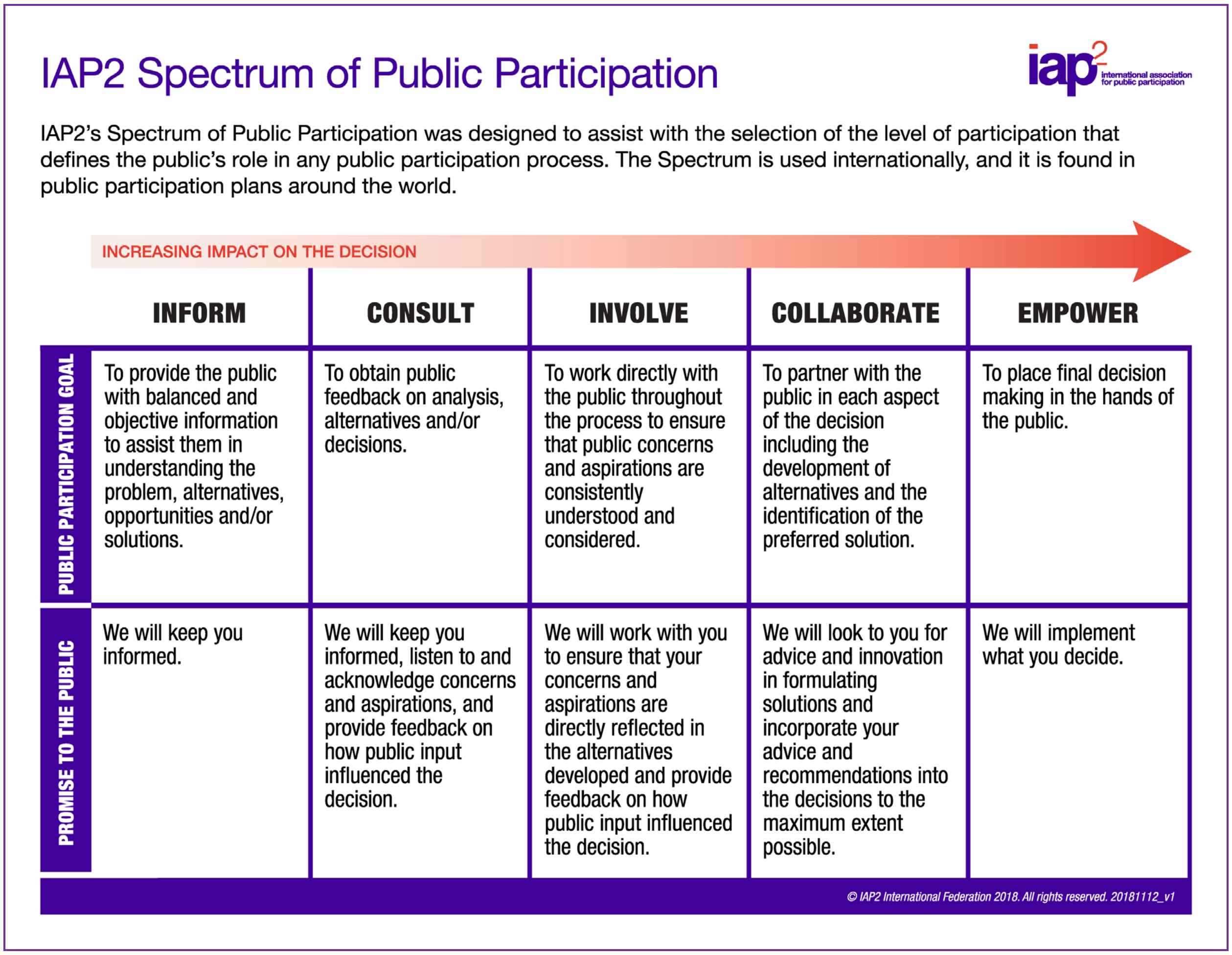


Fig 3. Percent of Minnesotans with Medicaid as source of coverage, by race, 2018-2019

*Source: SHADAC analysis of the 2018-2019 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files. Note: Data years 2018 and 2019 were combined to increase the sample size and improve the reliability of estimates among Minnesotans by race and ethnicity.*

COVID-19 exemplifies the need for the Department of Human Services to examine its policies and programs in the context of their historical, current and future health and racial equity impact. This examination cannot be performed in government's usual silos. Communities impacted the most by structural racism and inequity need to be engaged early and provided accountability, as Minnesota strives to dismantle systems of harm and build systems that support the health of all. This report aims to continue the evolution of how policy within DHS is designed, proposed and considered by intentionally striving for community co-creation at the level of "Involve" along the International Association for Public Participation's (IAP2) spectrum (Figure 4).



IAP2 Spectrum of Public Participation

IAP2's Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. The Spectrum is used internationally, and it is found in public participation plans around the world.

INCREASING IMPACT ON THE DECISION

| | INFORM | CONSULT | INVOLVE | COLLABORATE | EMPOWER |
|---|---|---|---|---|---|
| **PUBLIC PARTICIPATION GOAL** | To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions. | To obtain public feedback on analysis, alternatives and/or decisions. | To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered. | To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution. | To place final decision making in the hands of the public. |
| **PROMISE TO THE PUBLIC** | We will keep you informed. | We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision. | We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision. | We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible. | We will implement what you decide. |

Fig 4. Spectrum of Public Participation. (c) International Association for Public Participation www.iap2.org.

To meet the level of "Involve," at the outset of this report staff met with individuals from the U.S.-born Black community and leaders of organizations that are a part of the community or working to advance racial equity in health care for Black Minnesotans. During these initial meetings, staff outlined four levers within Medicaid policy that could be used to continue to build racial equity for U.S.-born Black Minnesotans: Eligibility/Enrollment, Access, Quality and Early Opportunities.

**Initial Community Contributors**

- MDH Health Equity and Advisory Leadership (HEAL) Council
- DHS Cultural and Ethnic Communities Leadership Council
- Council for Minnesotans of African Heritage
- Voices for Racial Justice
- African American Leadership Forum
- Cultural Wellness Center
- Center for Economic Inclusion
- Former Minnesota State Senator Jeff Hayden

**Community Conversation Participants**

- Minnesota Health Care Program (Medicaid) enrollees
- Health Care Providers
- Community Based Organizations
- County Public Health and Human Service staff
- Managed Care Organization staff
- University of Minnesota School of Public Health and Medical School faculty
- Minnesota DHS and other State agency staff

Staff then took the input received from those initial meetings to relevant policy areas within DHS. Staff met with specific DHS divisions involved in the creation and stewardship of those policy areas. Those conversations further informed the initial “Calls to Action” drafted for this report. DHS then held two public Community Conversations to share the initial draft “Calls to Action” and sought further guidance from community members through facilitated discussion. Reflections and comments from all of these conversations have been incorporated into this report. The final report will also be purposefully shared back with community members upon release.

The hope is that through the path and guidance this report lays out, health and state policies continue to move toward a standard where the work is more fully informed by the communities that make up the state and that are served. And that work leads to rebuilding of trust with communities whose trust has been violated over generations. Ultimately, the state must realize its potential to offer all Minnesotans the same level of opportunity for health.

# II. Why focus on racial equity

## DHS' Equity Policy

DHS has worked for years on improving equity within the agency and in the experience of Minnesotans who rely on its services. In 2017, DHS institutionalized the agency's Equity Policy. This policy emphasizes the agency's commitment to "advancing equity, reducing disparities in DHS program outcomes, and improving access to human services for all communities experiencing inequities." This policy models the Minnesota Department of Health's Health in All Policies (HiAP) approach, with the goal of having a human-centered design framework that considers achieving health beyond just the absence of disease, instead realizing a complete state of physical, mental and social wellbeing. Recognizing that Minnesota's structural inequities cut across sectors, DHS' HiAP approach requires solutions that both focus within DHS and also cut across agency and public-private sector boundaries to address the broad factors that make up the drivers of health (Healthy People 2020). This policy requires that communities experiencing inequities be consulted when programs are designed, implemented and evaluated. The DHS Equity Policy compels all DHS employees to include considerations for equity impacts on decisions specific to service delivery and workforce, program and project design and implementation, strategic planning, and legislative proposals, among other focus areas.

The State Medicaid Agency within DHS administers the Medicaid program and has worked to operationalize the DHS Equity Policy since its inception. Following the policy as a guiding principle, the Medicaid Agency institutionalized racial equity mechanisms and tools (Government Alliance on Race and Equity, 2022) to include an equity lens in all areas of work. The design has a process improvement lens, in which progressive development of trainings, beta testing and implementation of tools is done at a granular level. The Medicaid Agency's approach considered business needs and employee feedback, keeping the diverse needs and backgrounds of enrollees at the fore. The Medicaid agency's equity committee developed a comprehensive set of racial equity tools that have enhanced the effectiveness of Medicaid programs, policies, decisions and administrative procedures.

**Know the History**
Consider historical events that have negatively impacted Black, Indigenous, and Communities of Color. Acknowledge them and create space for communities to share as to not repeat the same mistakes.

**Develop the Proposal**
What is the policy, program, practice, or budget decision under consideration? What are the desired results and outcomes?

**Monitor Data**
What is the data? What does the data tell us? Are they disaggregated by race?

**Engage the community**
How have communities been engaged? Are there opportunities to expand engagement?

**Analysis and strategies**
Who will benefit from or be burdened (intent vs. impact) by your proposal? What are your strategies for advancing racial equity or mitigating unintended consequences?

**Implementation**
What is your plan for implementation?

**Accountability and Communication**
How will you ensure accountability, communicate, and evaluate results?

The Medicaid agency's equity tools and mechanisms support the DHS Equity Policy's goal of eliminating inequity. When incorporating an equity assessment analysis and best practices into program, policy and procedure decisions:

- How the equity tool is implemented and used will differ from program to program, department to department and county to county. Accountability for implementation and use within the Medicaid agency and to respective communities is essential.
- Approach equity analyses from a continuous improvement perspective, as opposed to a checklist. We will seek to strengthen programs, policies and procedures until health inequities are eliminated.
- That if the strategy, practice, policy or procedure works for the most disadvantaged communities, it works for everyone.

We have made strides in weaving equity considerations into everyone's work. While not yet where we aim to be, we are making progress on our commitment to equity. However, there is an awareness of the need to lead with a racial equity lens. This report therefore builds upon the work of so many others at DHS and in the communities we serve.

## Why focus specifically on U.S.-born Black Minnesotans

All racially minoritized communities in Minnesota experience health disparities in one or more chronic conditions, however, U.S.-born Black Minnesotans notably have among the worst outcomes (Breslin et al., 2021):

- Adults experience increased rates of diabetes, asthma, HIV, hypertension, cardiovascular disease, substance use disorder and post-traumatic stress disorder.
- Children experience increased rates of preterm birth, low birth weight/very low birth weights, asthma, obesity, anxiety, suicidal ideation, potentially preventable emergency department visits and preventable hospitalizations.

Fig 5. Structural racism’s connection to U.S.-born Black health disparities

U.S.-born Black people are predominately descended from individuals and communities subjected to chattel slavery, Jim Crow segregation and mass incarceration. These features of structural racism directly contribute to the racial health disparities seen today (Fig 5). This legacy of chattel slavery is distinct to U.S.-born Black people.

Much of the available data understate the problems faced by U.S.-born Black Minnesotans, because the data clump immigrant and U.S.-born people together. As noted in the Minnesota Department of Health's 2019 report on culturally responsive care, the data "mask disparities impacting U.S.-born Blacks. This is in some part due to a healthy immigrant effect – a well-known phenomenon where immigrants are on average healthier than those who were born in the United States. The disparities are also attributable to structural racism and historical trauma that have negatively impacted outcomes across generations. We see these disparities between U.S. and foreign-born Black populations in Minnesota across education and health outcomes, such as: Minnesota Comprehensive Assessment test scores, high school graduation rates, infant mortality, and birth outcomes." (Minnesota Department of Health, 2019a)

Table 1 shows the notable health disparities between U.S.-born Black/African-American people enrolled in Medicaid programs compared with those who immigrated to the United States. Although the average age of enrollees in the two groups was the same, U.S.-born Black/African-American people had higher rates in every adverse outcome than those who immigrated to the United States. Between these groups, rates of asthma, heart failure/hospitalized heart conditions and depression were three times higher for U.S.-born Black/African-American people. And overall, U.S.-born Black/African-American people had the highest prevalence of asthma, hypertension, and heart failure/hospitalized heart problems of any group, and the second or third highest rates of many other medical or behavioral health conditions.

Changes in immigration law and the opportunities that came with it resulted in notable differences in how different communities who identify as Black interact with government institutions in the United States (Anderson, 2015). There are also differences in how other communities of color, refugees and other immigrant populations interact with government and medical institutions. Given the distinct current and historical contexts that have contributed to the health of Black communities in the United States, and in order to focus on specific community strengths and the opportunities to build racial equity from their perspective, this report focuses on U.S.-born Black communities. This decision was not uniformly embraced by members of the Black community in Minnesota. During Community Conversations, several participants questioned this approach, citing that the data around a healthy immigrant effect was incomplete and therefore inconclusive, making exclusion of Black immigrant and refugee populations unnecessary. Other participants felt strongly that disaggregation was important given what is known about U.S.-born Black persons' health. One overarching intent is that this approach will lay the groundwork for similar, iterative work with other communities in Minnesota, including Black immigrants and refugees, who also face structural barriers to realizing health and racial equity. It is also important to note that neither the Black immigrant nor U.S.-born communities are monolithic. The experiences of Black Minnesotans can and do vary by their geography, income, sexual orientation and gender identity and the other communities and beliefs they identify with. However the impact of structural racism is felt by all to some degree and this is what guides the focus of this report.

**Throughout the rest of this report, the term "community" will refer to the U.S.-born Black community in Minnesota.** To maintain accuracy, however, the report will at times use African American or Black when referencing statutes, regulations, research or other data sources that use those terms to define individuals who identify as Black from the U.S.-born community.

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|  | Enrollees who were born in the U.S. |  |  |  |  |  | Enrollees who immigrated to the U.S. |  |  |  |  |  |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mortality and Morbidity** | American Indians* | African Americans | Whites | Hispanics | Asians | Others/ Unknown | African Americans | Whites | Hispanics | Asians | Other/ Unknown | All MA Enrollees |
| Mortality over 2.5 years | 1.35 | 0.8 | 0.95 | 0.51 | 0.28 | 0.49 | 0.21 | 0.37 | 0.31 | 0.58 | 0.09 | 0.78 |
| Type 2 Diabetes | 12.37 | 8.28 | 6.19 | 7.6 | 4.9 | 5.32 | 7.66 | 7.54 | 10.88 | 9.71 | 6.52 | 6.95 |
| Asthma | 12.48 | 16.47 | 9.56 | 9.97 | 4.55 | 7.53 | 4.82 | 4.61 | 3.79 | 4.02 | 2.86 | 9.4 |
| HIV/Hep-C | 4.52 | 2.67 | 1.48 | 1.66 | 0.36 | 0.9 | 1.09 | 0.8 | 0.72 | 1.02 | 0.96 | 1.6 |
| Hypertension | 7.69 | 9.6 | 3.93 | 5.55 | 3 | 3.61 | 8.03 | 5.34 | 6.74 | 4.5 | 5.07 | 5.14 |
| Heart failure, hospitalized heart conditions | 2.05 | 1.96 | 1.46 | 0.65 | 0.57 | 1.08 | 0.64 | 0.96 | 0.79 | 1.27 | 0.59 | 1.37 |
| COPD | 11.91 | 8.4 | 10.17 | 6.72 | 2.98 | 6.33 | 5.1 | 5.65 | 3.92 | 4.46 | 2.74 | 8.53 |
| Lung, Laryngeal Cancer | 0.25 | 0.2 | 0.27 | 0.07 | 0.07 | 0.17 | 0.1 | 0.19 | 0.05 | 0.18 | 0.1 | 0.22 |
| **Behavioral Health** |  |  |  |  |  |  |  |  |  |  |  |  |
| Substance Use Disorder | 35.37 | 20.09 | 15.64 | 14.12 | 4.33 | 12.34 | 2.56 | 3.75 | 3.97 | 2.78 | 2.37 | 14.42 |
| PTSD | 10.54 | 8.64 | 5.62 | 6.06 | 2.41 | 3.58 | 6.31 | 6.76 | 3.09 | 6.05 | 2.51 | 5.9 |
| Depression | 30.27 | 20.58 | 22.4 | 19.23 | 7.53 | 15.33 | 6.78 | 12.36 | 10.32 | 9.65 | 5.39 | 19.22 |
| SPMI | 7.36 | 7.09 | 6.19 | 4.77 | 2.94 | 3.68 | 2.73 | 4.47 | 1.59 | 5.48 | 1.38 | 5.55 |

Table 1. Prevalence of mortality and chronic conditions, by race/ethnicity and immigration status in Minnesota Medicaid enrollees, 2014. *All American Indians were included in this column. *Dark grey shading indicates the worst outcomes and light grey shading indicates the next worst. The values in the table are simple prevalence rates among all Medicaid enrollees, without any adjustments for other factors. For example, 6.95% of all Medicaid enrollees (in the far right column) had a diagnosis of type 2 diabetes.*

# III. Levers within Medicaid to address racial equity for U.S.-born Black Minnesotans

In his book, "How to be an Antiracist," Dr. Ibram Kendi defines an antiracist policy as "any measure that produces or sustains racial equity between racial groups." When looking at how Medicaid policies can build racial equity for U.S.-born Black Minnesotans, DHS approached the work by considering four key "levers" of Medicaid policy development: eligibility/enrollment, access, quality and early opportunities.

These levers capture multiple decision points where racial equity can be embedded: Who is eligible for Medicaid? How do they enroll and re-enroll? Are they able to access the care they need? Does that care meet the community's definition of quality? What role does Medicaid play in providing health equity from the very start in our community?

## Eligibility and enrollment

Federal and state Medicaid policies, county-worker capacity, availability of a navigator, the complexity of information technology (IT) systems, and many other variables influence who is eligible for Medicaid and how easy or difficult it is to enroll and stay enrolled. In addition, the personal resources of the applicant can also make it easier or harder to enroll. These factors include their language and reading proficiency, technological expertise, understanding of health insurance and financial terminology, home address stability, and knowledge of their familial and social support networks. Most Medicaid enrollees must renew and prove their eligibility at least once a year. An individual's eligibility is based on factors such as household income and assets, family size, age, disability status, and citizenship or immigration status. These criteria are set by federal and state law and vary by eligibility category. In Minnesota, income eligibility ranges from 100% to 283% of the federal poverty level (FPL) depending on other factors (Fig 6).

Despite being eligible for Medicaid, many people who would benefit from Medicaid coverage aren't enrolled at all or experience gaps in their coverage. Forty-nine percent of uninsured individuals in Minnesota were estimated to be eligible for public health insurance programs like Medicaid in 2019 (Minnesota Department of Health, 2021b). Nearly one in four Medicaid enrollees nationally have had to change coverage within one year, and a majority experienced a gap in coverage (Sommers et al., 2016). This has been attributed to how frequently states require Medicaid enrollees to renew enrollment or re-verify their eligibility, the amount of time states provide enrollees to respond and the income fluctuation among populations covered by Medicaid. One survey found that the experience of income volatility differed by the race/ethnicity of communities, with 38% of Black households, 45% Hispanic households and 32% of white households reporting some income volatility (Sugar et al., 2021). Another study noted that Black Medicaid enrollees were more likely than white enrollees to go off Medicaid for more than six months. Those who were off more than six months were less likely than those who stayed on to have a regular source of care, more likely to forego health care for financial reasons and more likely to report problems paying medical bills (Goold et al., 2020).

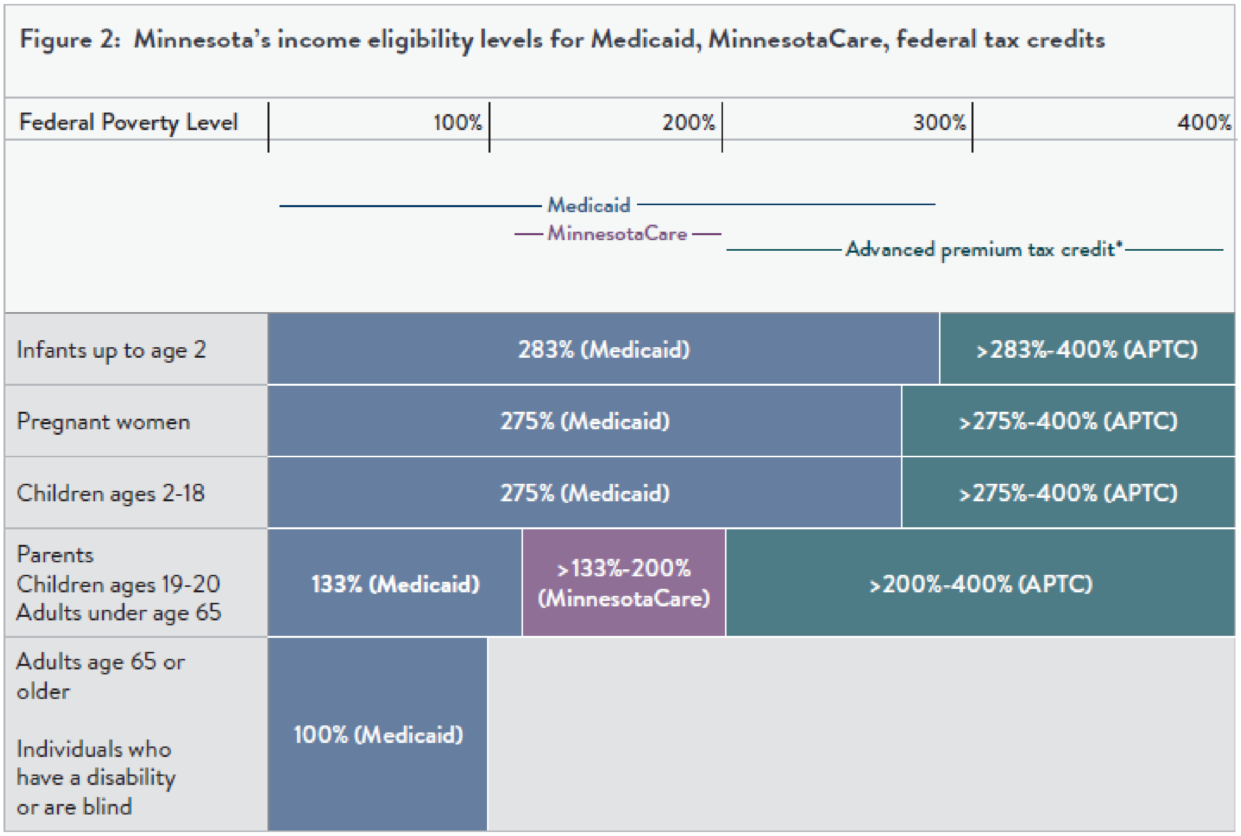

Figure 2: Minnesota's income eligibility levels for Medicaid, MinnesotaCare, federal tax credits

| | | | |
|---|---|---|---|
| Infants up to age 2 | 283% (Medicaid) | >283%-400% (APTC) | |
| Pregnant women | 275% (Medicaid) | >275%-400% (APTC) | |
| Children ages 2-18 | 275% (Medicaid) | >275%-400% (APTC) | |
| Parents<br>Children ages 19-20<br>Adults under age 65 | 133% (Medicaid) | >133%-200% (MinnesotaCare) | >200%-400% (APTC) |
| Adults age 65 or older<br>Individuals who have a disability or are blind | 100% (Medicaid) | | |

Does not reflect MinnesotaCare coverage from 0 to 200 percent of the federal poverty guidelines for lawfully present noncitizens who are ineligible for Medicaid.

* Advanced premium tax credits reduce the cost of premiums for coverage purchased through MNsure and were made available under the Affordable Care Act.

Fig 6. Minnesota's income eligibility levels for Medicaid, MinnesotaCare, federal tax credits * for 2021 and 2022, premium tax credits also apply to people above 400% FPG.

## Access

Access refers to enrollees' ability to access care: Is there a primary care provider within a reasonable distance from home? Do they have access to culturally relevant care that is delivered with humility? Do they have reasonable access to specialists, behavioral health care or dentistry? There is ample evidence that access is a significant barrier for Medicaid enrollees. The Medicaid and CHIP Payment and Access Commission (MACPAC) analysis of national household survey data has shown that "adults with Medicaid are more likely to report delayed medical care because of concerns about out-of-pocket costs, difficulty obtaining appointments, or because they do not have transportation" (MACPAC, 2021). Access to specific care like mental health providers can be especially inequitable. A 2014 JAMA study found that only 43% of psychiatrists accept Medicaid (Bishop et al., 2014). Barriers to care have been demonstrated among Minnesotans on Medicaid with a 2017 analysis of survey data showing that 55% reported some access barriers (Allen et al., 2017).

Access is a key lever to building racial equity within Medicaid. Black community members experience additional disparities in accessing care. The 2018 AHRQ National Healthcare Quality & Disparities Report noted that “12.3% of Black adults who had a doctor’s office or clinic visit in the last 12 months and needed care, tests, or treatment sometimes or never found it easy to get the care, tests, or treatment compared with 6.8% of white adults” (U.S. Department of Health and Human Services, 2019). And while Minnesota DHS’ 2021 Medicaid consumer satisfaction survey (Minnesota Department of Human Services, 2021a, c) found no difference in how Black respondents “felt judged or treated with disrespect by a health professional because of their race,” they were statistically significantly more likely to be “told they showed up too late to an appointment to still be seen,” a question Minnesota DHS added in 2021 as a proxy for missed opportunities for care. A 2017 analysis of Minnesotans on Medicaid found that 21% of enrollees who identified as U.S-born Black reported having foregone care in the past year, the highest percentage of any racial/ethnicity group surveyed. And Minneapolis and St. Paul both scored among the most segregated cities in the United States in 2019, according to the Othering & Belonging Institute at the University of California, Berkeley’s *The Roots of Structural Racism Project* (University of California, Berkeley). This geographic segregation contributes to the barriers in access Black Minnesotans experience. For example, a JAMA study (Goedel et al., 2020) examining access to medication for opioid use disorder found that “counties with highly segregated African American and Hispanic/Latino communities had more facilities to provide methadone per capita, while counties with highly segregated white communities had more facilities to provide buprenorphine per capita.” In Minnesota, buprenorphine is available in many primary care offices throughout the state while methadone at only 12 opioid treatment programs, highlighting the role geography and place play.

As the single largest payer for health care services in the state, Minnesota Medicaid has a critical role in driving increased racial equity in health care access, particularly in areas of care where Medicaid’s footprint is largest, such as pediatric, obstetric and mental health services, and long-term services and supports. Given that nearly 80% of Medicaid enrollees are served by a managed care organization, it is also important that Medicaid work with, measure and incentivize managed care organizations’ efforts to improve racial equity in access to care.

## Quality

Once an enrollee successfully gets access to care, do they receive care at the same level of quality as other Medicaid members or other Minnesotans? Are the measures used to define “quality” consistent with what the community would define as “quality” care? It has been noted for more than a decade that enrollees in Medicaid managed care have significantly lower rates in common health care quality measures across the board compared to other payers (Minnesota Community Measurement, 2021a). Among Medicaid enrollees, Black/African-American members consistently experience even lower rates on a majority of measures than other groups of enrollees (Table 2). Minnesota Community Measurement’s 2020 report on Health Care Disparities by Race, Hispanic Ethnicity, Language and Country of Origin states that “Black patients whose preferred language is English have significantly lower rates of optimal diabetes care, optimal vascular care, and depression remission at six months compared to Black patients whose primary language is not English” (Minnesota Community Measurement, 2021b). This speaks to additional barriers U.S.-born Black Minnesotans may face receiving the same level of quality care in Minnesota. It also highlights the need for further disaggregation of race and ethnicity data used to measure quality and other metrics within the Medicaid program. Currently, Medicaid has racial demographic data for 93% of enrollees. To truly understand inequities in the quality of care received by Medicaid enrollees will require their trust in sharing their race and ethnicity data. Part of building that trust is having communities define what “quality care” actually entails.

| **MEASURE** | 2020 MHCP MCO Race Average* | RACE | | | | | | | | | | 2020 MHCP MCO Ethnicity Average* | ETHNICITY | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Asian | Black | Indigenous/ Native | Multi Race | Native Hawaiian/ Other Pacific Islander | White | Chose Not to Disclose/ Declined | Patient Reported Race Unknown | Some Other Race | Unknown Race | | Hispanic/ Latinx | Not Hispanic/ Latinx | Ethnicity Not Reported |
| PREVENTIVE HEALTH MEASURES | | | | | | | | | | | | | | | |
| Breast Cancer Screening | 64.2% | ▲ | ▼ | ▼ | ● | ● | ● | - | - | - | ● | 63.3% | ▲ | ● | ▼ |
| Colorectal Cancer Screening | 59.7% | ▲ | ▼ | ▼ | ● | ● | ▲ | ▼ | ▼ | ● | - | 59.7% | ● | ● | ▼ |
| CHRONIC CONDITIONS MEASURES | | | | | | | | | | | | | | | |
| Optimal Diabetes Care | 35.6% | ▲ | ▼ | ▼ | ▼ | ● | ● | ● | ● | ▲ | - | 35.8% | ● | ● | ● |
| Optimal Vascular Care | 47.2% | ▲ | ● | ▼ | ● | NR | ● | ▲ | NR | ● | - | 47.5% | ▲ | ● | NR |
| Optimal Asthma Control - Adults | 45.2% | ▼ | ▼ | ▼ | ● | ● | ▲ | ● | ▼ | ● | - | 45.2% | ● | ● | ▼ |
| Optimal Asthma Control - Children | 53.4% | ▼ | ● | ▼ | ● | ● | ● | ▼ | ▼ | ● | - | 53.9% | ● | ● | ● |
| MENTAL HEALTH MEASURES | | | | | | | | | | | | | | | |
| Adolescent Mental Health and/or Depression Screening | 89.4% | ● | ▼ | ● | ● | ● | ▲ | ● | ▲ | ● | - | 87.8% | ▼ | ▲ | ● |
| Adult Depression: Follow-Up PHQ-9/PHQ-9M at Six Months | 48.5% | ● | ▼ | ▼ | ▼ | NR | ▲ | ▼ | ▼ | ● | - | 48.3% | ▼ | ● | ▼ |
| Adult Depression: Response at Six Months | 15.9% | ● | ▼ | ▼ | ● | NR | ● | ● | ▼ | ● | - | 15.8% | ● | ● | ● |
| Adult Depression: Remission at Six Months | 8.3% | ● | ▼ | ▼ | ● | NR | ● | ● | ● | ● | - | 8.3% | ● | ● | ● |
| Adolescent Depression: Follow-Up PHQ-9/PHQ-9M at Six Months | 41.8% | ● | ▼ | ● | ● | NR | ● | ● | NR | ● | - | 41.4% | ● | ● | NR |
| Adolescent Depression: Response at Six Months | 13.1% | ● | ▼ | ● | ● | NR | ● | ● | NR | ● | - | 13.3% | ● | ● | NR |
| Adolescent Depression: Remission at Six Months | 6.3% | ● | ● | ● | ● | NR | ● | ● | NR | ● | - | 6.3% | ● | ● | NR |

▲ Significant above statewide MHCP MCO race/ethnicity average ● Average ▼ Significantly below statewide MHCP MCO race/ethnicity average

NR = Not reportable. Did not meet minimum reporting threshold of at least 30 patients - Race category not reported for HEDIS/DDS measure

*Statewide MHCP MCO rates were re-calculated for those with race/ethnicity information available.

Table 2. 2020 Comparison of Minnesota Medicaid managed care enrollees’ quality metric rates by race and ethnicity. *Source*: *Minnesota Community Measurement’s 2020 Minnesota Health Care Disparities by Insurance Type report*

## Early opportunities

Prenatal, maternal and early childhood health and development also play a significant role in the emergence of racial health disparities. In Minnesota, about eight in 10 births to mothers who identify as

Black are to people insured by Medicaid. Yet data from Minnesota Vital Records showed that between 2011 and 2017 African American/Black birthing people were 1.5 times more likely to die during pregnancy, delivery or the year post-delivery than non-Hispanic white birthing people. More specifically, U.S.-born African American/Black women are 2.8 times more likely to die during pregnancy, delivery, or the year post-delivery than non-Hispanic white women (Minnesota Department of Health, 2019b). Other studies have shown that Black pregnant women have a substantially lower likelihood of receiving any medication for the treatment of opioid use disorder, and when they do receive treatment, they have a lower likelihood than white non-Hispanic pregnant women of receiving buprenorphine treatment compared with methadone (Schiff et al., 2020).

Minnesota also has some of the nation's worst disparities in birth outcomes for Black people. Black birthing people have higher rates of giving birth prematurely (9.3%) than white birthing people (8.6%) as well as having a newborn with low birth weight (9.5% and 5.9%, respectively). Among births covered by Medicaid in 2019, the low birth weight rate was 6% for white birthing people, and 12% for U.S.-born Black birthing people with the preterm birth rate landing at 9 and 12%, respectively. Prematurity, low birth weight and neonatal opiate withdrawal are the leading causes of costly neonatal intensive care unit admissions. These adverse birth outcomes are strongly associated with lifelong health problems like illnesses that affect breathing, feeding and digestive problems, cerebral palsy, and intellectual and developmental delays that lead to challenges in school.

The environment and level of support children are raised in during their first five years is critical to reaching their full potential. Early experiences shape brain development in a way that impacts not only education and school readiness, but lifelong health (Center on the Developing Child at Harvard University, 2017). Minnesota has numerous opportunity gaps when it comes to providing an equitable start for our youngest Minnesotans (Chomilo, 2019). Minnesota Medicaid has previously participated in grant-funded planning work around a newborn child's first 1,000 days on Medicaid that identified several key areas critical to provide them with an ideal start: integrating cross-sector data, identifying assessment tools and shared metrics, building state and community-level cross-agency partnerships, creating new clinical models and community linkages to medical practices and targeting highest risk infants, families and neighborhoods (Somers & Maul, 2021). Black children are among the groups more likely to experience interruptions in coverage, which has been shown to lead to delayed care, unmet medical needs and unfilled prescriptions (Olson et al, 2005). As noted earlier, in Minnesota 64% of Black children are covered by Medicaid (Fig 7). Therefore focusing on how we explicitly build racial equity into eligibility/enrollment, access, and quality for our mothers and youngest Minnesotans is critical. A failure to address racial equity in maternal and early childhood policy will set the health and opportunities presented to Black children on a different trajectory and make the state's commitment to equity that much more difficult to achieve.

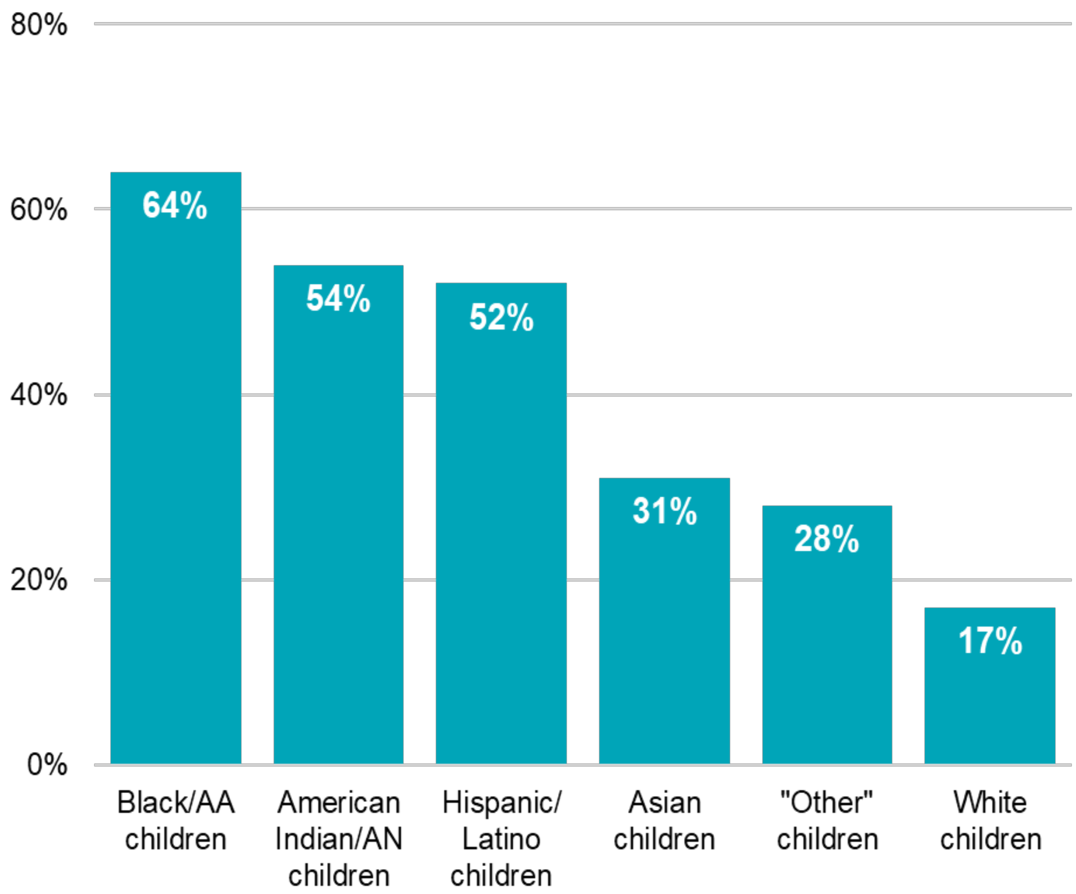

Fig 7. Percent of Minnesotan Children with Medicaid as source of coverage, by race, 2017-2018

*Source: SHADAC analysis of the 2017-2018 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files. Note: Data years 2017 and 2018 were combined to increase the sample size and improve the reliability of estimates among Minnesotans by race and ethnicity.*

# IV. What Medicaid can do now to address racial equity for U.S.-born Black Minnesotans

The result of the iterative process described above, this report lays out the Medicaid policies and programs most commonly cited by the U.S.-born Black Minnesotan community members involved: Enrollment and renewal, access to culturally-relevant care, and community engagement and co-creation. The report shares the problem as well as opportunity in each of these areas. It then tries to answer the following questions: Why does the problem exist? What has Medicaid done to address it? And finally, the report provides one to two "Calls to Action" that are needed right now to build racial equity into the walls of the Medicaid program along with potential indicators of progress to set some initial degree of accountability.

**What will accountability to U.S.-born Black Minnesotans look like for Medicaid?**

Recognizing that changes in Medicaid policy can require state or federal legislative authority or funding, accountability for the Calls to Action covered below can be difficult to place. These call outs intend to present broad outcomes that the Medicaid agency within DHS can be accountable to with the U.S.-born Black community in Minnesota. The aim of that accountability is to be Medicaid-focused and on the outcome of racial equity and not just the process. The Calls to Action are some of the ways proposed to improve racial equity for U.S.-born Black Minnesotans based on the iterative process involving community members and DHS staff. However, many actions can realize racial equity. The process is important, but accountability ultimately comes from a change in outcomes.

Importantly, since Medicaid service eligibility cannot currently be dependent on an individual's racial background, none of these calls to action seek to create Medicaid-funded services that are racially exclusive. Instead, they recognize the long overdue need to ensure policies, programs and the administration of each are done with awareness and action toward racial equity. With that frame as a guide, focusing the agency's efforts on changes, which will be available to all, and the communication of these changes to communities most impacted by structural racism, can notably improve health and opportunity for U.S.-born Black Medicaid enrollees.

## Enrollment and renewal

### *What is the problem, and why does it exist?*

U.S.-born Black Minnesotans enrolled in Medicaid programs often talk about challenges they face in enrolling in Minnesota Health Care Programs (Medicaid and MinnesotaCare).

Public programs of all types are criticized for difficult enrollment processes. There are many reasons for this, including complex federal and state eligibility rules, requirements for extensive documentation, the need to go to a county or tribe or to use an online system to apply. Medicaid enrollment is no exception.

Many barriers exist outside of DHS' control. However, there are some barriers which DHS, in collaboration with agency partners, could improve upon.

In interviews with families with children who were living in poverty (DHS, 2020) (Minnesota Department of Human Services, 2020), of the 27 parents asked about health insurance, six (22%) appeared to be income-eligible for Medicaid but were not enrolled. This was concerning as all six families had significant health care needs. Two parents were pregnant or just had a baby, one parent had diabetes, and three parents had serious mental illness.

Some of the uninsured parents were confused by the Medicaid enrollment process. Two parents had submitted applications but were unsure where they were in the process. For example, a mother of two teenagers has urgent needs for health care. She has diabetes, and she wants help for one of her children who is having emotional outbursts.

> *"We applied for MNSure, but I didn't do it through there. I did it on paper. They say it's backed up on paper, so I should have done it online because it's quicker. I wonder if I should do it online. But they said what would happen is I would get knocked off the list for already having it. It's confusing."*
>
> — *Female, African American*

When she contacted the consumer helpline to find out why her paper application was taking so long, they were only able to tell her that it was being processed, and did not seem to have access to any other information. This is probably because the county was processing her application, and DHS did not have up-to-date information on it. However, it is frustrating for applicants to call the DHS Health Care Consumer Support line and be unable to get questions answered about their particular case.

### *Enrollment and renewal: Lack of communication with applicants and enrollees*

Once a person has enrolled, DHS needs to continue keeping them up to date on their case, and there are many indications that this does not always happen. The Improve Group conducted interviews with people in the Twin Cities area who were living in poverty, people who are homeless and people who have immigrated (The Improve Group, 2016). They noted that several people described going to a health care appointment or to a pharmacy to fill their prescription, and were surprised to learn that they had lost their Medicaid coverage. As a result, they sometimes had to go without the care or the medication. One woman described this experience.

> "It was difficult to get MA [sic]. The first time I applied for MA it took 2-3 months to get it, but it was a while longer before I got my card. Then I had it and they cut me and my kids off, I don't know why. I was only on MA a couple months, and they said I needed a renewal, so I did my renewal but went to get my birth control and my MA was inactive."
>
> — Female, African American, 18-25 years old (MA stands for Medical Assistance, Minnesota's Medicaid program)

The Improve Group also described some situations where the paperwork to renew a person's Medicaid eligibility found its way to them *after* the renewal deadline, so they lost their coverage. Others described discovering that they had been moved to a different managed care organization and didn't understand how this happened or if their benefits changed.

In a discussion with DHS staff who attended a 2020 presentation on how chronic stress adversely impacts clients, many were aware of and concerned about a lack of communication, and described the challenges noted above from their own points of view. Staff in one of the help desk areas noted that "the frustration of having to make multiple calls and wait to get one's questions answered is exacerbated by the urgency of people's questions … People are already in a state of stress when they are contacting DHS — often with health conditions that they need to see a doctor for."

In these first-hand accounts, people had many complaints about the enrollment system, but they often seemed most upset by the lack of communication. Their application was stalled and they couldn't find someone who could tell them what was going on, even when they called the help desk. Their coverage was dropped, and they only found out about it when they tried to get health care. These comments suggest that even if the application form is complex and the methods for applying are less than ideal, DHS could make the application process much less frustrating if there were reliable ways for applicants to get all of their questions answered and for them to get regular updates on their application and renewals. One way this might be improved is if DHS stopped relying exclusively on paper notices that are sent through the mail and made notices available online. If these could be accessed through a mobile phone or other modes of communication, people might be more likely to receive them when and where they need them.

### *Enrollment and renewal: Opportunities and strengths identified by community*

Multiple sources suggested the value of having navigators help people apply for coverage through the MNSure portal. Navigators are located within health care systems, county or tribal human services agencies, and trusted community nonprofits. They help people apply, enroll and manage their paperwork and will sometimes help people find a health care or other provider. They play an especially important role in helping people overcome technology barriers when applying for coverage online through MNSure. This is particularly valuable for people without a computer or internet access at home. The paper application alternatives require completing and mailing in or dropping off a form, and then waiting for the county or tribal agency to process the form and send notice of the determination. However, access to a computer and internet is far from universal; only 69% of African Americans in the United States have a computer at home, and 71% have broadband internet (Pew Research Center, 2021) (Atske & Perrin, 2021).

As mentioned by the Community Wellness Center staff, navigators can be located within culturally-specific organizations. Working with a member of their community can be important for Black Americans, given the unethical treatment they received historically from the medical industry (e.g., the Tuskegee syphilis study) as well as the unequal treatment that continues today (Epstein et al., 2000; Petersen et al., 2002). Working with a trusted individual who shares a common history with them may make it more comfortable to share sensitive information about themselves, and thus enable the navigator to help them access all the services they need.

The Improve Group (The Improve Group, 2016) found that "participants who received help applying for coverage from MNsure navigators reported a far better experience and fewer challenges in getting started with MA than those who did not" (p. 20). In a discussion with the Cultural Wellness Center, their staff lauded navigators as providing people with help to enroll, but also to help guide families to other services they may need. They emphasized that their value comes from their location within the community, and living and working alongside the families they support.

Two of the stakeholder groups named continuous enrollment as a potential solution. The African American Leadership Forum expressed interest in the idea of continuous enrollment at a state or even a federal level, and asked what it would take to make that happen. This group also asked whether it would be possible to give more leeway to people who were enrolled but have a lapse in enrollment due to a glitch in the notification process. Leaders in the Center for Economic Inclusion asked about auto enrollment or auto re-verification of these programs. Participants of the Community Conversations hosted by DHS also deemed continuous enrollment important. Of all the Calls to Action, participants were most excited about proposals to extend periods of continuous enrollment among enrollees.

### *Enrollment and renewal: What is Medicaid doing to address this?*

One of the ways DHS has tried to support people applying for Medical Assistance, is to ensure that community navigators stay in business during the COVID-19 pandemic. DHS staff learned from the Navigator Coalition that navigators were adversely impacted by significant funding shortfalls. The steps DHS took to help Minnesotans maintain health care coverage during the emergency resulted in a steep decline in the number of new applications and suspended virtually all renewal activities. This caused a decrease in navigator incentive payments, funds navigators receive when they help applicants and enrollees successfully apply and renew health care coverage. DHS sought and the Minnesota Legislature approved a state law change to distribute unused 2021 incentive payment funds as grants to help support navigators during the pandemic. It is critical that navigators remain available to assist enrollees when standard eligibility and enrollment activities, particularly annual renewals, resume at the conclusion of the public health emergency.

DHS plans to make the Medicaid application process simpler by allowing people to apply using an online portal and phone app called MN Benefits. This tool allows Minnesotans to simultaneously apply for programs such as SNAP (food stamps), MFIP (cash assistance for families with children), emergency assistance, housing support, and child care support. This tool could allow people to apply for Medicaid at the same time. DHS has received positive feedback from users on the tool's ease of use. At the time of this report's publication, DHS is in the planning phase of this work.

Improving Medicaid enrollment and renewal policies for justice-involved populations provides another step in improving racial equity among Medicaid enrollees. In 2015, Black Minnesotans were incarcerated 9.1 times more than white Minnesotans. While research shows that this disparity in incarceration rates contributes to racial health disparities (Wildeman & Wang, 2017), it also points to how increased access to care may lead to improved outcomes, such as decreased hospitalization or recidivism (Guyer et al., 2019; Plotkin & Blandford, 2017). No federal law, statute, regulation or policy prevents individuals from being enrolled in Medicaid before, during or after incarceration in jail or prison (McKee et al., 2015).

However, under federal regulations, federal Medicaid funds may not pay for services provided to people who are inmates of a public institution, other than for inpatient hospitalization. As a result, Minnesota has traditionally terminated people's Medicaid coverage upon incarceration. This requires them to reapply for Medicaid when they are about to be released, which can be very challenging to do from prison.

During the COVID-19 emergency, DHS put in place a procedure to ensure that Medicaid enrollees remain enrolled in Medicaid without interruption, creating a special code to ensure that Medicaid funds only inpatient hospitalization. Under this new policy and procedure, Medicaid enrollees remain enrolled during incarceration and have full coverage restored upon release. DHS is currently working to make these changes permanent in all Medicaid eligibility systems.

**What will accountability to U.S.-born Black Minnesotans look like for Medicaid in enrollment and coverage renewals?**

- Advancing proposals to change Minnesota laws regarding continuous eligibility for those aged 0-19.
- Taking demonstrable steps to improve enrollment and renewal processes.
- Continuing to support navigators.
- Making renewal notices more accessible to enrollees, e.g., available electronically in addition to mailed paper documentation.

Outcome: Minimal disparity in the percent of U.S.-born Black Minnesotans who maintain coverage at the end of the federal public health emergency compared to average Medicaid enrollees.

### *Call to Action: Simplify and support enrollment and re-enrollment*

DHS eligibility policy and operations staff have many ideas for making enrollment easier, preventing lapses in eligibility and communicating more effectively. Many of the recommendations simplify the application process but require significant technical changes to the Minnesota Eligibility Technology System (METS). Given the high costs, lengthy timelines and even lengthier queues for any modifications to the online system, these recommendations must be thought of as long-term goals, and they are identified with an "IT" indicator. Other ideas could be implemented in the shorter term, especially once changes are completed to bring the system back to pre-pandemic rules. Based on iterative discussions with community and DHS staff, DHS should focus on two steps to simplify and support enrollment and renewal in a way that will improve racial equity for U.S.-born Black Minnesotans on Medicaid in the near term:

#### *1. Pursue continuous eligibility policies*

Continuous eligibility (also referred to as continuous enrollment) allows enrollees to maintain their enrollment regardless of changes in circumstances for up to 12 months at a time.

Twelve-month continuous eligibility for children is a long-standing retention strategy for states, and 32 states already offer this (Medicaid, 2021). The Social Security Act currently gives states the option to provide continuous eligibility to children under age 19 for up to 12 months. This means that the child's enrollment cannot end, regardless of any changes in circumstances, unless the child

- a) reaches the end of the 12-month period and is no longer eligible;
- b) reaches age 19;
- c) ceases to be a state resident; or
- d) passes away.

States also have the flexibility to tailor continuous eligibility for children to the specific needs of the state, such as choosing the age range for continuous eligibility and length of the continuous eligibility period. For example, Florida provides continuous eligibility for 12 months for children under age 5, while children ages 6 through 18 receive six months of continuous Medicaid eligibility (Kaiser Family Foundation, 2020). Indiana provides 12 months of continuous Medicaid eligibility only to children under 3 years old (Kaiser Family Foundation, 2020).

Minnesota has no continuous eligibility policy yet for children. However, Minnesota currently provides continuous eligibility to pregnant people (recently extended in the 2021 legislative session from 60 days to 12 months following the end of pregnancy) and their newborns through the first year of life. Philosophically, adding continuous eligibility for children is the logical next step. Providing continuous eligibility to children reduces churn during the year, which is administratively expensive and a barrier to children getting needed care (Brooks, 2021). In addition, changes that may be temporary or permanent, such as a new job or taking on more hours of work during the busy season, would not impact children's eligibility until their next annual renewal. Continuous eligibility could also benefit the entire family by keeping the family's case open even when adult family members lose eligibility. Once a family's case is closed, they have to complete a new application to reapply. If their child had continuous eligibility, parents whose eligibility is terminated due to a change in circumstances or for failure to comply with an eligibility requirement could be reinstated on their child's case if they become eligible again during the year or at the next renewal without having to complete and submit a whole new application. Given the many ways outlining how structural racism impacts families of color, it is little surprise that gaps in coverage due to churn are more likely to impact Black and Hispanic children, with this report also showing that the Midwest had one of the highest gaps in coverage by region (Alker & Osorio, 2021).

The importance of continuity for children is further emphasized by its inclusion in the federal Build Back Better Act, which at this writing has been passed by the House and is being considered in the Senate. While states currently have the option to provide continuous eligibility to children under age 19 through the Social Security Act, this bill would make it a *requirement* for states to do so. All children under age 19 eligible for Medical Assistance would receive continuous enrollment for a 12-month period, beginning on the date of the determination of eligibility. States will no longer have the option to limit the child's age or the time length of the continuous eligibility period.

If this bill becomes law, it will require changes in the IT systems at both MNsure (METS) and the system used by counties (MAXIS). However, even if the Build Back Better Act is not passed, **DHS should pursue**

**the state plan option under the Social Security Act to provide continuous eligibility to children.** This can be accomplished by submitting a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) for approval. When given the option, Minnesota should choose to provide the full 12 months of continuous eligibility to all children under age 19. This aligns with the continuous eligibility period for both pregnancy people and newborns.

Additionally, DHS should pursue additional expansion of continuous eligibility. Given what is known about the importance of the first five years on early brain development and what has occurred in the past two years during the COVID-19 pandemic, **DHS should explore an 1115 Medicaid Demonstration Waiver to implement 72 months of continuous eligibility for children on Medicaid up to age 6 and establish 24-month continuous eligibility for all enrollees age 6 and older.**

Both of these changes have recently been proposed by Oregon's Medicaid Agency, the Oregon Health Authority, in its 2022-2027 1115 Medicaid Demonstration Waiver proposal (Oregon Health Authority, 2021). In it, they note that 72-month eligibility for children up to age 6 will, "stabilize their insurance coverage and thus increase access to early-childhood screenings and necessary treatment … reduce frequent enrollment and disenrollment in this vulnerable population and allow for more predictable access to care, which is an important driver of improved health. Because many of these children remain eligible for coverage, eliminating churn also reduces state administrative costs and burden for families in application reprocessing. Further, expanding the pool of children who are continuously covered may ultimately reduce per member costs of coverage, as children who stay on OHP [Oregon Health Plan] longer will have better access to preventive and primary care services that can reduce the need for higher-cost treatments due to delayed care. Increasing the time between eligibility reviews for other family members will further ease the administrative burden on families and increase coverage stability for individuals and families on OHP." Regarding 24-month continuous eligibility for all enrollees age 6 and up they argue that, "Establishing continuous enrollment and increasing the length of time between eligibility renewals will preserve the coverage continuity gains achieved in the wake of federally enacted COVID relief bills passed in 2020. In 2018 and 2019, nearly 25% of new OHP enrollees had been enrolled in OHP within the previous 6 months. Over the last 6 months of 2020, this rate fell to just 5% of new enrollees. The speed with which people re-enrolled in OHP suggests that they may have been losing OHP coverage despite being eligible. The drop in the new enrollee rate suggests that federal policies enacted around the pandemic to keep people covered successfully reduced Medicaid churn."

### *2. Support navigators and simplify the enrollment and renewal process*

Comments on the enrollment process emphasized applicants' frustration that they were not kept up to date on the progress of their applicati*on, and that help desk staff were unable to answer questions on their particular case.* People also felt frustrated that they received no notification when a change had occurred, e.g., they lost coverage. Given the complexity of enrolling and renewing coverage, how many people in poverty lack a home computer with internet access, and that navigators are located within communities, increasing the availability and utilization of navigators is an important way to help people to apply. Navigator funding comes from contracts with counties, health care systems or other organizations. **DHS should therefore work with navigators and the U.S.-born Black community to**

**develop a plan focused on ensuring eligible Black Minnesotans gain or maintain Medicaid coverage** throughout the year but in particular as the federal public health emergency ends.

## Access to culturally relevant care

### *What is the problem?*

> ***"Culture is missing"***
>
> ***— Community leader***

Improving eligibility and enrollment in Medicaid and the care it covers is not synonymous with improving care and access for all communities. Studies of the impact of Medicaid expansion under the Affordable Care Act have had mixed results when it comes to decreasing racial disparities in several markers of access and care (Guth et al., 2020). A participant in the Community Conversations reflected, "They [medical practitioners] don't listen to us [Black people] when we explain our problems; Black patients do not receive the same treatment as white patients." A significant amount of literature validates the lived experience shared by this community member, both in how Black adults (Ayotte & Kressin, 2010; Federspiel et al., 2011; Angraal et al., 2018; Hsia et al., 2011; Mortensen et al., 2004; Green et al., 2007) and children (Todd et al., 2000; Goyal et al., 2015) are the recipients of unequal care. The 2017 analysis of Minnesotans on Medicaid found that 49% of enrollees reported experiencing some discrimination (described as unfair treatment due to gender, ability to pay, enrollment in Medicaid, or race/ethnicity/nationality). This highlights the need for systems of care to be intentional about connecting community members to health care professionals who provide culturally relevant care. As another community member shared during the Community Conversations, "relational care matters more than some medical care."

This sentiment was echoed in meetings with multiple community leaders who stressed the importance of culture in the health and well-being of community members. Culture was described as the fabric that links an individual to their community through shared beliefs, knowledge, practices and protections. Loss of culture in the healing space therefore contributes to illness by separating an individual from one of their shared strengths. This has been seen over time by racist policies that attempted to strip communities of their culture and codify a white supremacy approach to health as the only legitimate path (United Nations, 2016; Edwards, 2021; Yearby, 2020; Crear-Perry et al., 2021). In the face of this, many communities, including the U.S.-born Black community, have maintained their culture and the strength that comes with it. Health care systems are only beginning to value this resilience, and access to care that honors culture remains difficult.

MDH noted in its 2019 report on Culturally Responsive Care that "Cultural competency is critical to providing equitable, effective and respectful care and services. It includes but is not limited to being responsive to diverse beliefs and values related to health and wellbeing, delivering services in preferred languages, and being mindful of health literacy and numeracy. Providing culturally appropriate care is increasingly important as Minnesota becomes more diverse … Providing culturally responsive care to U.S. born black women and children living in Minnesota includes (but is not limited to) acknowledging the historical trauma that has affected black communities in Minnesota and the current oppression and racism that restrict access to resources, education and health care."

Lastly, one of the ways to identify and prioritize culturally relevant services is via information technology systems. Unfortunately, many remain archaic and were not designed with the end user in mind. Culturally specific data needs to be integrated into technology systems. Modernization of these systems is complex, bringing with it multiple layers that may from the outside appear simple. Adding to this is that until relatively recently differences between the U.S.-born Black community and Black immigrant and refugee communities weren't acknowledged and therefore these communities have not been involved as end users in conversations about developing an equitable IT infrastructure.

### *Access to culturally relevant care: Opportunities and strengths identified by community*

Community leaders emphasized a strong need for culturally specific care in conversations. Panelists consistently discussed the important role culture plays in an individual's health and a community's health. One interviewee called for a new definition of health that emphasizes a community's (cultural group's) ability to care for each other. Trauma-informed care also emerged as a theme in many conversations. In health care, trauma is often understood as specific events and their impacts on an individual's life and wellbeing. However, when a cultural lens of health care is applied, trauma can be viewed in a macro-sense and the impacts of historical and systemic racism become very relevant. Many DHS interviewees discussed the pressing need for more focus, training and attention on historical and ongoing trauma. Community interviewees noted that Medicaid and other state agencies can support culturally relevant care in concrete ways, such as incentivizing and building a stronger infrastructure of Black clinicians and clinics centered on care that values culture along with an allopathic approach to health and healing.

### *Access to culturally relevant care: What is Medicaid doing to address this?*

Recognizing the problem and addressing it are two different things. Among DHS staff, a consistently noted barrier to addressing culturally relevant care was a lack of routinely and standardly disaggregated racial demographic data — data that would allow a better understanding of where specific communities experienced barriers and successes. Without good data, even staff aware of issues creating barriers found it very difficult to prioritize specific communities, health plans or providers with interventions (e.g., quality benchmarks, payment withholds, incentives).

Many DHS staff also observed the lack of trauma-informed providers in the community. It was also noted that most trauma-informed practices are not well designed to capture the historical and ongoing trauma that can often face U.S.-born Black community members.

Physicians who share the same racial background as the communities they serve often improve culturally relevant care. Reduced racial discrimination and bias is one of the cited reasons that racial provider-patient concordance, where providers and patients share the same racial background, has been shown to impact outcomes positively for Black patients (Shen et al., 2017; Greenwood et al., 2020). In Minnesota, although Black residents make up 7% of the general population, only 2.6% of Minnesota physicians and 1% of physician assistants identified as Black or African American in 2019

(Minnesota Department of Health, 2019c). Care provided by paraprofessionals who live in the same communities as patients experiencing disadvantage has also been shown to decrease disparities (Redding et al., 2014).

DHS has attempted to foster more culturally relevant care via non-licensed paraprofessionals who are more likely reflect the diversity of their patients. DHS staff observed that the agency has expanded coverage for doulas, community health workers (CHWs) and community emergency medical technicians (EMTs). Unfortunately, these benefits are not highly used. In partial response, DHS increased doulas' reimbursement rates. But in addition to reimbursement, DHS realizes it, and its county and managed care partners, must find ways to support the development of a community-based workforce and the awareness among Medicaid providers that these services are available and clinically beneficial.

Minnesota Medicaid's approach to improving culturally relevant care is evolving. There are several ongoing efforts to improve the race and ethnicity demographic data of our programs but nothing focused on disaggregating Black community members. Similarly, no specific withhold measures or incentives are in place to target U.S.-born Black enrollees or culturally specific care delivery. The Integrated Health Partnerships (IHP) program (Minnesota Department of Human Services, 2021b) does have requirements that participating partnerships have a patient board with representation from the community it serves, however there is no specific racial group requirement. DHS highlighted the importance of racial equity and culturally specific needs for Black pregnant people in its most recent managed care request for proposals for pregnant people and children and is looking at ways to decrease barriers to non-licensed provider participation in Medicaid.

**What will accountability to U.S.-born Black Minnesotans look like for Medicaid in access to culturally relevant care?**

- Ongoing development and funding of programs that include a U.S.-born Black Minnesotan-specific focus
- Contracting with managed care and other organizations that provide culturally relevant training to Medicaid providers.

Outcome: Increase in number of and utilization of culturally specific providers.

### *Call to Action: Increase investment in culturally relevant care*

A culturally specific lens to health can better orient systems to strengths instead of deficits. Instead of asking where the most illness is seen, the focus can be on where health is seen — particularly in spite of numerous systems that have been built to a community's disadvantage. Viewing health through this lens is crucial as DHS aims to continue to rebuild trust that has been violated and whose loss has contributed to the inequities occurring today. Based on the iterative discussions with community and DHS staff, DHS should focus on two steps to address access to culturally relevant care for U.S.-born Black Minnesotans on Medicaid in the near term:

### *1. Invest in an internal structure that has a specific focus on U.S.-born Black Minnesotans*

As illustrated above, within government, U.S.-born Black people face structural disadvantage yet do not have any specific institutional power. To address generations of structural inequity will require sustained intention. A dedicated internal structure could provide a direct connection to U.S.-born Black Medicaid enrollees, community-based organizations and other institutions to inform and co-create policies and programs that elevate strengths and address inequities. A division focused on Black Medicaid enrollee health could also ensure that efforts throughout DHS and other state agencies, e.g., the Minnesota Department of Health, are leveraging all available funding sources to close the gaps seen in health outcomes. Participants in Community Conversations expressed a desire for DHS to find ways to incentivize or require larger health care and insurance companies to train their employees and clinicians on how to engage with people of color. They also seek accountability measures around disparities in outcomes and experiences of racial discrimination. While engaging physicians and other licensed providers, DHS staff from this division could also ensure Medicaid providers are aware of the evidence and efficacy of referring their patients to culturally relevant services and paraprofessionals, such as doulas, CHWs and community EMTs. Staff dedicated to health services utilization research would be able to identify which services are being used, when and where, as well as highlight successes and opportunities to improve. Importantly, since Medicaid services cannot currently be granted solely on the basis of an individual's racial background, this division wouldn't create racially exclusive policy or programs. Rather, it would help focus the agency's efforts around changes that will be available to all yet notably improve health and opportunity for U.S.-born Black Medicaid enrollees.

There is some precedent for this approach. In April 2020, DHS launched the African American Child Well-Being Unit to help address structural racism in the child welfare system by providing oversight and assistance to county agencies as well as grants to community-based organizations working with African American families.

Recently passed legislation improving the allergy and asthma benefit set for Medicaid enrollees might serve as an example of what this division could do on a much more regular basis. The legislation aims to address health disparities for those living in urban areas. The bill seeks to improve health outcomes for children with asthma and reduce asthma-related emergency room visits and hospitalizations. This is accomplished through reimbursement for environmental specialists to complete home evaluations and coverage for certain equipment and supplies ordered in the evaluation (e.g., allergen-rated air filters, dehumidifiers, HEPA air cleaners). An analysis of adult Medicaid enrollees age 18-64 found that U.S.-born African Americans had dramatically higher rates of asthma (16.5%) than any other racial or ethnic group (Minnesota Department of Human Services, 2018). It is therefore noteworthy that this legislation was initiated by the community and included the American Lung Association, Ramsey County, the city of Minneapolis and the Minnesota Department of Health based on a program previously piloted in Ramsey County. A division with a U.S.-born Black Minnesotan focus could therefore conduct a retrospective evaluation of this legislation, and others similar to it, to identity what critical components could be applied to other racial inequity-related projects. Domains for consideration could include legislation, resource allocation, community support, constituent engagement and political will.

Another example of what the division could focus on is how services intended to address social drivers of health perform in the U.S.-born Black Minnesotan community. In July 2020, DHS launched Housing Stabilization Services, an innovative and nation-leading Medicaid home- and community-based service to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing. Interest and enrollment has far outstripped the initial projected estimates. A division with a U.S.-born Black Minnesotan focus could ensure that U.S.-born Black Minnesotans know about this benefit while taking steps to create more culturally specific features in the benefit to improve racial equity and inform other policy development around the social drivers of health.

### *2. Continue to prioritize standardization and disaggregation of race, ethnicity and language data*

Race, ethnicity and language (REL) demographics of communities are among the few ways systems can get some insight into the impact of and need for culturally relevant care. While an incomplete and imperfect proxy for culture, REL data can serve as an important initial signal and inform conversation and collaboration with communities. One Community Conversation participant noted a need to "proactively identify data — there's not enough data, and the way we collect data is not moving at the same speed as how diversity is increasing." In fact, many of the reflections and solutions proposed by participants in the Community Conversations would rely at some point on precise REL data. Ideas such as assessing if a health plan's network of providers reflects the communities they serve or tying payment incentives or withholds based on decreases in racial health outcome gaps require reliable REL data. To use as much information as possible about where gaps persist, Medicaid REL data also needs to align with public health REL data.

In 2021, CMS classified Minnesota's Medicaid race and ethnicity data as "medium concern" because 10-20% were missing and out of alignment with the U.S. Census Bureau's American Community Survey (SHADAC, 2020).

A number of strategies have been suggested to improve the collection of REL data during enrollment and renewal (Lukanen & Zylla, 2020). DHS staff are considering updated wording on enrollment forms, engaging enrollment navigators about the importance of enrollees volunteering their REL data and imputing REL data from other publicly available sources. These approaches are most effective when informed and led by community. Both community members and staff acknowledge a general lack of trust in government. Building that trust will be a critical component of ethical and accurate data utilization. As noted earlier neither the U.S.-born Black community, nor any other community as captured by our current, broad racial and ethnic definitions, is monolithic. Further disaggregation will therefore lead to where within communities gaps are largest and opportunity the least. To accomplish this DHS must improve how it communicates the benefits of sharing one's demographic data and balance the protection of data with the ability to close clear and present gaps.

During the COVID-19 pandemic, the Minnesota Electronic Health Records Consortium has grown to include all of Minnesota's large health care systems and the Minneapolis Veterans Affairs Medical Center. A partnership with the Minnesota Department of Health has allowed the pooling of aggregate data from health care systems' electronic health records to provide insight into COVID-19 testing and vaccination. This has resulted in the identification of gaps in Minnesota's COVID-19 response and allowed the state to achieve 93% REL data completion as it reports vaccination rates by race and ethnicity. Once REL data categories become disaggregated and standardized in Minnesota, collaboration between the consortium and DHS could lead to better identification of where gaps and strengths exist within the U.S.-born Black community and other historically disadvantaged communities. This can then inform investment in interventions that work as well as structure incentives around closing gaps.

For example, all DHS managed care organizations must conduct performance improvement projects to improve the care and services provided to Medicaid enrollees. Project goals must be clear, precisely defined and address a critical issue that enrollee's face. Moreover, the managed care organizations must provide objective, measurable indicators to assess the effectiveness of the interventions. These projects could be one lever to engage community about defining quality care and services. Standardized and disaggregated REL data will be important for identifying communities as well as holding DHS, the managed care organizations, counties, clinicians and others who serve Medicaid enrollees accountable.

## Engaging the communities and families Medicaid serves

### *What is the problem?*

The importance of community engagement cannot be overstated. Health inequities and the social conditions, including racism, that cause disparities have existed for centuries. Top-down policy solutions have been tried for at least a generation, and yet disparities continue to grow. Meaningful solutions must be found in consultation and partnership with communities (Interlandi, 2019). While engaging enrollees in heterogeneous groups (e.g., engaging people from multiple racial and ethnic backgrounds or people with and without disabilities at the same time) can be very helpful, culturally specific engagements are equally important. Focused engagement is more likely to draw out some of the different barriers and strengths of various groups of people as well as the common experiences that cut across racial and ethnic or other categories. This theme echoed through DHS conversations with U.S.-born Black leaders. All stressed the need for community consultation in general and for culturally specific consultation. One group expressed regret that they had not been consulted even earlier in the process of this report. All also expressed the desire to be kept in the loop as work to complete this report and implement its recommendations progress. It's important that what DHS learns is "given back to community."

This extended to how staff throughout DHS, not just those in the Medicaid program, looked to work with community directly. They wish to do so in a way that community members understand who is working with them and that it was doing so in a coordinated way.

### *Engaging the communities and families Medicaid serves: Opportunities and strengths identified by community*

Community members expressed skepticism about "engagement," citing experience that it's been merely a check-the-box exercise in the past. They asked for more tangible work to address disparities, including sustained funding for racial equity work. One person said that she was tired of pilot programs that end when the funding ends. Addressing racial disparities was noted to require an authentic, ongoing, and intentional commitment to community engagement. “Be real and honest about engaging people; people can pick up on that [lack of authenticity] right away, and will not be open but will close down.”

Many also stressed that engagement about Medicaid should encompass engagement about how providers treat patients and families. One person observed that Black providers experience bias from their white colleagues in the same way that Black patients do. He suggested the strategy of “being communal in how we care for each other,” building true partnerships between providers and patients. Medicaid and providers should be learning from how “we [the Black community] have conversations amongst each other.”

DHS Medicaid colleagues agreed that there had been little-to-no engagement specific to U.S.-born Black communities to date. Indeed, most agreed that there had been insufficient community engagement across the board, regardless of specific racial or ethnic focus.

### *Engaging the communities and families Medicaid serves: What is Medicaid doing to address this?*

Some parts of the agency have sought enrollee input directly, with one example being listening sessions with U.S.-born Black Minnesotans and Black providers to hear what has been going on in response to multiple high-profile police murders of Black men in Minnesota. However, some parts of the agency have mostly relied on insight from staff members from the U.S.-born Black community.

Some of the people interviewed were familiar with DHS’ Integrated Care for High Risk Pregnancies (ICHRP) program, a grant-supported program administered by DHS in full partnership with African American community leaders and clinicians in the Twin Cities. (ICHRP also includes a parallel initiative in partnership with Native American communities and tribes.) Interviewees spoke of the need for more of these types of power-sharing arrangements to address health disparities beyond birth outcomes.

Important features of ICHRP include:

- Leadership by a community-based advisory council, whose work is facilitated and coordinated by African American consultants under a contract administered by DHS. As of this writing, the council has just become incorporated as an independent nonprofit corporation.
- Fiscal support for community infrastructure. Appropriations within the state’s base budget currently fund ICHRP. The new nonprofit corporation will soon be positioned to seek other forms of programmatic and philanthropic funding.
- Embrace of an evidence-based model specific to the psychosocial risks that are heightened among many minoritized groups. In ICHRP, this model centers on community-based, culturally specific paraprofessionals who reach out to potential clients, identify psychosocial needs and navigate to appropriate services. In some cases, health care providers refer pregnant Black people to ICHRP for the assessment and navigation; in other cases, the paraprofessionals work in reverse, helping expectant mothers and fathers who are not yet obtaining prenatal care connect to a local clinic.

- Paraprofessional services, to the extent permitted by federal and state Medicaid policy, should be covered by Medicaid directly, in order to free up programmatic funds to support the infrastructure.

DHS staff pointed to some other success stories around the agency. For example, as part of their efforts to understand and prevent child abuse and neglect, the Children and Families Services Administration uses federal funding to support an intensive training program for parents who have been involved with child protection. Parents learn about legislative and agency advisory councils and become effective members of such bodies. Similarly, staff have learned important principles, such as the importance of having more than one parent voice on any advisory body, so that parents participate on an equal footing with the many other stakeholders present.

In 2015, DHS obtained a philanthropic grant from the Bush Foundation to increase the agency's capacity to engage communities. An advisory council comprising community experts and DHS staff oversaw DHS' grant-supported activities, and approximately 25 staff members from all corners of the agency received training on facilitation methods and real-time opportunities to conduct engagement. Unfortunately, many employees who participated in the Bush-supported work have since left the agency, and there have been no initiatives of similar scale to sustain the work.

Many DHS staff expressed a strong desire to do more to engage enrollees, but felt disempowered due to insufficient resources, lack of staff and lack of training. No one questioned the value of community engagement, only the will within the agency to get it done.

### *Call to Action: Fund community conversations with U.S.-born Black Minnesotans on Medicaid*

Community members noted that the COVID-19 pandemic has clearly demonstrated the impact of a fractured trust between state agencies and the U.S.-born Black community. A repair of this trust requires relationships be built over years and gives that community the opportunity to "start a journey of trusting larger agencies that provide resources and services." As noted above, this must be intentional. Organizations asked DHS to adopt a co-design model for health care policy and programs, creating *with* the community, not *for*. They stressed that relationship building is key, and that power should be shared. The challenge is for DHS to do it better by doing it differently. DHS employees were able to easily identify the organization's own role in perpetuating certain aspects of systemic racial health inequity in Minnesota. Concerted, reliable and consistent efforts must occur to earn back the trust of the Black community in Minnesota. Internally, DHS divisions stressed that relationship building with the community cannot be a one-time or sporadic event. To be meaningful, engagement must be dedicated, intentional and iterative.

Therefore, **DHS should integrate not just community engagement in general but longitudinal, culturally specific engagement of enrollees and their families into routine policy, budget and administrative activities.** Minnesotans who receive the services are the ones best positioned to inform what needs to be done differently in order to move the needle on health disparities. Indeed, the agency should have standing contracts with respected community partners who can engage enrollees with and for DHS. This will allow community members to share their experiences and needs and improve DHS' ability to share what resources are currently available and how people can navigate them. Contractors are often better positioned to host these conversations, and contracting with a community facilitator makes it easier to ensure that participants can be compensated for their time and reimbursed for expenses, such as travel and child care.

**What will accountability to U.S.-born Black Minnesotans look like for Medicaid in engagement?**

- Creating a mechanism and expectation that community will be consulted early about current policy and budgets and future proposals that impact them.
- Developing more models of care that are community co-created and led with true power sharing.

Outcome: Sufficient funding for longitudinal, authentic community conversations.

Cultural Wellness Center CEO Elder Atum Azzahir offered the example of their “Year of Learning” approach to connecting with community members in an intentional, longitudinal process of growth both for both DHS and the community. Participating members commit to conversations that happen regularly over 12 months, receive compensation for their time and get support from community navigators and Elders who connect them to resources as needs arise. This model also centers on bi-directional learning and unlearning that places all participants in the role of both student and teacher to create transformational knowledge-sharing. A longitudinal, community-centered approach to engagement allows staff from Medicaid and other DHS programs to be in ongoing conversation. Seeing community as true partners and co-creators at all times, not just during a pandemic or to address a specific, research-identified gap, will go a long way toward repairing the trust that has been broken.

## V. Capturing the moment for change

While this report prioritizes some specific Medicaid policy solutions, there were other notable observations from conversations that warrant discussion. There is a clear sense of urgency. The interviews and data that comprise this report confirm the indisputable fact that Minnesota has a staggering racial health equity problem. While Minnesota's racial health disparities have been known to those in the field for decades, the murder of George Floyd and the COVID-19 pandemic pushed the issue straight to the forefront of the public's awareness. These historic events made Minnesota's health and racial disparities international news and finally impossible to ignore. Because the general populace and their representative governments are now willing to acknowledge that racial health disparities do exist exorbitantly in Minnesota, there is an urgency for DHS to act quickly on the current momentum and commitment of many leaders and partners to substantive change.

Throughout these conversations there was a shared concern that, as in the past, DHS' current focus on health disparities is again just another flash in the pan. Organizations and staff alike have been down this road before and are all too familiar with well-intended efforts losing steam. Yet, despite the weariness, there is a willingness to try again.

All agreed that leadership, at the highest level, must play a critical role in DHS' ability to improve racial health disparities for U.S.-born Black Minnesotans; they called for prioritization, agency-wide alignment and resource allocation. Finally, and most importantly, there was a plea to keep the conversation going, because ignoring the stain of institutional racism in Minnesota has not made it go away.

## VI. Conclusion

On his first full day in office, President Biden issued Executive Order 13995, establishing the Presidential COVID-19 Health Equity Task Force. He charged the task force with recommending actions against long-standing and emerging health inequities exacerbated by the COVID-19 pandemic. Ten months later, after hundreds of working sessions, extensive literature reviews, meeting with more than 100 subject-matter experts and eight public meetings, the Task Force submitted its final report (U.S. Department of Health and Human Services, 2021). The report includes 55 recommendations with five actions proposed as overarching priorities:

1. Invest in community-led solutions to address health equity.
2. Enforce a data ecosystem that promotes equity-driven decision making.
3. Increase accountability for health equity outcomes.
4. Invest in a representative health care workforce, and increase equitable access to quality health care for all.
5. Lead and coordinate implementation of the COVID-19 Health Equity Task Force's recommendations from a permanent health equity infrastructure in the White House.

Given the incredibly broad scope of the task force, it is notable that all five of the proposed priorities are reflected in some way in this report's Calls to Action to build racial equity into the walls of Medicaid for U.S.-born Black Minnesotans. This gives further credence to the belief that choosing to focus on a historically under-resourced community is vital to authentically addressing racial health inequities. One example of how this approach has taken hold throughout Minnesota is the Minnesota Business Coalition for Racial Equity, which comprises leaders from 80 organizations including most of Minnesota's Fortune 500 companies. Their purpose: "coming together to build an equitable, inclusive and prosperous state with and for Black residents." This is not a zero sum tactic; it instead improves policies and programs for all, getting the state closer to an overall goal where, "all Minnesotans are provided the opportunity to lead healthy, fulfilled lives," as detailed in Governor Tim Walz' very first executive order: 19-01 Establishing the One Minnesota Council on Diversity, Inclusion and Equity.

The Calls to Action detailed and justified in this report serve as a guide to prioritize actions to improve racial equity for U.S.-born Black Minnesotans on Medicaid. They also overlap with the needs of other historically under-resourced communities. The iterative process established in developing this report, its policy recommendations and the subsequent accountability for action also aim to set the expectation for other work within DHS. Next steps must include reports on building racial and health equity into Medicaid for Native and Indigenous Minnesotans, Hispanic/Latino Minnesotans, Asian-Pacific Islander Minnesotans, immigrants/new Minnesotans, Minnesotans who are LGBTQ+, Minnesotans living with disabilities, unhoused Minnesotans and incarcerated Minnesotans.

What may surprise readers of this report most is that these are not revolutionary ideas and approaches to the work of population health. More than 100 years ago, sociologist and civil rights activist W.E.B. Du Bois was pointing out the impact of structural racism and how social drivers of health impacted the opportunity of Black Americans. The solutions he proposed then echo throughout this report. In 1906, he wrote in *The Health and Physique of the American Negro*, "The Conference recommends the formation of local health leagues among colored people for the dissemination of better knowledge of sanitation and preventive medicine. The general organizations throughout the country for bettering health ought to make special effort to reach the colored people. The health of the whole country depends in no little degree upon the health of Negroes."

Some 116 years later, Americans are still striving to create a system that has racial equity built into the walls instead of being simply seen as optional wallpaper. To meet this moment, it's time to heed another piece of advice Du Bois shared, this time in his book, *The Souls of Black Folk*:

> *"Now is the accepted time, not tomorrow, not some more convenient season. It is today that our best work can be done and not some future day or future year."*

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# Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic

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## KEY POINTS

- Research shows that disruptions in Medicaid coverage are common and often lead to periods of uninsurance, delayed care, and less preventive care for beneficiaries.
- Studies indicate that beneficiaries moving in and out of Medicaid coverage (sometimes called "churning") results in higher administrative costs, less predictable state expenditures, and higher monthly health care costs due to pent-up demand for health care services.
- One study found adults with 12 full months of Medicaid coverage in 2012 had lower average costs ($371/month in 2021 after adjusting for inflation) than those with six months of coverage ($583/month) or only three months of coverage ($799/month).
- The postpartum period is a particularly high-risk time for churning as studies show that 55 percent of women with Medicaid coverage at delivery experience a coverage gap in the following six months compared to 35 percent of women with private insurance. This is of particular concern for pregnant women of color, who experience large disparities in maternal mortality before and after childbirth and account for a larger proportion of Medicaid beneficiaries compared to the overall U.S. population.
- The Families First Coronavirus Recovery Act has helped reduce Medicaid churning, temporarily, through its continuous enrollment requirements for enhanced funding for the duration of the COVID-19 Public Health Emergency.
- State decisions, such as adopting the Affordable Care Act's Medicaid expansion to adults and the extended continuous eligibility option for postpartum coverage starting in April 2022 under the American Rescue Plan, can play an important role in reducing rates of churning.

## INTRODUCTION

Coverage disruptions and coverage loss in Medicaid, often referred to as "churning," frequently occur among Medicaid beneficiaries. Difficulties navigating state renewal and redetermination procedures – even among individuals who are still eligible – as well as income fluctuations and changing family circumstances can lead to the loss of coverage. Churning occurs when people lose Medicaid and then re-enroll within a short period of time. Gaps in health coverage occur because many people experiencing churning do not transition successfully to Marketplace or employer-based coverage for the months in which they were not enrolled in Medicaid.[1] The Families First Coronavirus Response Act (FFCRA) maintenance of eligibility (MOE) and continuous enrollment requirements have temporarily halted most Medicaid churning. Under the continuous enrollment provision in FFCRA, states that accept the law's temporary increase in federal Medicaid funding are prohibited from terminating most beneficiary enrollment for the duration of the public health emergency with limited exceptions.[i] This Issue Brief reviews evidence on churning among the Medicaid population and different policy options for states and the federal government to reduce churning, including continuous eligibility, Medicaid expansion to adults, express lane eligibility, presumptive eligibility, multimarket plans, and limiting premiums and cost-sharing.

## PREVALENCE AND CAUSES OF MEDICAID CHURN

### Prevalence of Medicaid Churn

The typical Medicaid beneficiary is covered for less than 10 months out of the year. Length of coverage is slightly higher for beneficiaries with disabilities (10.8 months) and seniors (10.3 months), and lower for non-elderly, non-disabled adults (about 8.6 months).[2,3] One study found nearly 25 percent of Medicaid beneficiaries changed coverage within one year and most of these beneficiaries (55 percent) also experienced a gap in coverage.[4] Churning rates are somewhat lower in children, in part due to higher income eligibility levels and policies designed to improve continuity of coverage in this population; however, not all states have taken advantage of federal policy options that could reduce churning among children further.[5,6] The postpartum period is a particularly high-risk time for churning, as studies show that 55 percent of women with Medicaid coverage at delivery experience a coverage gap in the following six months, compared to 35 percent of women with private insurance. Pregnant women are also more likely to experience a coverage gap after delivery if they do not speak English at home or have a family income between 100–185 percent of the federal poverty level (FPL).[7]

### State Eligibility and Renewal Policies

Policies that affect individuals' ability to maintain Medicaid coverage vary by state. As of January 2020, 23 states have adopted the Medicaid state option to provide a full 12 months of continuous eligibility for children.[8] In the 36 states that have implemented the Medicaid adult group expansion, the median income eligibility limit for all non-elderly adults is 138 percent of the FPL. In non-expansion states, the median income eligibility limit for parents is 41 percent of FPL, and other adults without disabilities are generally ineligible for Medicaid regardless of their income level with the exception of a few state demonstrations (e.g., Georgia, South Carolina and Wisconsin). More restrictive eligibility criteria mean that modest and temporary increases in monthly income can lead to loss of Medicaid eligibility, even among very low-income beneficiaries.

States are required to review eligibility only once every 12 months for beneficiaries whose eligibility is based on Modified Adjusted Gross Income (MAGI) methodologies and at least once every 12 months for non-MAGI beneficiaries. States must first attempt to renew eligibility for all beneficiaries based on available information prior to contacting the individuals. The state must provide MAGI enrollees, for whom the state cannot renew eligibility based on available information, at least 30 days to return their renewal form and any required information. Between yearly renewals, enrollees must timely report changes that may affect eligibility (e.g., income changes) and states can conduct periodic data checks to identify potential changes. In 2020, 30 states reported periodic data checks however, as of March 2021, five states have discontinued periodic data checks during the public health emergency. If the state has information indicating an enrollee has experienced a change, it must request additional information from the individual. Some states provide as few as 10 days for enrollees to respond, raising concerns about the limited time allowed to gather appropriate documentation, which means eligible individuals may lose coverage if they do not respond to state information requests within the required timeframe.

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[i] Exceptions include when a beneficiary's state residence changes or voluntary disenrollment from the program.

In some cases, state compliance with eligibility redetermination policies can result in significant coverage declines. In 2018, enrollment in Medicaid and the Children's Health Insurance Program (CHIP) decreased by over 1.5 million enrollees, and there is evidence that state enrollment policies were a driving factor. For example, the three states with the largest percentage drops in enrollment - Tennessee, Arkansas, and Missouri - required the use of phone or mail for eligibility renewals, which can be fraught with problems. Beneficiaries may change addresses or miss mailings, and phone applications typically involve long wait times and problematic voice interfaces.[9] In Missouri, enrollment dropped by 70,000 in one year, including 55,000 children, mostly due to families not returning a mailed renewal form created by the state's new automated eligibility system. In Tennessee, after the state started conducting manual eligibility redeterminations in 2016 using a complex renewal packet, there was a nearly 10 percent decrease in Medicaid enrollment (over 148,000 individuals) between 2017 and 2018. Tennessee was under an approved mitigation plan at this time and had not conducted renewals for several years. While some disenrolled individuals were likely not eligible and needed to be terminated, eligible people were also disenrolled during this process. [10]

There is generally less Medicaid churning among children compared to other Medicaid populations, as noted earlier. In states with more restrictive redetermination policies, however, churning can be high among children as well. For example, about 90 percent of the coverage loss in Texas between December 2017 and 2018 was among children (over 144,000 enrollees), similar to Missouri's experience in 2018. Texas conducts multiple checks of state income data throughout the year and sends routine mailings to parents and caregivers to verify income. These requests require a response within 10 days or children are at risk of coverage loss. This restrictive time period for verifying income has resulted in Medicaid coverage loss for children; for instance, the Texas Children's Health Coverage Coalition reported that missing the 10-day window for a response accounts for over 90 percent of the losses in coverage.[11]

**Income Fluctuations**

Research shows that people with lower incomes are more likely to experience frequent income fluctuations compared to higher income populations. One study of low and moderate-income households found that they experienced an average of 2.5 months each year in which income fell by more than 25 percent, and 2.6 months in which income increased by 25 percent.[12] This is far greater than income fluctuations seen among higher earners. For example, a 2014-2015 survey of 5,661 individuals about family finances found 53 percent of low-income households (less than $25,000 per year) experienced significant income changes (i.e., changes greater than 25 percent) compared to 27 percent of upper income households ($85,000 or more per year).[13]

Moreover, people of color and those with less education experience greater income volatility.[14] In the 2014-2015 survey, 38 percent of Black households and 45 percent of Hispanic households experienced income volatility, compared to 32 percent of white households. In that same year, 40 percent of households with a high school diploma or less experienced income volatility compared to 28 percent of households with a bachelor's degree. These income changes in turn can make individuals temporarily ineligible for Medicaid for short periods of time before their income changes again and they reestablish eligibility, requiring them to re-enroll in coverage. Income fluctuations have become even more common during the COVID-19 pandemic.[15]

## IMPACTS OF MEDICAID CHURNING

### Continuity of Care and Health Outcomes

People who experience churning or coverage disruptions are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits. One study found that unstable Medicaid coverage increased emergency department use, office visits, and hospitalizations between 10 percent and 36 percent and decreased use of prescription medications by 19 percent, compared to individuals with consistent Medicaid coverage.[16] Children with interruptions in coverage also are more likely to have delayed care, unmet medical needs, and unfilled prescriptions.[17] Lack of coverage affects access to care, and even short periods of uninsurance affect access. One study found individuals lacking coverage for 1-5 months had worse access to care compared with those covered for all 12 months. [18]

While disruptions in coverage often lead to periods of uninsurance, transitioning between health plans can also result in impeded access to care due to differing provider networks, benefits, and drug formularies. One study examining low-income adults whose insurance status changed but did not have a gap in coverage found that 13 percent had to change at least one provider, 22 percent skipped doses or stopped taking prescription medications, and 29 percent reported an overall harmful effect on the quality of their health care.[19] An analysis of one health insurance carrier in 2019 found one-third of Medicaid expansion enrollees changed coverage type (i.e., fee-for-service, Medicaid managed care or individual market plans) or disenrolled within one year, and one-third of those who left re-enrolled with the same payer within one year.[20] Moreover, a 2015 survey of low-income adults in Arkansas, Kentucky, and Texas found one in four respondents changed health coverage at least once. Over half of respondents who changed insurance plans experienced a gap in coverage, and 47 percent reported a decline in their overall health.[21]

**Administrative and Beneficiary Costs**

Churning increases administrative costs and is associated with more avoidable and less predictable expenditures on medical care by beneficiaries cycling in and out of Medicaid. A 2015 analysis estimated the administrative cost of one person's churning, including disenrolling and reenrolling, to cost between $400 and $600.[22] Providers and Medicaid managed care organizations are also burdened by churning as it limits the ability to provide effective care and achieve managed care quality requirements, and increases administrative costs, such as the costs of processing new applications.[23]

While churning lowers Medicaid medical expenditures by creating smaller monthly patient caseloads, it can lead to higher monthly per member costs. Some studies suggest people who churn in and out of coverage have higher Medicaid monthly health care costs due to pent-up demand for health care services after a period of ineligibility.[24] One study found adults with 12 full months of Medicaid coverage in 2012 had lower average costs ($371/month enrolled in 2021 after adjusting for inflation) than those with six months of coverage ($583/month enrolled) or only three months of coverage ($799/month enrolled).[25] Cost impacts may be especially pronounced for beneficiaries with chronic conditions. For example, Medicaid beneficiaries with diabetes with a lapse in coverage had per member per month costs that were $239 greater during the three months after reenrollment than in the three months prior to the coverage lapse.[26] Thus, by reducing churn, states spend more on Medicaid overall, but do so in a more efficient manner that improves care for beneficiaries: continuous coverage leads to more predictability in monthly caseload expenditures, lower average monthly spending, lower enrollee spending on administrative costs, and better overall continuity of care for beneficiaries.

## FAMILIES FIRST CORONAVIRUS RESPONSE ACT

### Maintenance of Eligibility and Continuous Enrollment

FFCRA provides a 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) for certain Medicaid spending to support states and promote coverage stability during the pandemic. To receive the enhanced FMAP, states must meet certain maintenance of eligibility (MOE) requirements, including ensuring continuous enrollment for current enrollees through the end of the public health emergency.[27] Following enrollment declines from 2017 through 2019, preliminary data show that total Medicaid and CHIP enrollment grew to 77.3 million in September 2020, an increase of almost 6.7 million (9.4 percent) from actual enrollment in February.[28] Medicaid enrollment is increasing at a much greater rate than applications. Thus, enrollment increases are likely being driven by existing enrollees remaining eligible due to the FFCRA MOE requirements.[29]

Upon conclusion of the public health emergency, normal state Medicaid operations will resume, including eligibility redetermination. This will represent a substantial and unprecedented undertaking for Medicaid programs, with the potential for significant coverage losses and disruptions. The end of the public health emergency may be a natural time to consider making Medicaid coverage more stable and less administratively burdensome using some of the policies described in this Issue Brief, including the American Rescue Plan's (ARP) new option for continuous eligibility for women after childbirth.

## POLICY OPTIONS TO ADDRESS CHURNING

### ACA Medicaid Expansion to Adults

Research has found that part of the ACA's reduction in the uninsured rate can be attributed to increased retention of Medicaid enrollees, and states that have adopted the Medicaid adult group expansion have lower rates of churning in and out of Medicaid than non-expansion states.[30] Among Medicaid beneficiaries aged 19–64, disruption in coverage decreased by 4.3 percentage points in states that expanded Medicaid compared to states that have not expanded, amounting to approximately half a million beneficiaries maintaining their coverage each year. Among pregnant women, nearly half of women in Medicaid non-expansion states experienced an insurance disruption from preconception to postpartum between 2015-2017, compared to one-third of women in Medicaid expansion states.[31,32] Further, there was a greater decrease in disruptions of coverage among people of color compared to white individuals in expansion states compared to non-expansion states. Researchers have highlighted three likely ways Medicaid expansion has reduced churning:

1. The higher income threshold of 138 percent of FPL accommodated larger monthly fluctuations in income without loss of eligibility;
2. The standardized upper eligibility threshold simplified requirements across states; and
3. Expansion states generally increased their outreach efforts and enrollment assistance for Medicaid.[33]

Moreover, expanding Medicaid to more parents also benefits their children. Family coverage has been shown to play an important role in whether eligible children renew their coverage in Medicaid or CHIP,[34] and research demonstrates that states that have expanded Medicaid coverage for low-income parents have experienced significantly greater gains in enrollment among eligible children as well.[35]

The ARP encourages non-expansion states to take up Medicaid expansion by providing an additional temporary fiscal incentive. Under the ARP, states receive the ACA 90% FMAP for the adult group expansion population costs. In addition, states that do not have expansion in place when the ARP was enacted are eligible for a 5 percentage-point increase in the state's traditional FMAP rate for two years (2021-2022) if they implement the expansion for the adult group. The traditional FMAP applies to most services for non-expansion groups, including children, non-expansion adults, seniors, and people with disabilities.[36] In addition to receiving the ARP's temporary FMAP increase, states will also receive the 90 percent ACA FMAP for the expansion population costs.

### Continuous Coverage

Continuous eligibility policies allow Medicaid beneficiaries to maintain continuous coverage even if they experience a change in circumstances (e.g., income) during the continuous eligibility period. One 2015 analysis found Medicaid churning within a calendar year would decrease by 30 percent with 12 months of continuous eligibility. This translates to 20 percent (5 million) more beneficiaries covered all year, increasing the average monthly caseload by 17 percent (6.8 million).[37]

States have been able to allow children to stay enrolled in Medicaid and/or CHIP for up to 12 months regardless of changes in their families' circumstances under the "continuous eligibility" option since 1997. As of January 2020, 23 states provide 12-month continuous eligibility for children in Medicaid and 25 states do so for children enrolled in CHIP.[38] Children living in these states are much less likely to be uninsured (7.8 percent vs. 11.7 percent) and to have had a gap in coverage in the previous 12 months (11 percent vs. 15.9 percent) compared to children in states without continuous eligibility.[39]

While not the same as continuous eligibility (which guarantees ongoing coverage even with a change in circumstance), extending the time period for eligibility renewals and redeterminations can also impact continuity in coverage. In the first two years after California extended its Medicaid redetermination period for children from 3 months to 12 months, the percentage of children who had continuous coverage increased from 49 percent to 62 percent, and there was a reduction in hospitalizations related to ambulatory care-sensitive conditions, reducing hospital spending by $17 million.[40]

Two states, Montana and New York, have approved 1115 demonstration projects that provide continuous eligibility for adult group beneficiaries. The Medicaid and CHIP Payment and Access Commission (MACPAC) has recommended that Congress create a state plan continuous eligibility option for adults in Medicaid so states could adopt it without a waiver, concluding that the option would reduce "churning and the negative health effects that may result."[41] In evaluating the New York and Montana demonstrations that extended continuous eligibility to adults, the Centers for Medicare & Medicaid Services (CMS) estimated that increased enrollment due to the policy would raise costs for the Medicaid expansion population by 2 to 3 percent, which is similar to cost increases seen in states when extending continuous coverage to children.[42]

The ARP established a new state plan option for states to extend postpartum coverage in Medicaid and CHIP to women for 12 months and provide continuous eligibility through the extended postpartum period. Starting in April 2022, women covered under this option will receive comprehensive Medicaid benefits, not just pregnancy-related benefits, and will have continuous eligibility for the extended postpartum coverage period regardless of change in circumstances for the 12-month period. This option will be available to states for five years, granting states the opportunity to extend postpartum coverage without a section 1115 demonstration.[43] Medicaid covers about 42 percent of all births in the U.S., so extending Medicaid coverage in the postpartum period may increase rates of health insurance coverage during this period. This new option also may help address the U.S.'s high rates of maternal mortality and severe morbidity, which include deaths up to one year postpartum, particularly among Black and American Indian and Alaska Native (AI/AN) mothers. Overall, Black and AI/AN women are 2 to 3 times more likely to die of pregnancy-related causes than white women. These disparities exist across all age groups but increase with maternal age. For example, in the under 20 age group, Black women have a pregnancy-related mortality rate 1.5 times higher than white women, but in the 30-34 age group, Black women have a mortality rate 4 times higher.[44] While maternal mortality rates generally decrease with education attainment, racial and ethnic disparities in the rates widen. College-educated Black women have maternal mortality rates over 5 times higher than college-educated white women and over 1.6 times higher than white women without a high school diploma. Similarly, maternal morbidity rates are almost twice as high among Black and AI/AN women than among white women.[45] Black and AI/AN individuals also account for a larger proportion of Medicaid beneficiaries compared to the overall U.S. population, raising the importance of Medicaid coverage policies in addressing racial and ethnic disparities in maternal health outcomes. [46]

All state Medicaid programs must provide pregnancy-related coverage under the state plan regardless of changes in income, through the end of the month that a 60-day postpartum period ends, at which point women who qualify for Medicaid on the basis of pregnancy risk becoming uninsured or experiencing disruptions in coverage. Women in states that have not expanded Medicaid to the adult group are particularly vulnerable as states' income eligibility levels for parents are often much lower than for pregnancy.[47] Some states have sought to extend Medicaid's postpartum period through section 1115 demonstration projects. To date, CMS has approved targeted extensions of postpartum coverage in the Georgia Planning for Healthy Babies demonstration and the South Carolina Palmetto Pathways to Independence demonstration, as well as in a number of states that have used section 1115 authority to extend the duration of Medicaid eligibility for pregnant women beyond the 60-day postpartum period to provide a benefit of family planning and related preventive women's health services. In addition, five states (Georgia, Indiana, Missouri, New Jersey, and Texas) have pending section 1115 requests for postpartum coverage extensions from six months up to 12 months, including the existing 60-day postpartum period.[ii] Four of these states are seeking to provide full Medicaid benefits beyond the standard 60-day postpartum period. One state seeks to provide targeted benefits to address major health conditions recognized as contributing to maternal morbidity and mortality. These states are also seeking to align the continuous eligibility period provided to pregnant women with the extended postpartum period to maintain enrollment regardless of changes in income. In addition, through a state funded program, California has extended coverage for up to 12 months for eligible individuals diagnosed with a maternal mental health condition, such as postpartum depression, through the state's Provisional Postpartum Care Extension.[48]

### Express Lane Eligibility and Presumptive Eligibility

Express Lane Eligibility (ELE) allows states to use eligibility findings from other public programs to verify Medicaid and CHIP eligibility for children, eliminating duplication of administrative efforts and easing the burden on families from having to provide the same information to multiple agencies.[49] ELE agencies may include: Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Women, Infants, and Children (WIC).[50] ELE may be adopted by states through a state plan amendment, which 13 states have done for children in Medicaid and/or CHIP. These states have reported reduced administrative burden and cost savings.[51]

Presumptive Eligibility (PE) is a Medicaid state option to allow specific "qualified entities," such as health care providers, hospitals, schools, government agencies and community-based organizations, to screen pregnant women, children, parents and other non-elderly adults for Medicaid eligibility and temporarily enroll them. These policies allow individuals determined presumptively eligible to secure covered health care services without delay while they complete the regular application process for ongoing coverage. As of January 2020, 30 states had implemented PE policies for pregnant women, 19 states had PE for children, 9 states had PE for parents, and 8 states provided PE for other non-elderly adults.[52] PE can be used in conjunction with targeted efforts at the community level to find and enroll the hardest to-reach, uninsured children. It also simplifies the enrollment process through direct, one-on-one assistance.[53]

ELE and PE policies support President Biden's whole-of-government equity agenda.[54] A central component of this agenda is identifying and addressing barriers that underserved communities and individuals may face related to enrollment in and access to benefits and services in federal programs.

### Shared Plans between Medicaid and Marketplace

Having the same insurers in both Medicaid and the Marketplace can help keep beneficiaries in more consistent coverage, with similar provider networks and formularies, even if they have to transition from Medicaid to Marketplace or vice versa.[55] The ability for issuers to participate across multiple public financing arrangements and provide stable provider networks is essential to achieving continuity of care.[56] Medicaid managed care companies may be suited to playing a role in this area. In 2021, 47 percent of all parent insurers offered a Marketplace plan and Medicaid plan in the same state, and there were 36 states with at least one of these parent insurers.[57] However, these multimarket plans – while reducing the potential disruption from churning – only address churning between Medicaid and Marketplace coverage (but not employer coverage) and do not eliminate the underlying disruption in coverage, unlike some of the other policies discussed earlier.

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[ii] Illinois received approval on April 12, 2021 for a demonstration project extending postpartum coverage for 12 months.

**Limiting Premiums and Cost-Sharing**

Using section 1115 authorities, states have implemented premiums and cost sharing in Medicaid with the stated goals of promoting personal responsibility, preparing beneficiaries to transition to commercial and private insurance, and supporting consumers in making value-conscious health decisions. However, research has shown premiums act as a barrier to accessing care and maintaining coverage, including increasing disenrollment and shortening length of enrollment in Medicaid and CHIP among adults and children.[58] [59]

## CONCLUSION

Churning between sources of health coverage, including periods without health insurance, occurs frequently in the Medicaid and CHIP population and is associated with adverse effects on health care access. Continuous coverage or allowing beneficiaries to maintain Medicaid coverage for a set period of time irrespective of changes in their circumstances, helps prevents disruptions in health care for beneficiaries and provides states more predictable and efficient spending. While the FFCRA MOE and continuous enrollment requirements have temporarily halted most Medicaid churning, the pandemic's health and economic toll has increased the importance of the Medicaid program for beneficiaries and providers, and there is the potential for significant coverage disruptions and losses of health insurance coverage when the public health emergency ends. As states prepare to return to normal operations, policymakers should consider a range of policies that promote more stable coverage in the Medicaid population, including Medicaid expansion and continuous coverage options such as those created by the ARP.

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# Florida

## SUMMARY

According to CCF's child health coverage report, the number of uninsured children stabilized in 2022 due in large part to the continuous coverage protection that prevented children from being disenrolled from Medicaid during the COVID-19 public health emergency. However, the continuous coverage protection has now been lifted and children are losing coverage as Florida redetermines eligibility for everyone enrolled. Nationwide, an estimated three out of four children losing coverage during this period will still be eligible for Medicaid or CHIP but could fall through the cracks due to procedural issues.

Health coverage is important for children because it improves access to pediatrician-recommended care and services that support healthy development. When children get the health care they need, they are more likely to succeed in school, graduate from high school and attend college, earn higher wages, and grow up into healthy adults. Scroll down for an in-depth look at child health care trends across Florida.

# Coverage Trends

Health care coverage is important for children because it improves access to pediatrician-recommended care and services that support healthy development. When children get the health care they need, they are more likely to succeed in school, graduate from high school and attend college, earn higher wages, and grow up into healthy adults. Scroll down for an in-depth look at child health care trends in this state.

**Uninsured** Florida

# 7.4%

of **children** do not have health insurance

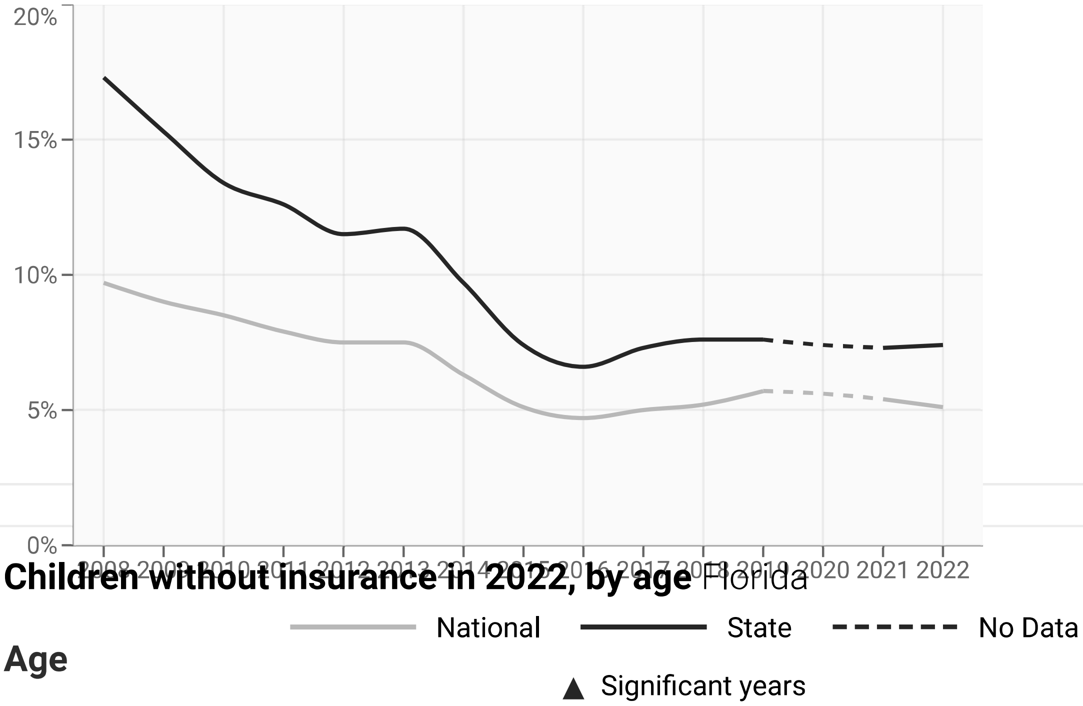
Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) Health Insurance Historical Table HIC-5. Health Insurance Coverage Status and Type of Coverage by State—Children Under 19: 2008 to 2022. Because of data quality issues related to the pandemic, the Census Bureau did not publish standard, comparable 1-year estimates for 2020; CCF excludes 2020 ACS data from all of its analyses.

Rank among states 2022

**46**/51

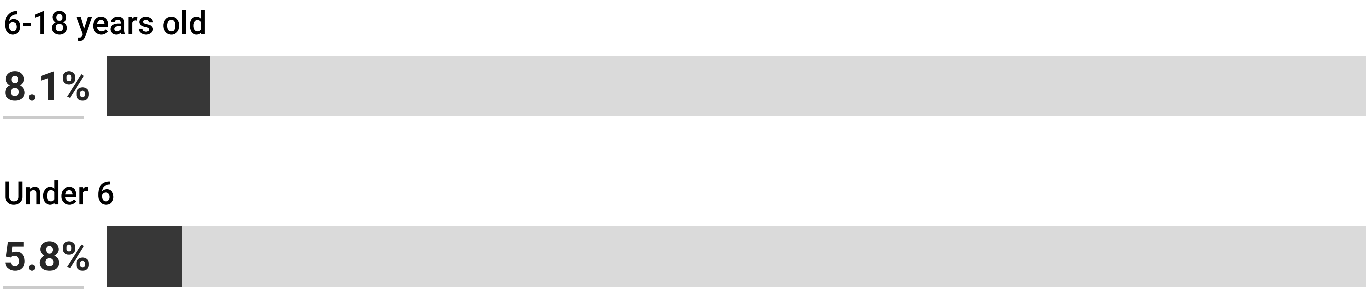
When children are uninsured, they are more likely to have unmet health needs and lack a usual source of care, diminishing their chances to grow into healthy and productive adults.

Rate of uninsured children under 19.



## **Children without insurance in 2022, by age** Florida

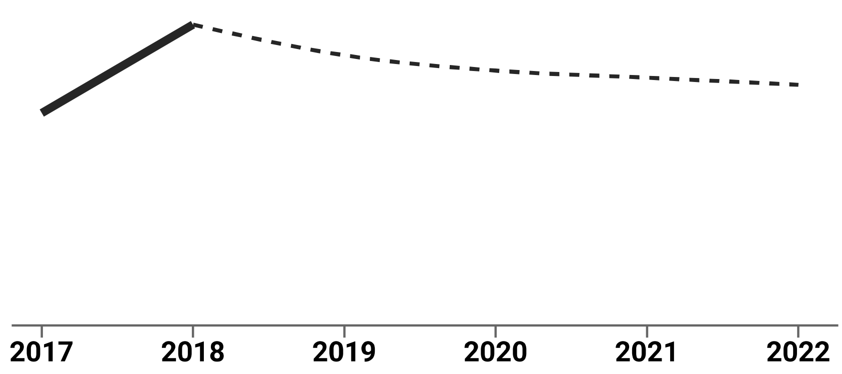
### Age



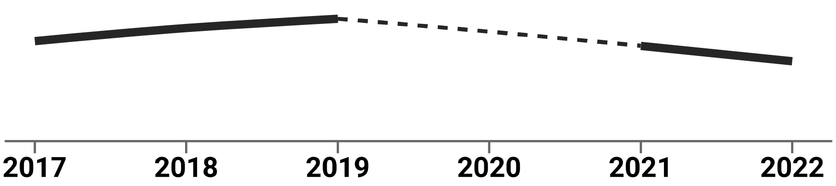
Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau 2022 American Community Survey (ACS), Table S2701: Selected Characteristics of Health Insurance Coverage in the United States.

## **Children without insurance, by Race** Florida

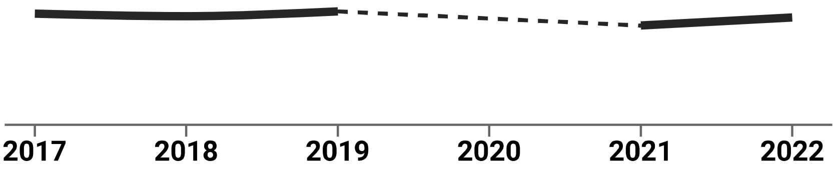
### American Indian/Alaskan Native



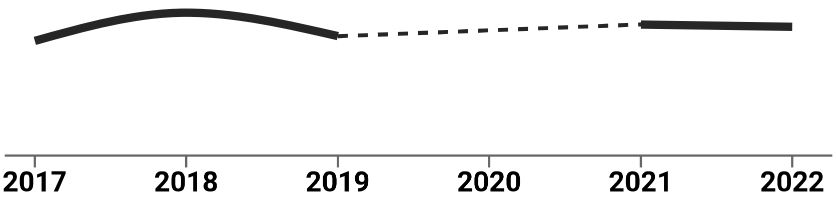
### Asian/Native Hawaiian/Pacific Islander



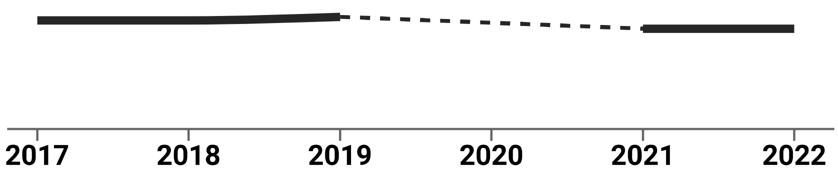
### Black/African American



### Other/Multiracial



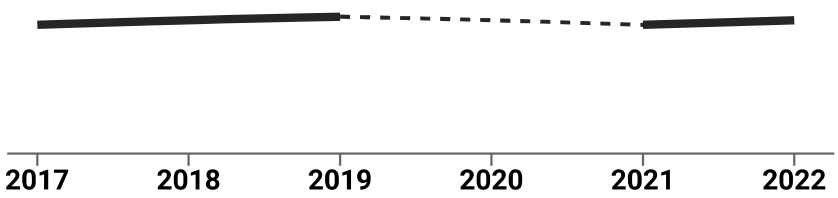
### White



Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau 2022 American Community Survey (ACS), Tables C27001A-I: Health Insurance Coverage Status by Age. Triangles indicate change is statistically significant at the 90% confidence level relative to the prior year indicated. Blank data indicates that an estimate is not available due to insufficient sample. In 2020, the Census Bureau made changes to the ACS race and ethnicity questions, which may affect health coverage comparisons related to race and ethnicity. As a result, the Census Bureau recommends caution in comparing 2019-2021 ACS estimates related to race and caution in comparing both 2019-2021 and 2021-2022 ACS estimates related to ethnicity.

## **Children without insurance, by Ethnicity** Florida

### Hispanic/Latino

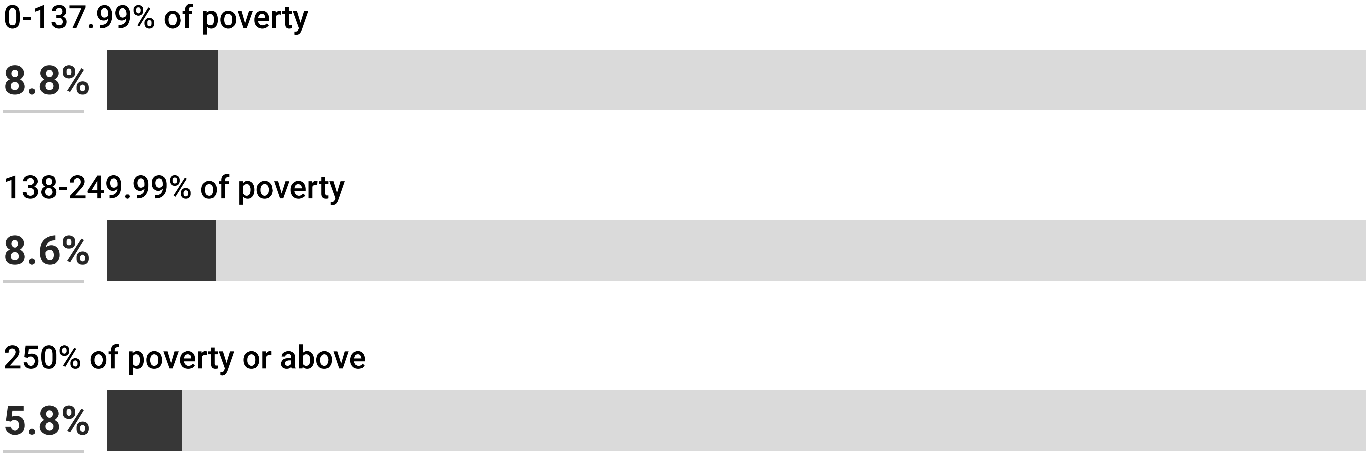


### Not Hispanic/Latino

Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau 2022 American Community Survey (ACS), Tables C27001A-I: Health Insurance Coverage Status by Age. Triangles indicate change is statistically significant at the 90% confidence level relative to the prior year indicated. Blank data indicates that an estimate is not available due to insufficient sample. In 2020, the Census Bureau made changes to the ACS race and ethnicity questions, which may affect health coverage comparisons related to race and ethnicity. As a result, the Census Bureau recommends caution in comparing 2019-2021 ACS estimates related to race and caution in comparing both 2019-2021 and 2021-2022 ACS estimates related to ethnicity.

## **Children without insurance in 2022, by poverty threshold** Florida

### Child Uninsured Rate by Poverty Threshold: Income by Percentage/Dollars in Florida

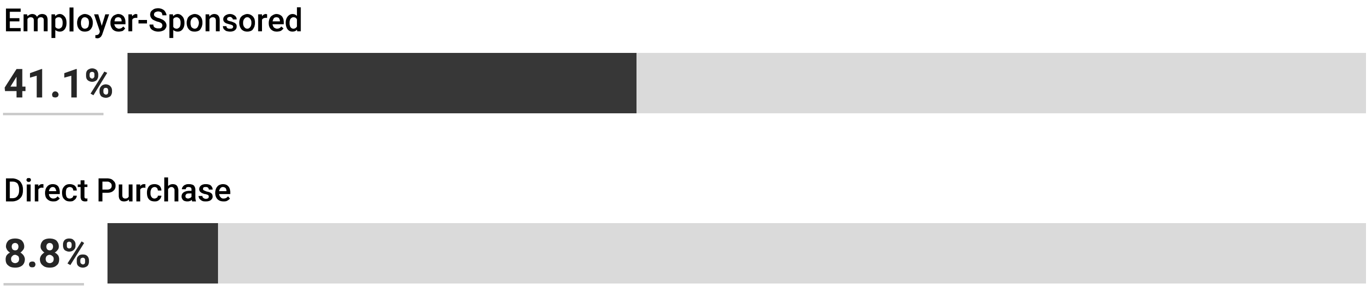


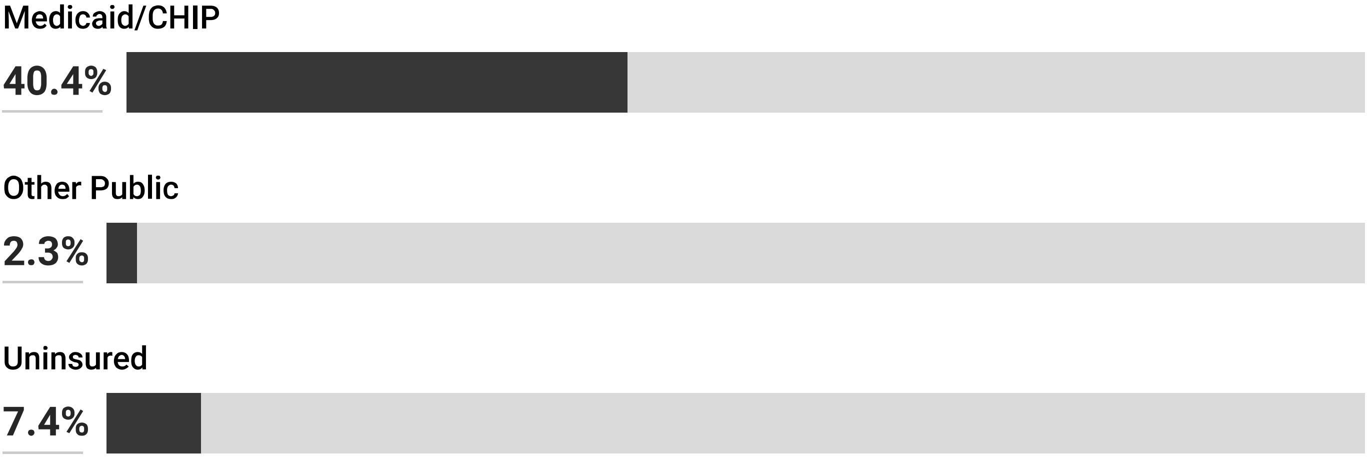
Source: Georgetown University Center for Children and Families analysis of the U.S. Census Bureau 2022 American Community Survey (ACS), Table B27016: Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age. Census Poverty Thresholds differ from the Poverty Guidelines (commonly known as the Federal Poverty Level or FPL) determined by the U.S. Department of Health and Human Services (HHS), and may differ considerably for the separate FPLs that HHS determines for Alaska and Hawaii. Dollar amounts shown reflect 2024 Poverty Guidelines.

## **How are children covered?** Florida

### Sources of Coverage for Children in Florida

Source: KFF, "Health Insurance Coverage of Children 0-18," available at https://www.kff.org/other/state-indicator/children-0-18/.





**Participation in Medicaid/CHIP** Florida

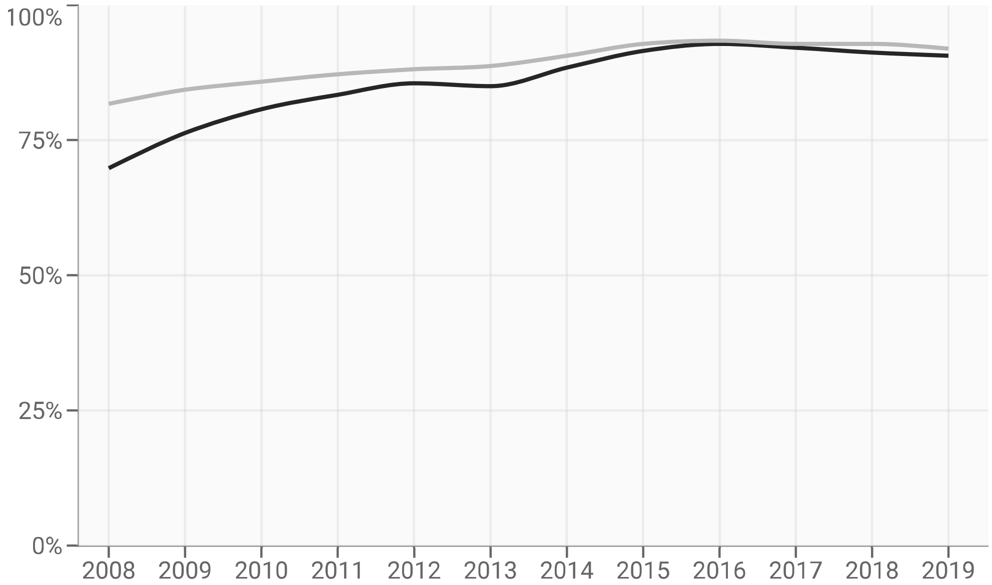
# 90.6%

of all eligible children participate in Medicaid/CHIP

Source: Haley, J., et al., “Uninsurance Rose among Children and Parents in 2019: National and State Patterns,” (Washington D.C.: The Urban Institute, July 2021); and Haley, J., et al., “Progress in Children’s Coverage Continued to Stall Out in 2018: Trends in Children’s Uninsurance and Medicaid/CHIP Participation,” (Washington D.C.: The Urban Institute, October 2020).

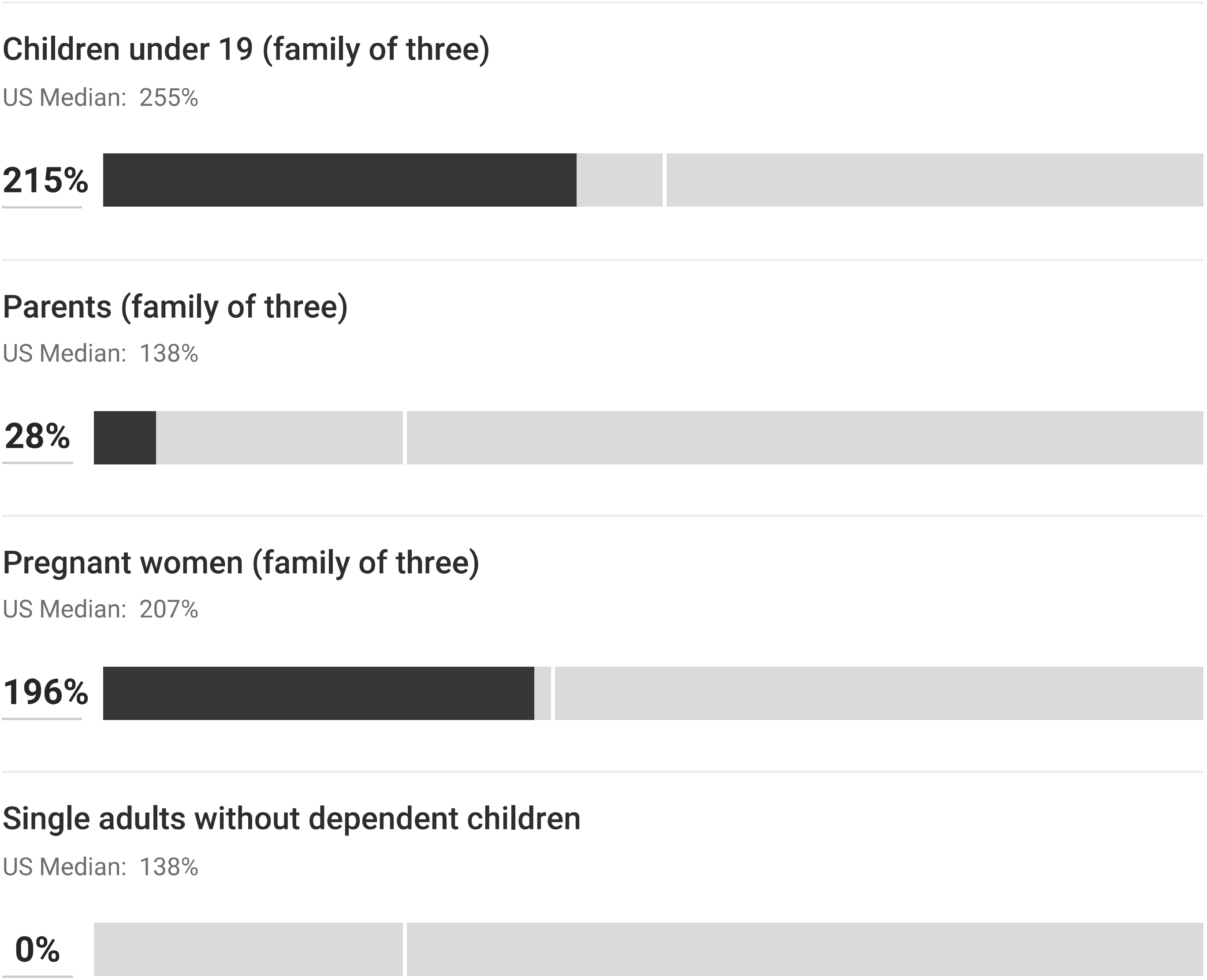
Many children who are eligible for Medicaid/CHIP may not be enrolled due to a lack of public outreach or administrative barriers. The child participation rates show the percentage of eligible children who are enrolled in Medicaid/CHIP.

Children's participation rate in Medicaid/CHIP over the last 10 years.



**Who Qualifies?** Florida

**Eligibility**: Upper income threshold for Medicaid/CHIP



Source: Brooks, T. et al., "Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision," (Georgetown University Center for Children and Families and Kaiser Family Foundation, March 2023), available at https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-prepare-for-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision/. Dollar amounts shown reflect 2024 Poverty Guidelines determined by the U.S. Department of Health and Human Services (HHS).

## Policy Options

Medicaid is a primary source of health insurance for children, providing guaranteed coverage, pediatrician recommended services, and premium and cost-sharing protections. Each state has the flexibility to design its program within federal guidelines as a condition of federal matching funds. The Children's Health Insurance Program (CHIP) builds on Medicaid to cover children in working families who are not eligible for Medicaid but cannot afford private coverage. Each state designs its program within federal parameters (and can expand Medicaid and/or establish a separate state program) but all CHIP programs provide affordable coverage with pediatric-appropriate benefits and networks. Within Medicaid and CHIP, states have several policy options available to help remove barriers to health coverage and improve children's enrollment and retention. Scroll down to see which policy options this state is leveraging to improve health coverage.

**Policy options** Florida

| | |
|---|---|
| **12-Month Continuous Child Eligibility (Medicaid)**<br>All states are required to provide 12 months of continuous eligibility starting January 1, 2024. | ✓ |
| **12-Month Continuous Child Eligibility (CHIP)**<br>All states are required to provide 12 months of continuous eligibility starting January 1, 2024. | ✓ |
| **No CHIP Waiting Period** | 2 months |
| **Child Eligibility for Lawfully Residing Immigrants (Medicaid)** | ✓ |
| **Child Eligibility for Lawfully Residing Immigrants (CHIP)** | ✓ |
| **Presumptive Eligibility for Children's Coverage (Medicaid)** | ✗ |

| | |
|---|---|
| **Presumptive Eligibility for Children's Coverage (CHIP)** | ✗ |
| **Allow Schools to be Reimbursed for Medicaid Services without IEP** | ✓ |
| **Medicaid Expansion** | ✗ |
| **Eligibility for Lawfully Residing Immigrants during Pregnancy (Medicaid)** | ✗ |
| **Eligibility for Lawfully Residing Immigrants during Pregnancy (CHIP)** | N/A |
| **Eligibility for From-Conception-to-End-of-Pregnancy Option in CHIP**<br>Formerly called "Unborn Child Option" | ✗ |
| **Postpartum Coverage**<br>Section 1115 Demonstration | 12 months |
| **Presumptive Eligibility for Pregnancy Coverage (Medicaid)** | ✓ |
| **Presumptive Eligibility for Pregnancy Coverage (CHIP)** | N/A |

Source: Georgetown University Center for Children and Families and Kaiser Family Foundation, “Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies: Findings from a 50-State Survey.” This survey is conducted annually; these data draw from surveys for 2020-2023.

# Quality of Care

Medicaid has been successful in providing children with a usual source of care while significantly reducing unmet or delayed needs for medical care, dental care, and prescription drugs due to costs. Focus on improving the quality of care for children covered by Medicaid/CHIP is critical to eliminating health disparities and further boosting the broader, long-term impacts of public coverage on children as evidenced by studies showing that Medicaid leads to better health, higher educational achievement, and greater economic success later in life. As Medicaid increasingly turns to private managed care as the primary delivery system, measuring quality is a critical check on plan performance in providing required services and benefits. The Child Core Set, a set of standardized, evidence-based measures to assess the quality of care and health outcomes for children covered by Medicaid/CHIP, are an important tool for measuring how states are performing. Reporting is currently voluntary for states, but reporting of these measures will be mandatory in 2024. Scroll down to learn more about how this state is performing on health care quality measures.

**Quality Measures** Florida

**Florida reporting on Behavioral Health Care, 2020**

## Behavioral Health Care

**FL Rate** Worst Median Best

Follow-Up After Hospitalization for Mental Illness: Ages 6 - 17 (Follow Up Visit Within 7 Days of Discharge)

★★★★

**37.9%**

Follow-Up After Hospitalization for Mental Illness: Ages 6 - 17 (Follow Up Visit Within 30 Days of Discharge)

☆☆★★

**61.8%**

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Ages 6 to 12 (1 Follow-Up Visit During the 30 Day Initiation Phase)

☆☆★★

**45.5%**

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Ages 6 to 12 (At Least 2 Follow-Up Visits During the 9 Month Continuation and Maintenance Phase Following Initiation Phase)

☆☆★★

**57.3%**

Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 to 17 (Blood Glucose Testing)

☆☆★★

**53.3%**

Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 to 17 (Cholesterol Testing)

☆☆☆★

**40.1%**

Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 to 17 (Blood Glucose and Cholesterol Testing)

☆☆☆★

**37.4%**

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to 17

★★★★

**60.5%**

**Florida reporting on Care of Acute and Chronic Conditions, 2020**

## Care of Acute and Chronic Conditions

**FL Rate** Worst Median Best

Asthma Medication Ratio: Ages 5 to 11

★★★★

**82.8%**

Asthma Medication Ratio: Ages 12 to 18

★★★★

**74.3%**

Asthma Medication Ratio: Ages 5 to 18

★★★★

**79.5%**

Ambulatory Care: Emergency Department (ED) Visits: Ages 0 to 19

★★★★

**55.5%**

**Florida reporting on Dental and Oral Health Services, 2020**

## Dental and Oral Health Services

**FL Rate** Worst Median Best

Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk

★★★★

**31.8%**

Percentage of Eligibles Who Received Preventive Dental Services: Ages 1 to 20

★★★★

**33.2%**

**Florida reporting on Maternal and Perinatal Health, 2020**

## Maternal and Perinatal Health

**FL Rate** Worst Median Best

Contraceptive Care: All Women Ages 15 to 20 (Most Effective or Moderately Effective Method of Contraception)

★★★★

**20.2%**

Contraceptive Care: All Women Ages 15 to 20 (Long Acting Reversible Method of Contraception)

★★★★

**1.4%**

Contraceptive Care: Postpartum Women Ages 15 to 20 (Most or Moderately Effective Method of Contraception within 3 Days of Delivery)

★★★★

**1.8%**

Contraceptive Care: Postpartum Women Ages 15 to 20 (Most or Moderately Effective Method of Contraception within 60 Days of Delivery)

★★★★

**36.3%**

Contraceptive Care: Postpartum Women Ages 15 to 20 (Long-Acting Reversible Method of Contraception within 3 Days of Delivery)

★★★★

**0.5%**

Contraceptive Care: Postpartum Women Ages 15 to 20 (Long-Acting Reversible Method of Contraception within 60 Days of Delivery)

★★★★

**10.6%**

Prenatal and Postpartum Care: Timeliness of Prenatal Care (Prenatal Care within the First Trimester or 42 Days of Medicaid/CHIP Enrollment)

★★★★

**91.5%**

Live Births Weighing Less Than 2,500 Grams

★★★★

**9.7%**

Prenatal and Postpartum Care: Postpartum Care (At Least One Visit on or Between 7 and 84 Days after Delivery)

★★★★

**73.3%**

### Florida reporting on Primary Care Access and Preventive Care, 2020

## Primary Care Access and Preventive Care

**FL Rate** Worst Median Best

Adolescent Well-Care Visits: Ages 12 to 21

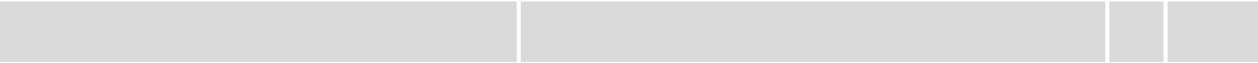
★★★★

**62.8%**

Childhood Immunization Status: Age 2 (Measles, Mumps, and Rubella (MMR) Vaccine)

★★★★

**NR%**



Childhood Immunization Status: Age 2 (Combination 3)

★★★★

**74.4%**

Chlamydia Screening in Women Ages 16 to 20

★★★★

**61.7%**

Developmental Screening in the First Three Years of Life: Ages 0 to 3

★★★★

**15.3%**

Immunizations for Adolescents: Age 13 (Human Papillomavirus (HPV) Series)

★★★★

**40.9%**

Immunizations for Adolescents: Age 13 (Combination 1: Meningococcal Conjugate and Tdap Vaccines)

★★★★

**75.6%**

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Ages 3 to 17 (Body Mass Index (BMI) Percentile Documentation)

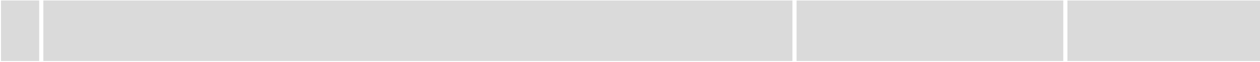
★★★★

**88.6%**

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Ages 3 to 17 (Counseling for Nutrition)

★★★★

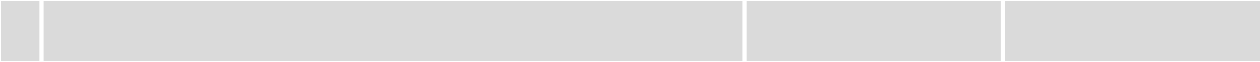
**NR%**



Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Ages 3 to 17 (Counseling for Physical Activity)

★★★★

**NR%**



### Well-Child Visits in the First 15 Months of Life (6 or More)

★★★★

**72.5%**

### Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

★★★★

**79.2%**

Source: Georgetown University Center for Children and Families analysis of the Centers for Medicaid and Medicare Services' (CMS) FFY 2020 Child Health Quality Measures Dataset. All figures reflect either Medicaid and CHIP beneficiaries combined or Medicaid alone. CHIP-only data was not used. Measures with fewer than 25 states reporting nationally are not reported by CMS and are not included in this analysis.

# Maternal & Early Childhood

The health of children and pregnant women has been a long-standing national priority and Medicaid has been the primary means of backing up this commitment. A child's brain develops most rapidly in the earliest months and years of life, building the foundation for future lifelong success. Healthy child development begins with healthy parents who have access to health coverage before, during and after a pregnancy. The bonds and relationships formed in the earliest years of a child's life shape their early learning and development. Medicaid, along with CHIP, serves the vast majority of children in low-income families and covers about half of U.S. births each year. Scroll down to learn more about how this state is doing on child and maternal health care.

**Quality Measures** Florida

**Florida reporting on Maternal and Perinatal Health, 2020**

## Maternal and Perinatal Health

**FL Rate** Worst Median Best

Contraceptive Care: All Women Ages 15 to 20 (Most Effective or Moderately Effective Method of Contraception)

★★★★

**20.2%**

Contraceptive Care: All Women Ages 15 to 20 (Long Acting Reversible Method of Contraception)

★★★★

**1.4%**

Contraceptive Care: Postpartum Women Ages 15 to 20 (Most or Moderately Effective Method of Contraception within 3 Days of Delivery)

★★★★

**1.8%**

---

Contraceptive Care: Postpartum Women Ages 15 to 20 (Most or Moderately Effective Method of Contraception within 60 Days of Delivery)

★★★★

**36.3%**

---

Contraceptive Care: Postpartum Women Ages 15 to 20 (Long-Acting Reversible Method of Contraception within 3 Days of Delivery)

★★★★

**0.5%**

---

Contraceptive Care: Postpartum Women Ages 15 to 20 (Long-Acting Reversible Method of Contraception within 60 Days of Delivery)

★★★★

**10.6%**

---

Prenatal and Postpartum Care: Timeliness of Prenatal Care (Prenatal Care within the First Trimester or 42 Days of Medicaid/CHIP Enrollment)

★★★★

**91.5%**

---

Live Births Weighing Less Than 2,500 Grams

★★★★

**9.7%**

### Prenatal and Postpartum Care: Postpartum Care (At Least One Visit on or Between 7 and 84 Days after Delivery)

★★★★

**73.3%**

Source: Georgetown University Center for Children and Families analysis of the Centers for Medicaid and Medicare Services' (CMS) FFY 2020 Child Health Quality Measures Dataset. All figures reflect either Medicaid and CHIP beneficiaries combined or Medicaid alone. CHIP-only data was not used. Measures with fewer than 25 states reporting nationally are not reported by CMS and are not included in this analysis.

This information was collected from the Georgetown University Center for Children and Families (CCF) Children's Health Care Report Card. CCF is a nonpartisan policy and research center, based at the McCourt School of Public Policy's Health Policy Institute, with a mission to expand and improve high-quality, affordable health coverage for America's children and families.

| A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|
| **Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations** | | | | | | |
| | **Previous Federal Fiscal Year** | **Federal Fiscal Year #1** | **Federal Fiscal Year #2** | **Federal Fiscal Year #3** | **Federal Fiscal Year #4** | **Federal Fiscal Year #5** |
| State's Allotment | **$ 671,582,970** | **$ 671,582,970** | **$ 671,582,970** | **$ 671,582,970** | **$ 671,582,970** | **$ 671,582,970** |
| Funds Carried Over From Prior Year(s) | **$ 726,360,344** | **$ 795,423,959** | **$ 817,960,736** | **$ 685,901,504** | **$ 492,980,131** | **$ 252,945,150** |
| SUBTOTAL (Allotment + Funds Carried Over) | **$ 1,397,943,314** | **$ 1,467,006,929** | **$ 1,489,543,706** | **$ 1,357,484,474** | **$ 1,164,563,101** | **$ 924,528,120** |
| Reallocated Funds (Redistributed or Retained that are Currently Available) | | | | | | |
| TOTAL (Subtotal + Reallocated funds) | **$ 1,397,943,314** | **$ 1,467,006,929** | **$ 1,489,543,706** | **$ 1,357,484,474** | **$ 1,164,563,101** | **$ 924,528,120** |
| State's Enhanced FMAP Rate | **72.04%** | **70.57%** | **70.02%** | **69.10%** | **68.59%** | **68.32%** |
| | | | | | | |
| **COST PROJECTIONS OF APPROVED SCHIP PLAN** | | | | | | |
| **Benefit Costs** | | | | | | |
| Insurance payments | | | | | | |
| Total Managed Care | $ 270,256,517 | $ 520,296,387 | $ 661,766,634 | $ 716,483,935 | $ 771,474,494 | $ 828,810,713 |
| per member/per month rate @ # of eligibles | | | | | | |
| Total Fee for Service | | | | | | |
| per member/per month rate @ # of eligibles | | | | | | |
| Total Benefit Costs (Managed Care + Fee for Service) | $ 270,256,517 | $ 520,296,387 | $ 661,766,634 | $ 716,483,935 | $ 771,474,494 | $ 828,810,713 |
| (Offsetting beneficiary cost sharing payments) (negative number) | | | | | | |
| **Net Benefit Costs** | $ 270,256,517 | $ 520,296,387 | $ 661,766,634 | $ 716,483,935 | $ 771,474,494 | $ 828,810,713 |
| | | | | | | |
| **Administration Costs** | | | | | | |
| Personnel | $ 2,074,489 | $ 2,270,009 | $ 2,270,009 | $ 2,270,009 | $ 2,270,009 | $ 2,270,009 |
| General administration | $ 156,800 | $ 242,288 | $ 242,288 | $ 242,288 | $ 242,288 | $ 242,288 |
| Contractors/Brokers | $ 15,849,491 | $ 19,312,947 | $ 20,544,171 | $ 22,990,425 | $ 23,507,600 | $ 17,899,220 |
| Claims Processing | $ - | $ - | $ - | $ - | $ - | $ - |
| Outreach/marketing costs | $ - | $ - | $ - | $ - | $ - | $ - |
| Other (specify) (Employee Expenses) | $ 87,479 | $ 87,479 | $ 87,479 | $ 87,479 | $ 87,479 | $ 87,479 |
| **Total Administration Costs** | $ 18,080,780 | $ 21,825,244 | $ 23,056,468 | $ 25,502,722 | $ 26,019,897 | $ 20,411,517 |
| 10% Administrative Cap | $ 27,025,652 | $ 52,029,639 | $ 66,176,663 | $ 71,648,393 | $ 77,147,449 | $ 82,881,071 |
| | | | | | | |
| Federal Title XXI Share | $ 207,703,772 | $ 382,586,077 | $ 479,506,288 | $ 512,727,619 | $ 547,009,377 | $ 580,171,643 |
| State Share | $ 80,633,525 | $ 159,535,554 | $ 205,316,814 | $ 229,259,037 | $ 250,485,013 | $ 269,050,587 |
| **TOTAL COSTS OF APPROVED SCHIP PLAN** | $ 288,337,297 | $ 542,121,631 | $ 684,823,102 | $ 741,986,656 | $ 797,494,391 | $ 849,222,230 |
| | | | | | | |
| **COST PROJECTIONS FOR DEMONSTRATION PROPOSAL** | | | | | | |
| **Benefit Costs for Demonstration Population #1 (specify)** | | | | | | |
| Insurance payments | | | | | | |
| Total Managed Care | | $16,999,053 | $69,794,099 | $106,984,015 | $125,152,604 | $135,457,940 |
| per member/per month rate @ # of eligibles | | | | | | |
| Total Fee for Service | | | | | | |
| per member/per month rate @ # of eligibles | | | | | | |
| Total Benefit Costs (Managed Care + Fee for Service) | $ - | $ 16,999,053 | $ 69,794,099 | $ 106,984,015 | $ 125,152,604 | $ 135,457,940 |
| **Benefit Costs for Demonstration Population #2 (specify)** | | | | | | |
| Insurance payments | | | | | | |
| Total Managed Care | | | | | | |
| per member/per month rate @ # of eligibles | | | | | | |
| Total Fee for Service | | | | | | |
| per member/per month rate @ # of eligibles | | | | | | |
| Total Benefit Costs (Managed Care + Fee for Service) | $ - | $ - | $ - | $ - | $ - | $ - |
| **Benefit Costs for Demonstration Population #3 (specify)** | | | | | | |
| Insurance payments | | | | | | |
| Total Managed Care | | | | | | |
| per member/per month rate @ # of eligibles | | | | | | |
| Total Fee for Service | | | | | | |
| per member/per month rate @ # of eligibles | | | | | | |
| Total Benefit Costs (Managed Care + Fee for Service) | $ - | $ - | $ - | $ - | $ - | $ - |
| **Benefit Costs for Demonstration Population #4 (specify)** | | | | | | |
| Insurance payments | | | | | | |
| Total Managed Care | | | | | | |
| per member/per month rate @ # of eligibles | | | | | | |
| Total Fee for Service | | | | | | |
| per member/per month rate @ # of eligibles | | | | | | |
| Total Benefit Costs (Managed Care + Fee for Service) | $ - | $ - | $ - | $ - | $ - | $ - |
| | | | | | | |
| **Total Benefit Costs (For All Demonstration Populations)** | $ - | $ 16,999,053 | $ 69,794,099 | $ 106,984,015 | $ 125,152,604 | $ 135,457,940 |
| (Offsetting beneficiary cost sharing payments - if applicable) | | | | | | |
| **Net Benefit Costs** | $ - | $ 16,999,053 | $ 69,794,099 | $ 106,984,015 | $ 125,152,604 | $ 135,457,940 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Administration Costs** | | | | | | |
| Personnel | | $ 456,942 | $ 456,942 | $ 456,942 | $ 456,942 | $ 456,942 |
| General administration | | $ 14,000 | $ 14,000 | $ 14,000 | $ 14,000 | $ 14,000 |
| Contractors/Brokers | | $ 1,686,303 | $ 1,634,728 | $ 1,558,344 | $ 1,720,124 | $ 1,720,079 |
| Claims Processing | | | | | | |
| Outreach/marketing costs | | | | | | |
| Other (specify) | | | | | | |
| **Total Administration Costs** | $ - | $ 2,157,245 | $ 2,105,670 | $ 2,029,286 | $ 2,191,066 | $ 2,191,021 |
| 10% Administrative Cap | $ - | $ 1,699,905 | $ 6,979,410 | $ 10,698,402 | $ 12,515,260 | $ 13,545,794 |
| | | | | | | |
| Federal Title XXI Share | $ - | $ 13,518,983 | $ 50,343,499 | $ 75,330,372 | $ 87,346,296 | $ 94,039,017 |
| State Title XXI Share | $ - | $ 5,637,315 | $ 21,556,270 | $ 33,682,930 | $ 39,997,373 | $ 43,609,944 |
| **TOTAL COSTS FOR DEMONSTRATION** | $ - | $ 19,156,298 | $ 71,899,769 | $ 109,013,301 | $ 127,343,670 | $ 137,648,961 |
| | | | | | | |
| **TOTAL TITLE XXI PROGRAM COSTS (State Plan + Demonstration)** | $ 288,337,297 | $ 561,277,929 | $ 756,722,871 | $ 850,999,958 | $ 924,838,060 | $ 986,871,191 |
| Federal Title XXI Share | $ 207,703,772 | $ 396,105,060 | $ 529,849,787 | $ 588,057,991 | $ 634,355,674 | $ 674,210,660 |
| State Title XXI Share | $ 80,633,525 | $ 165,172,869 | $ 226,873,084 | $ 262,941,967 | $ 290,482,386 | $ 312,660,531 |
| | | | | | | |
| Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds) | $ 1,397,943,314 | $ 1,467,006,929 | $ 1,489,543,706 | $ 1,357,484,474 | $ 1,164,563,101 | $ 924,528,120 |
| Total Federal Title XXI Program Costs (State Plan + Demonstration) | $ 207,703,772 | $ 396,105,060 | $ 529,849,787 | $ 588,057,991 | $ 634,355,674 | $ 674,210,660 |
| Unused Title XXI Funds Expiring (Allotment or Reallocated) | | | | | | |
| Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds) | $ 1,190,239,542 | $ 1,070,901,869 | $ 959,693,919 | $ 769,426,484 | $ 530,207,428 | $ 250,317,460 |

**Note: A Federal Fiscal Year (FFY) is October 1 through September 30.**