Medicaid 101
What Pediatric Department Leaders Should Know

May 9, 2025

Association of Administrators in Academic Pediatrics

Association of Medical School Pediatric Department Chairs
AMSPDC

Session Logistics and Reminders

- The session is being recorded and will be posted on the AMSPDC website
- Keep yourself muted unless speaking
- Please post questions in the chat at any time during the presentation
- All questions will be addressed during the Q&A
- During Q&A - raise hand or post question in chat

Association of Administrators in Academic Pediatrics

Association of Medical School Pediatric Department Chairs, AMSPDC

Speakers

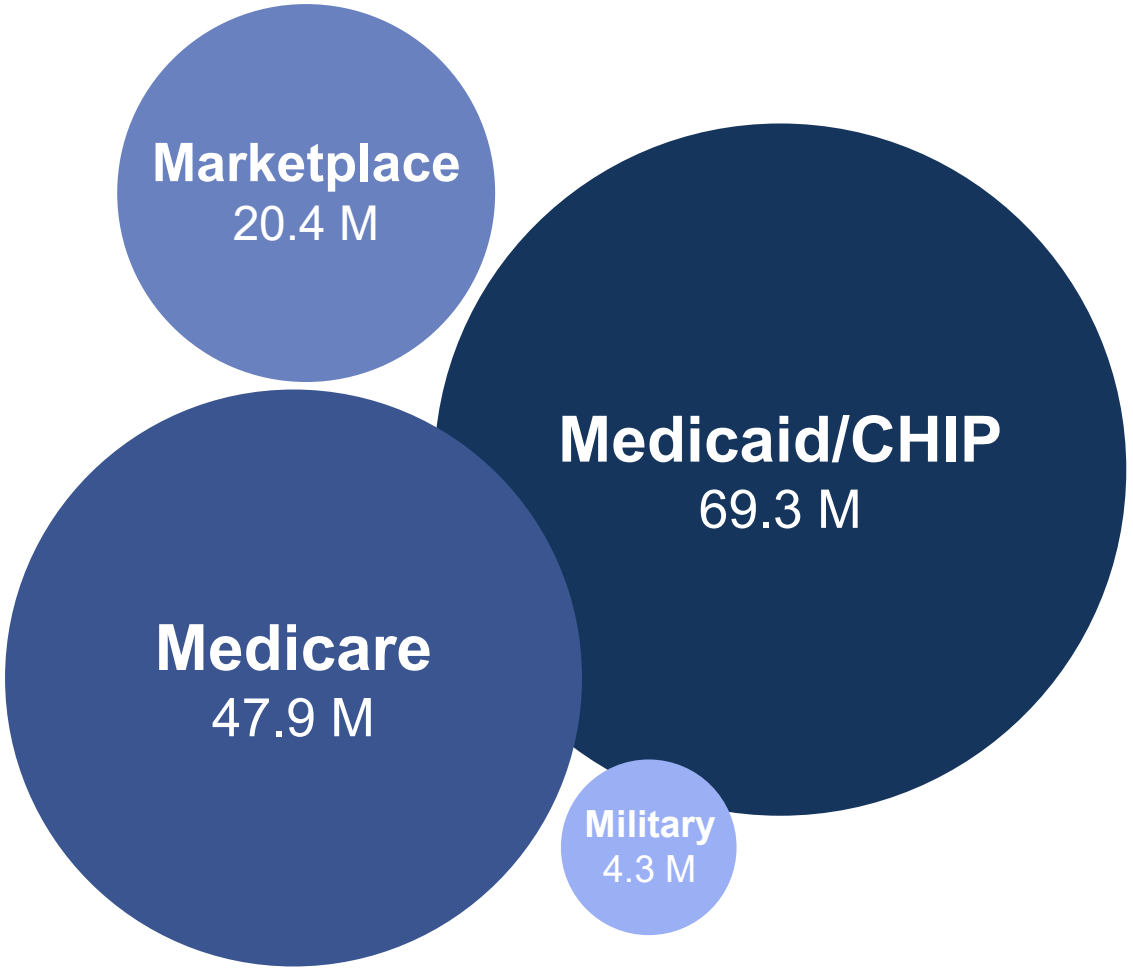
James M. Perrin, MD, FAAP
Professor of Pediatrics Emeritus, Harvard Medical School and MassGeneral for Children

Joan Alker, MPhil
Executive Director and Research Professor
Georgetown University Center for Children and Families

Disclosure Statement

Neither speaker has any relevant conflicts of interest to disclose—financial, ethical, or otherwise—that could influence the content of this presentation.

Health Insurance Supported by Federal Funding, 2023



Source: KFF, Health Insurance Coverage of the Total Population. Individuals who report more that one type of coverage are classified into one group only; individuals who report Medicaid and another source of coverage, including dual eligibles, are counted in the Medicaid category.

Medicaid and CHIP History

- Medicaid: established in 1965 as a public health insurance program for children from low-income families
  - *LBJ wanted universal health coverage – but Congress allowed two different programs – universal for elderly populations; restrictive with lower payment for children, blind people, and people with disabilities*
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (1967) statute requires states to provide all **medically necessary** services even if the service is not included in the state's usual Medicaid services
- Cover about half of all US children and youth

State Children's Health Insurance Program (CHIP)

- Coverage for children/youth in households with incomes too high for Medicaid
- Strong bipartisan support since 1997
- Not entitlement – requires periodic reauthorization

CHIP Differences

- CHIP is a **block grant**; each state has a capped allotment and can refuse an applicant if funds run out *(not entitlement)*
- States choose Medicaid expansions (majority) or standalone CHIP program
- Standalone programs (higher match rate)
  - Can impose premiums and cost-sharing
  - Less generous benefit package
  - Not required to follow EPSDT and other Medicaid rules
- CHIP requires periodic **congressional reauthorization** and is current through September 30, 2029

How do Medicaid and Medicare Differ?

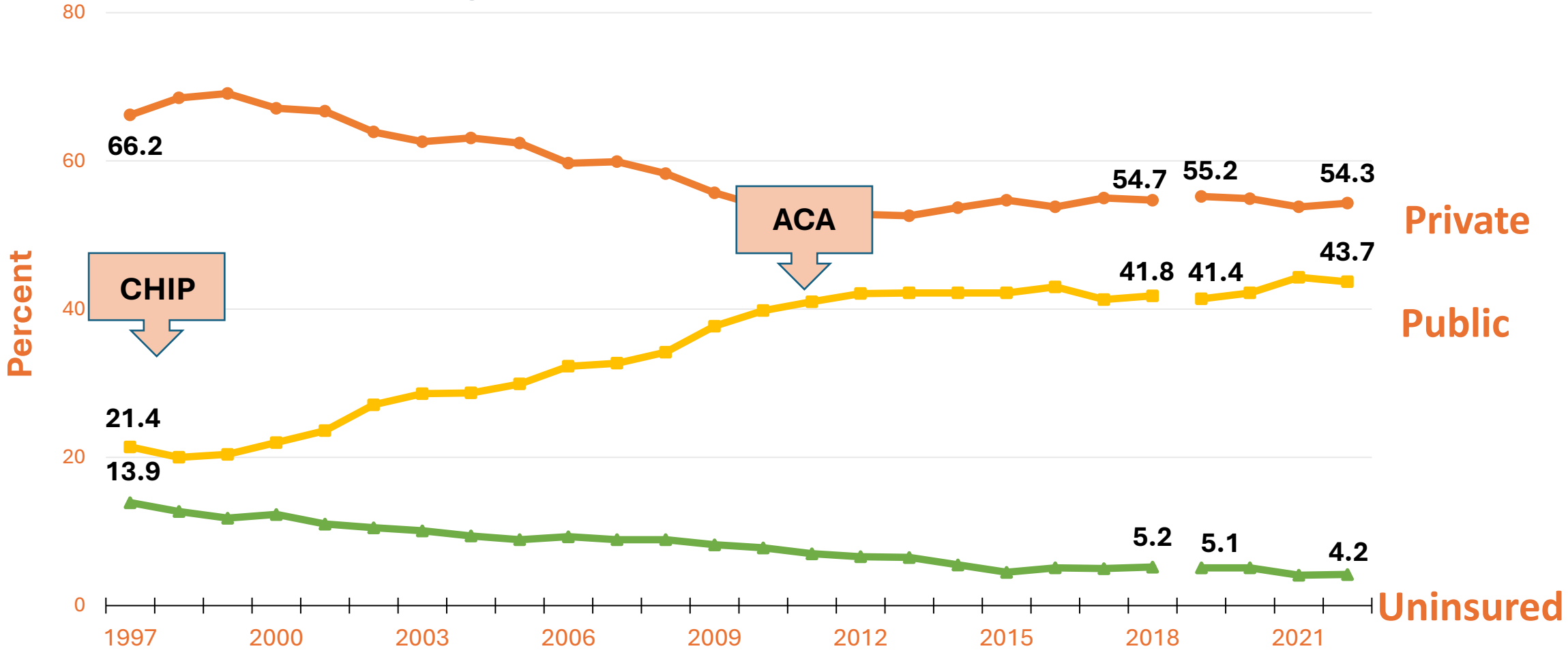
Medicare

- full Federal funding
- national benefit package
  - excludes LT care
- (essentially) national pay structure
- private state intermediaries

Medicaid

- state matching funds (FMAP)
- state options re eligibility, benefits
  - includes LT care
- state fee schedules
- public agencies run program

% of US Children (Ages 0-17) with Health Insurance by Coverage Type at Time of Interview, 1997-2022*

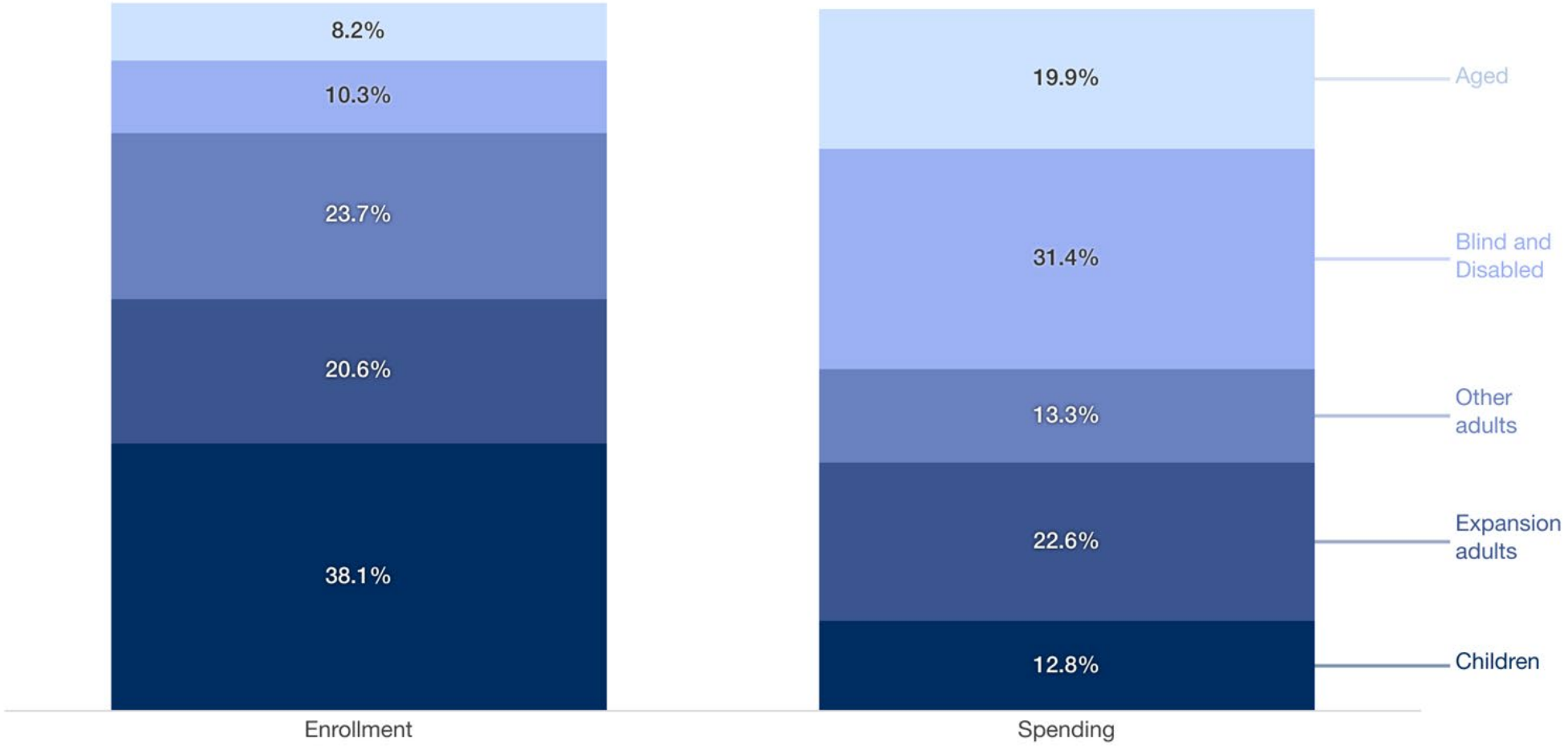


**Estimates for 2019 and beyond are not directly comparable to previous years due to a survey re-design.*

Source: CDC/NCHS, National Health Interview Survey – complied by American Academy of Pediatrics

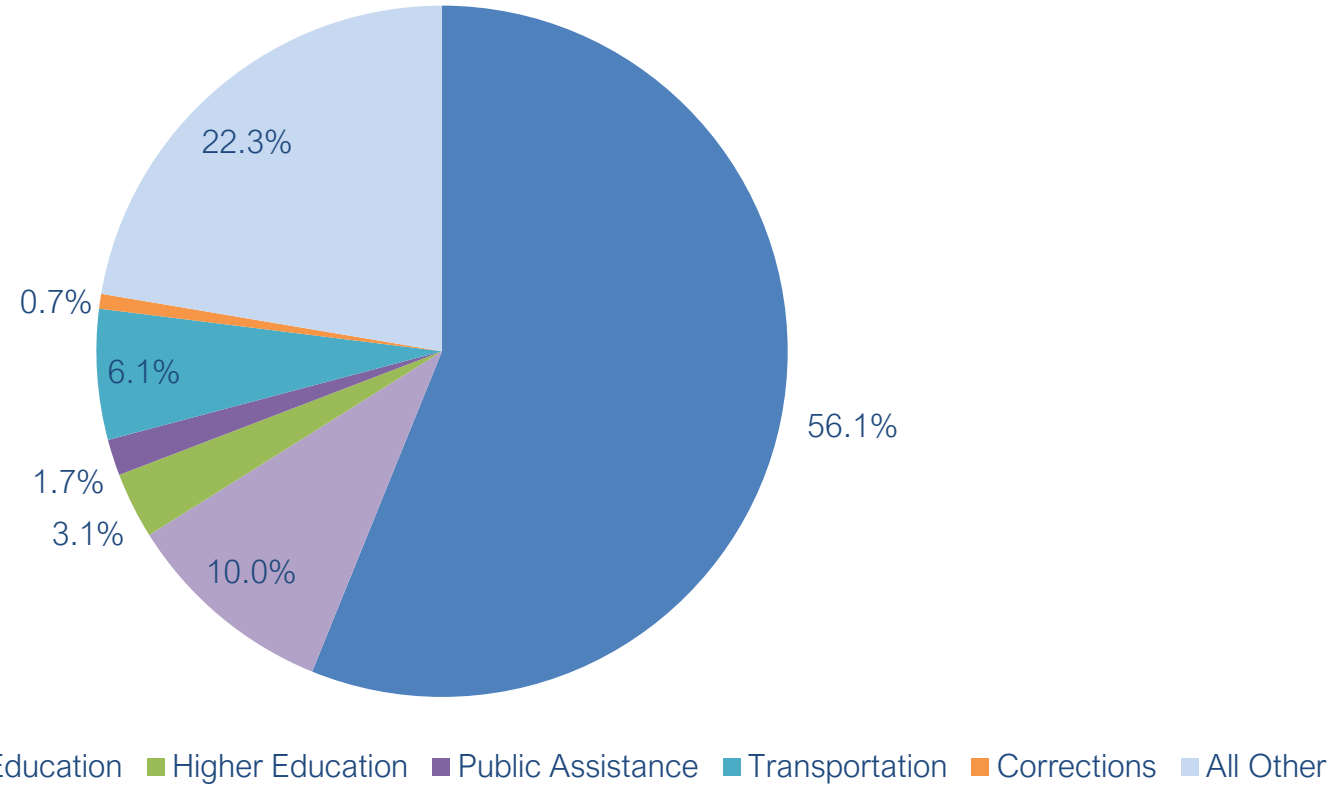
(1997-2010: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201106.pdf; 2011-2018: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201905.pdf and 2019-2022: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202305_1.pdf)

Medicaid Enrollment Versus Spending by Eligibility Category, 2023



Source: Federal Benefit Payments by Eligibility Category and Average Monthly Enrollment by Eligibility Category from Congressional Budget Office July 2024 Medicaid Baseline

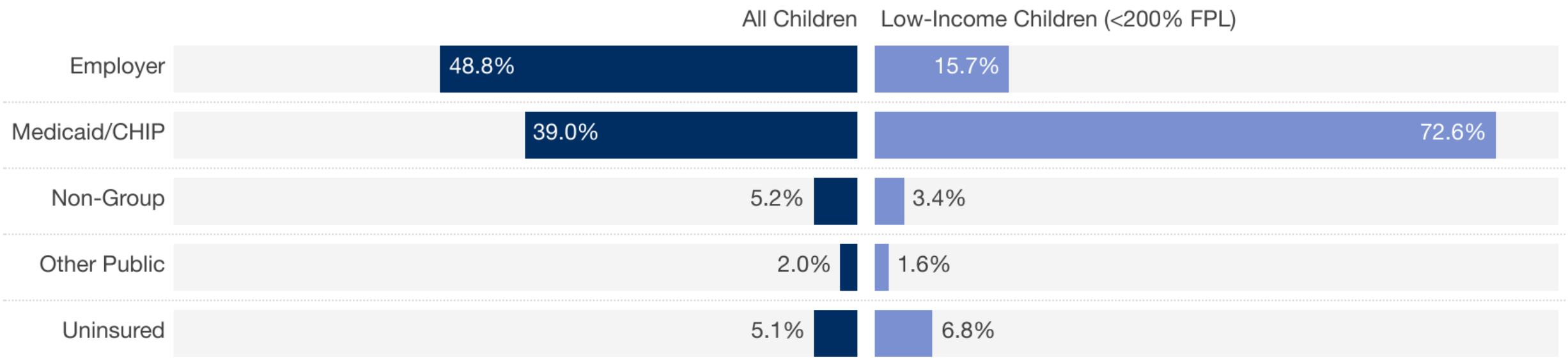
Medicaid Is Largest Source of Federal Funds for States



Georgetown University
McCourt School of Public Policy
CENTER FOR CHILDREN AND FAMILIES

Source: CCF analysis of National Association of State Budget Officers (NASBO) data for state fiscal year 2024 (estimated).

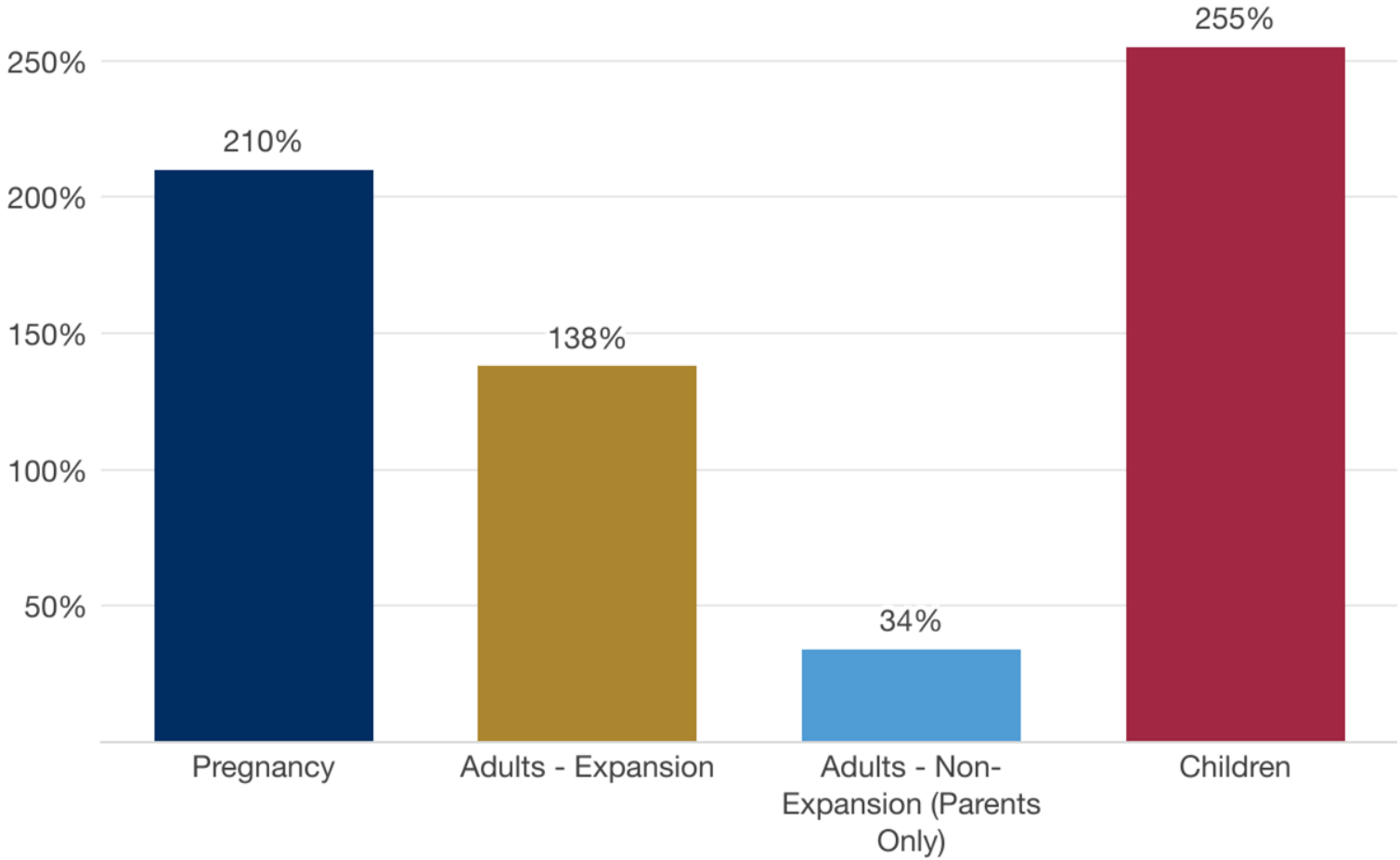
Sources of Children's Coverage, 2022



Georgetown University McCourt School of Public Policy CENTER FOR CHILDREN AND FAMILIES

Source: KFF, "Health Insurance Coverage of Children 0-18" and "Health Insurance Coverage of Low Income Children 0-18 (under 200% FPL)."

Median Income Eligibility Limit, June 2024



Source: Brooks, T. et al., "A Look at Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies During the Unwinding of Continuous Enrollment and Beyond" (KFF and Georgetown University Center for Children and Families: June 2024).

Benefits

Mandatory

Examples:

- Inpatient/outpatient hospital
- Physician and certified pediatric nurse practitioner services
- Family planning services and supplies

Optional

Examples:

- Prescription drugs
- Clinic services
- Dental services (adults)
- Occupational and physical therapy

Children's Medicaid Benefit: EPSDT

Identify problem **early**, starting at birth

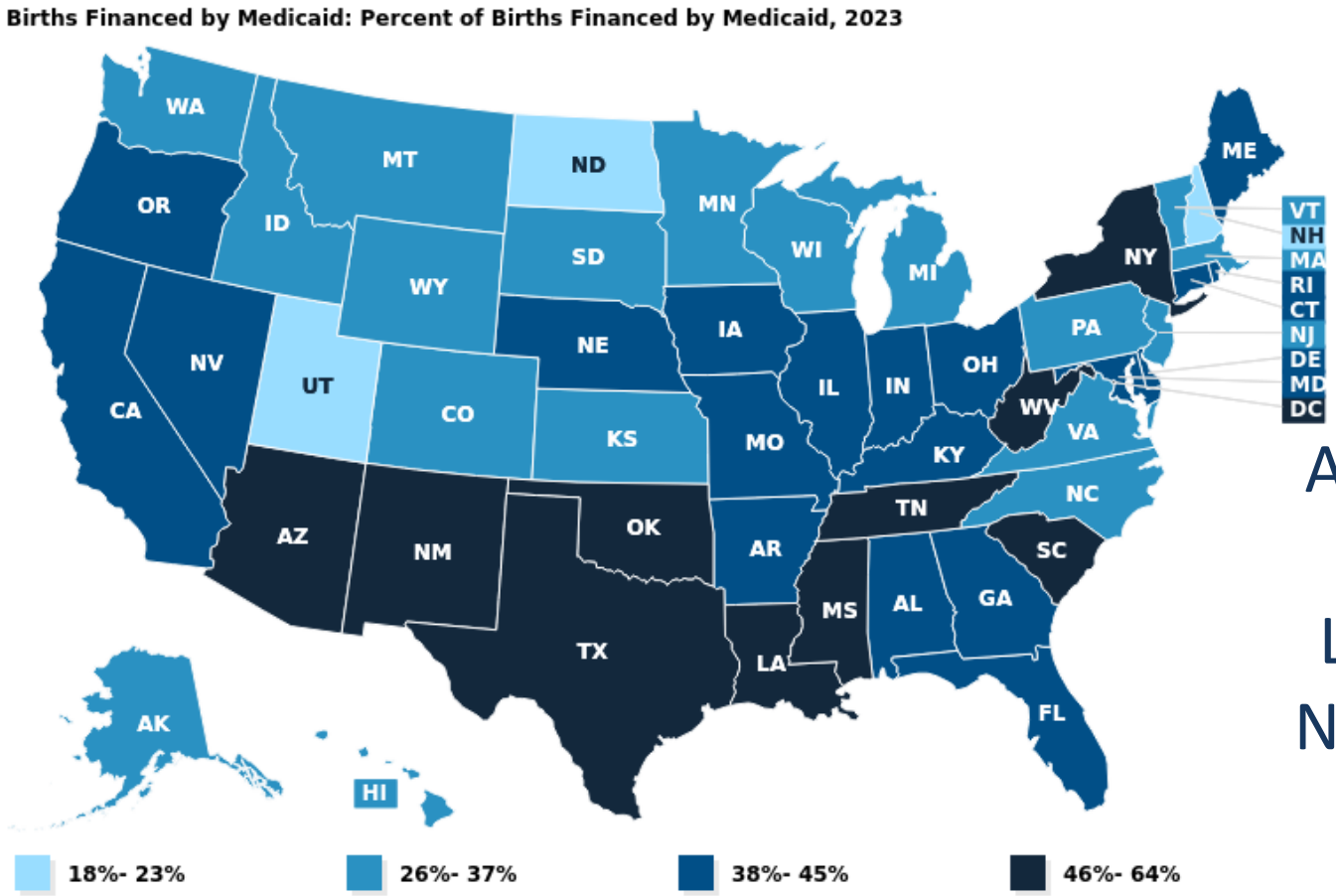
Check children's health and development at **periodic** intervals

Provide appropriate **screenings** to detect problems

Perform **diagnostic** tests to identify risks

Provide **treatment** for any problems found

Percentage of Births Paid by Medicaid by State



SOURCE: KFF's State Health Facts.

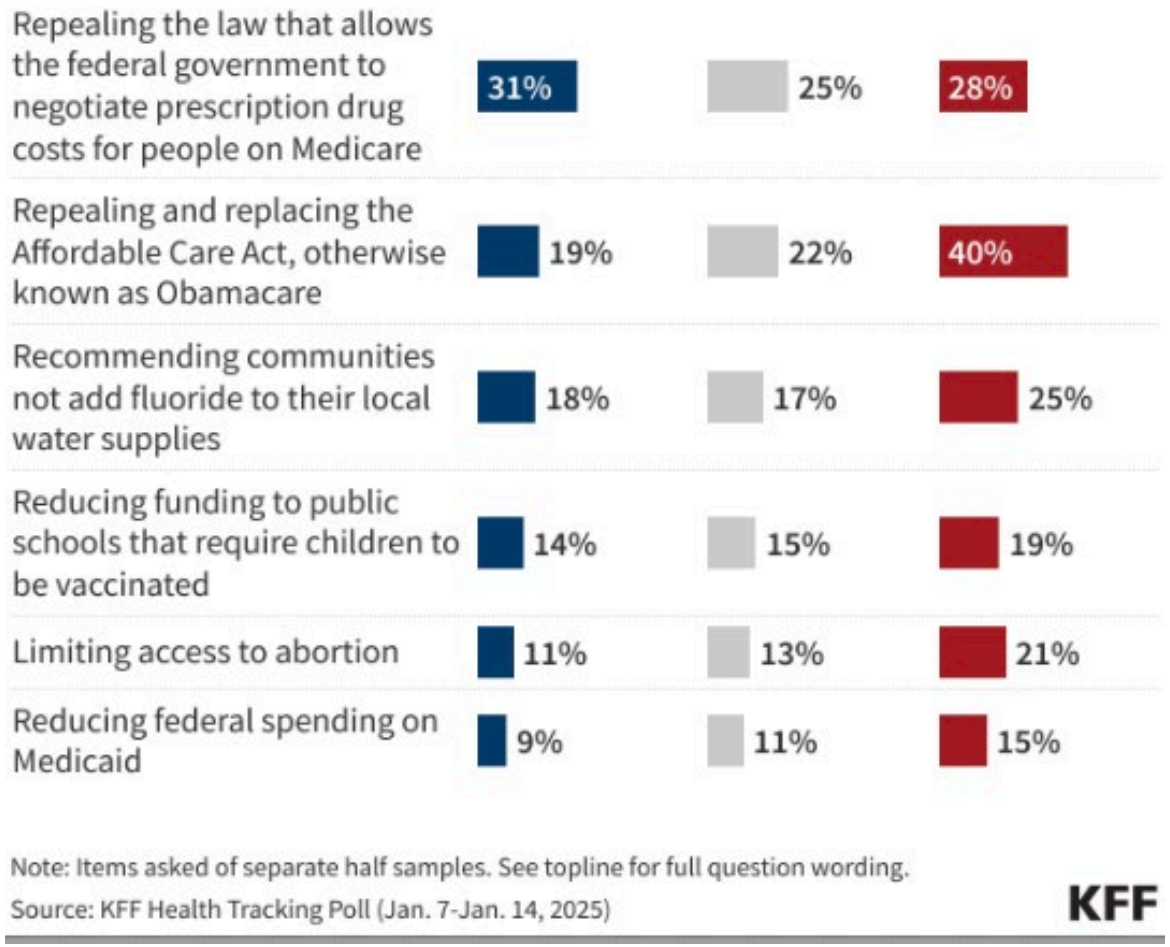
U.S. = 41%

States with 43% or more births financed by Medicaid:

Alabama, Arizona, Delaware, District of Columbia, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, New York, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, West Virginia

Source: Births Financed by Medicaid. (n.d.). *KFF*. Retrieved February 28, 2025, from https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/

Voters Do Not Want Medicaid Cut



Resources Available from CCF:

- All things Medicaid financing, regulation and legislation - https://ccf.georgetown.edu/topic/medicaid-proposals/
- AAP & CCF 50-State Snapshots - https://ccf.georgetown.edu/2025/02/25/medicaid-aap-ccf-50-state-snapshots/
- Medicaid Enrollment by Congressional District - https://ccf.georgetown.edu/2024/12/04/medicaid-chip-coverage-by-congressional-district-2023/
- Medicaid Enrollment by County (rural data) - https://ccf.georgetown.edu/2025/01/14/medicaid-coverage-in-metro-and-small-town-rural-counties-2023/
- Medicaid Enrollment by School District - https://ccf.georgetown.edu/2023/03/21/medicaid-chip-coverage-by-school-districts-2018-2022/
- State Data Hub - https://kidshealthcarereport.ccf.georgetown.edu/
- Say Ahhh! - A Health Policy Blog https://ccf.georgetown.edu/format/blog-posts/

Mass General Brigham
Mass General for Children

Medicaid 101

James M. Perrin, MD, FAAP

Professor of Pediatrics Emeritus, Harvard Medical School and MassGeneral for Children

Chair, AAP Committee on Child Health Financing

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Mass General Brigham
Mass General for Children

Federal Medicaid Assistance Percentage (FMAP)

- Unlike Medicare, Medicaid has joint state and federal funding
- Federal match rate depends mainly on state low-income levels – ie, states with larger low-income populations receive higher Federal match
- Match varies from 50-77%
- Certain populations receive enhanced match: esp., ACA adult expansion groups (90%)
- Match is with state Medicaid expenditures; states have strategies to increase their expenditures beyond straight budget allocations

Mass General Brigham
Mass General for Children

Major Medicaid Benefits and Strengths

Entitlement: States must enroll all eligible applicants

- *No waiting periods*
- *No copays*

EPSDT assures a national benefit base

- Statute (1967) requires states to provide any "medically necessary" service that a child needs even if the state does not include that service in its plan
- Supports regular screening (states typically use Bright Futures as guide)
- No national standard for medical necessity
- ***Recent CMS letter (9/24) and NEJM perspective (4/25) re EPSDT***

CHIP does not require similar benefits

Key Medicaid Characteristics

- Medicaid and CHIP insure almost half of all US children and youth
- Joint Federal-state funding allows states substantial program responsibility
  - Wide variation even among neighboring states in eligibility, enrollment, quality, payment levels
- Main direct payment levels vary widely as well, but on average, Medicaid payments are about 2/3 of equivalent Medicare payments and about ½ of commercial payments

Health Equity through Medicaid/CHIP

- **Immediate Benefits:**
  - Timely access to care
  - Reductions in neonatal and child mortality
  - Reductions in emergency care utilization and avoidable hospitalizations

- **Long-term Benefits:**
  - Less chronic disease in adulthood
  - Lower rate of teenage pregnancy
  - Higher rates of high school graduation
  - Increased college enrollment
  - Higher future wages

Health Equity Concerns

- Generally, states with higher population rates of minoritized children/youth have less generous Medicaid programs; spend less on their Medicaid population
- State variations affect access to appropriate care and networks
- Lower payment rates for low-income groups

Kusma JD, Boudreau AA, Perrin JM. How child health financing and payment mitigate and perpetuate structural racism. Academic Pediatrics, 2024

Mass General Brigham
Mass General for Children

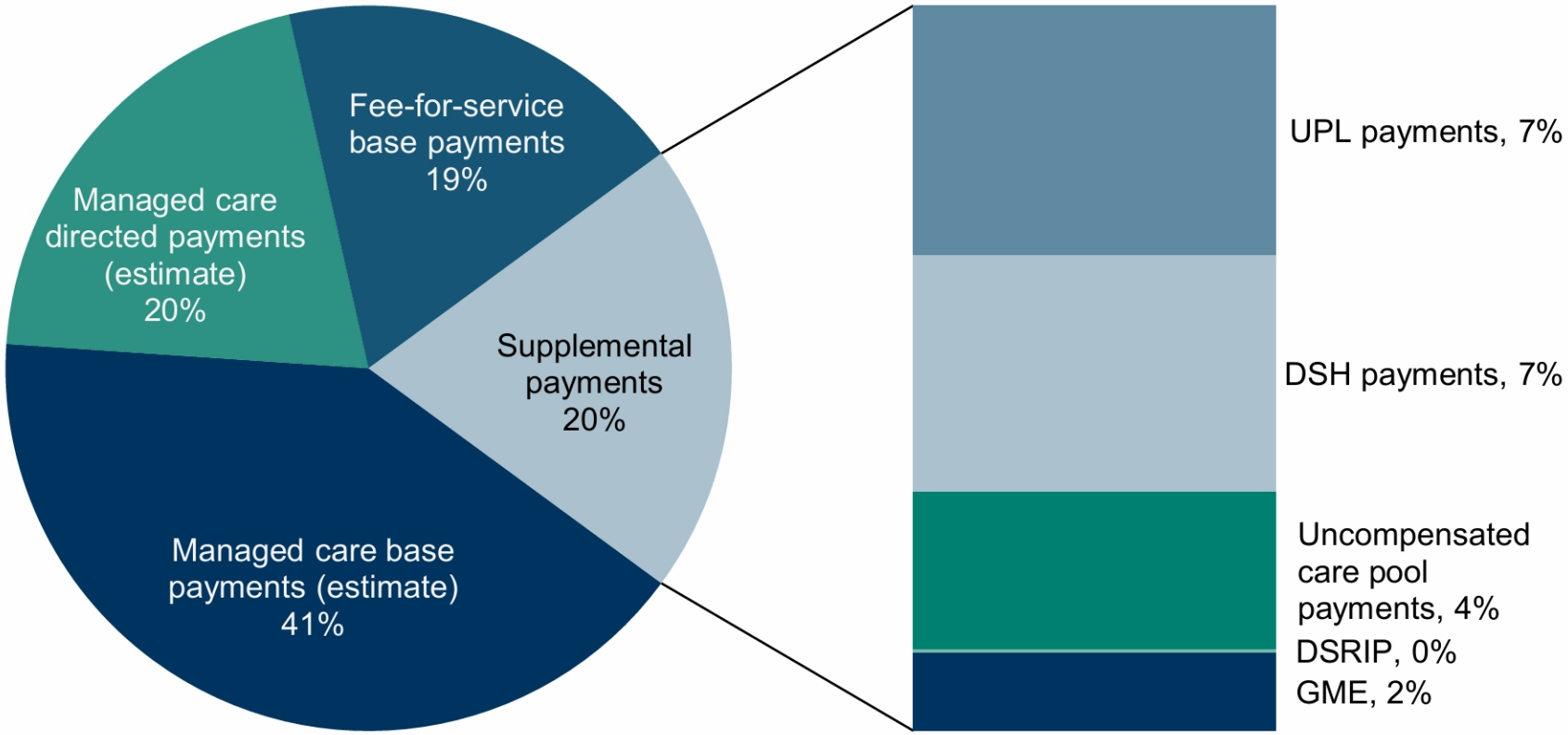
Medicaid Payments – Direct Care and Subsidies

- Base payments – usual fees or global payments for services provided – often via managed care
- Medicaid provides additional subsidies to hospitals, nursing homes, and provider groups – beyond base fee payments
- Disproportionate share; MCO directed payments; upper payment limit adjustments; others
- FY 2022, about 40% of Medicaid payments to hospitals in additional subsidies

How is your institution/department financed?

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Supplemental Payments are a Large Share of Medicaid Hospital Spending, FY 2022



Notes: FY is fiscal year. DSH is disproportionate share hospital. UPL is upper payment limit. DSRIP is delivery system reform incentive payment. GME is graduate medical education. DSRIP and uncompensated care pool payments must be authorized under Section 1115 waivers. Managed care payments to hospitals are estimated based on total managed care spending reported by states. DSRIP spending is a non-zero amount that rounds to 0%.
Sources: MACPAC, 2024, analysis of CMS-64 net expenditure data as of May 30, 2023 and CMS-64 Schedule C waiver report data as of September 29, 2023, and directed payment arrangements approved through February 1, 2023.

Mass General Brigham
Mass General for Children

Managed Care Organizations and Medicaid

- MCOs currently cover 85% of children and youth in Medicaid/CHIP
  - Five companies manage 50% of MCOs
- MCOs contract with states to administer Medicaid/CHIP; must meet state CMS requirements
- Claims denials have grown dramatically in past few years (highly relevant to children and youth)
- Opportunities: Contract reviews, **monitoring**, transparency; addressing denials

Prior Authorizations and Denials

- States or MCOs may require prior authorization – (EPSDT letter indicates limits on time to determination)
- Many MCOs deny services, claiming they are not medically necessary but also often that they are not covered (EPSDT requires coverage)
  - May use algorithms or determination methods based on adult population – not recognizing that children/youth have different benefits
  - “Medical necessity” definitions unclear
- Substantial legal work re contracts and statutory requirements (Disability Law Centers in most states; National Health Law Program)

Additional State Options and Activities

- Enhanced payment
  - For primary care vs all pediatric care
  - Federal 80% rule requirement
  - States that have made progress: NM, HI, GA, NJ, RI, CA
- Continuous Enrollment
  - Required to age 1; several states to age 6
- Health-related Social Needs *(changes in new administration)*
- 1115 Waivers

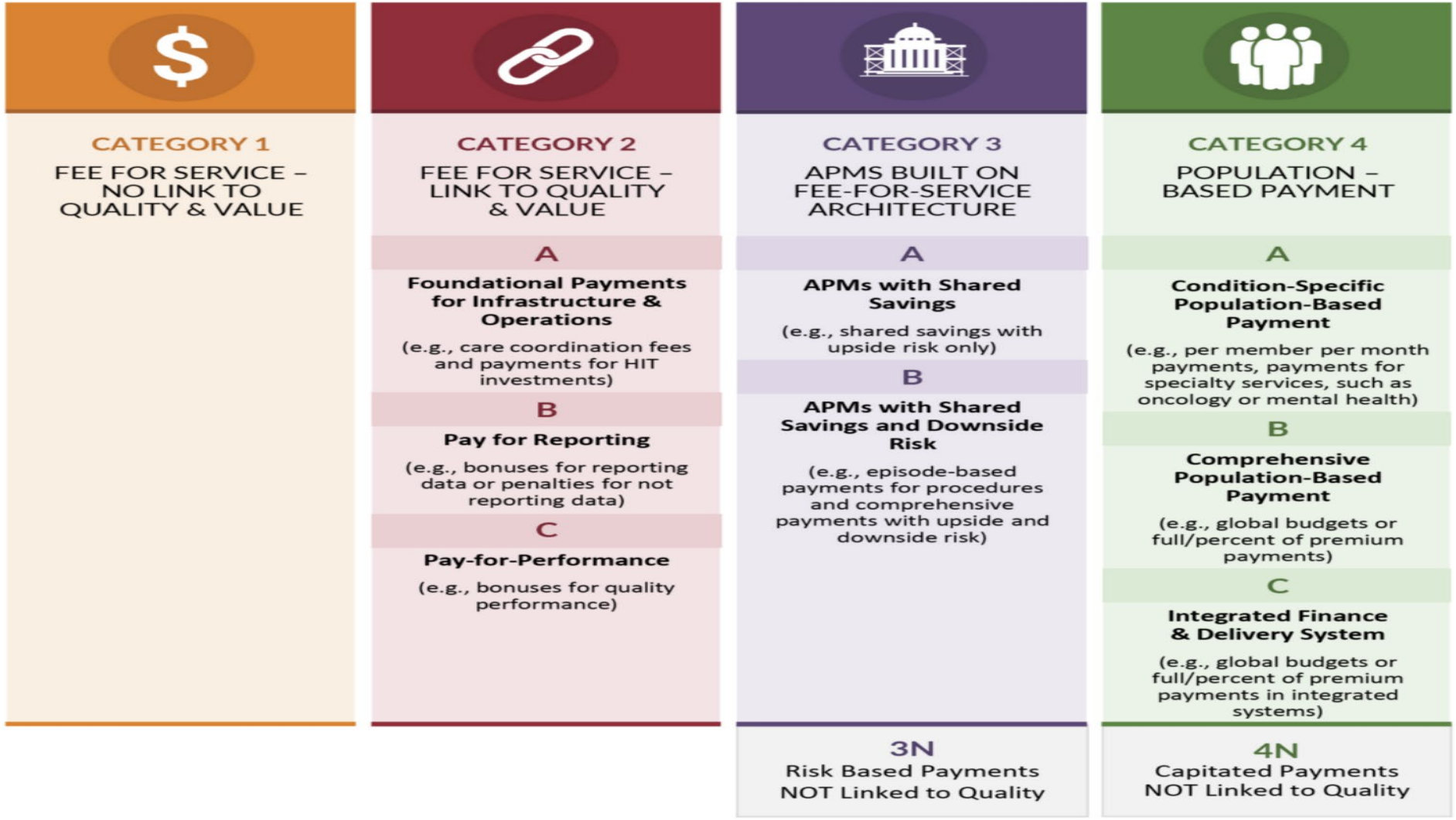
2024 Changes in Medicaid/CHIP

- CMS rules on access and managed care
  - Call for more transparency in several systems, including managed care and home/community-based services
  - Affirmation of other aspects of service access
  - 80% rule (primary care, mental/behavioral health, maternity)
- Efforts at continuous eligibility (CE)
  - State mandate for postpartum women for one year
  - Multiple states have used waivers to achieve up to 6 year CE and every two years after

Financing and Payment Reform

- Increase investment in children's health care and raise Medicaid payments
- Decrease state variation in Medicaid
- Value-based payment – *most pediatric experimentation in public sector, not commercial*
  - Cost savings few in pediatrics and cannot drive value
  - Change payment incentives

Payment Strategies and Value



Value in Pediatric Care

- Value = outcomes/cost
- Alternative payment methods – much work thru CMMI but essentially all older populations with clear opportunities for cost-savings
- Cost savings are few in pediatrics; returns are usually long-term and often in other sectors
- Alternative payment methods – *for younger populations*
  - Right measures – population health
  - Long-term financial accountability
  - Incentivize teams, prevention/promotion, equity, community engagement
  - Social risk adjustment

AAP: The Unique Value Proposition of Pediatric Health Care, *Pediatrics, January 2023*

What Value Incentives should Payers Use?

- Moving to value not volume*
  - Value in pediatric care emphasizes prevention and outcomes, not savings
  - Few short-term (18-36 month) opportunities for cost-savings
    - ***Lowering cost should not drive VBP or APM for children and youth***
- Pediatric value outcomes
  - Parent workforce participation
  - School readiness, special education need, high school graduation
  - Anxiety, depression, SUDs, STDs
  - Long-term savings – in multiple sectors

Summary

- Medicaid and CHIP have a long and complex history
  - Growth in the programs have led to 50% of all US children insured by public insurance – although the unwinding led to >4million losing coverage
- Together, they provide extraordinary support for the health care of US children and youth
- Major state-based inequities in Medicaid and CHIP call for reform to strengthen a critical program for the health of America's children

- Keep yourself muted unless speaking
- Raise hand or post questions in chat

Next Session

Federal Threats to Medicaid

Wednesday, May 21st 1:00–2:00 PM EST

Speaker: Edwin Park

Center for Children and Families

Research Professor at the Georgetown University McCourt School of Public Policy

REGISTER NOW at AMSPDC.org OR HERE

AMSPDC PWI - Share Your Stories

We’re collecting stories to put a human face on what’s happening to child health. Stories bring urgency, empathy, and depth to complex issues—and can meaningfully inform advocacy, guide leadership, and drive change.